

1 Wednesday, 18 January 2012

2 (9.30 am)

3 DR JACK GILLON (continued)

4 Questions by MR GARDINER

5 THE CHAIRMAN: Good morning, Dr Gillon.

6 Mr Gardiner?

7 MR GARDINER: Thank you, sir.

8 Good morning, Dr Gillon. Dr Gillon, you have  
9 previously appeared and given evidence to the Inquiry in  
10 connection with statistics and B5, which was the topic  
11 about information to patients in the context of HIV, and  
12 that was on the 24 June last year. At that time you  
13 talked about HIV look-back in Scotland. That's right,  
14 isn't it?

15 A. That's correct, yes.

16 Q. Today we are interested in Hepatitis C look-back and  
17 I think it would just be helpful if we could clarify  
18 a couple of terms with you because we get the impression  
19 that the word "look-back" is used to cover many  
20 different exercises. Is that correct?

21 A. That's correct and the big issue is really something  
22 that is called "targeted look-back", which starts from  
23 using a screening test on donors and finding a donor who  
24 is carrying the relevant infection and that then  
25 triggers the targeted look-back to the previous

1           donations in an attempt to find the recipients.

2    Q.   Yes.

3    A.   You can do it the other way round, which we coined the  
4           term "reverse look-back" for.  The North Americans refer  
5           to that as "trace-back", where a patient presents to  
6           a clinician, very often it would be a hepatologist, with  
7           signs of liver disease, discovered to have Hepatitis C  
8           in this instance, and the clinician, if they remember to  
9           do so, which I regret to say isn't always the case,  
10          thinks to inform the blood bank that they have such  
11          a patient who has a history of transfusion.

12                 We would then seek, first of all, details of that  
13                 transfusion episode, all of the units that were  
14                 transfused; we would identify the donors and carry out  
15                 investigations to see if we could find a donor who had  
16                 transmitted infection.

17                 That's what we call a "reverse look-back", which is  
18                 something that we had done long before there was  
19                 a screening test.  So you will see that that's not  
20                 dependent on a screening test being available or indeed  
21                 any kind of test.

22                 So prior to 1990, we would have been told that there  
23                 was a patient with non-A non-B Hepatitis and we would  
24                 have identified the donors, and what we would have to do  
25                 in those days, prior to the test, was haul those donors

1 in, tell them there had been a problem with a patient  
2 who had received their blood and that we needed to look  
3 into that, and obviously that was (a) onerous, because  
4 you had to get all of the donors back, and sometimes it  
5 would be hundreds but more often it would be a smaller  
6 number. You would take a full history, see if you could  
7 identify a risk factor, do liver function tests and the  
8 end result of that was often quite inconclusive.

9 So often those donors were left in limbo and we were  
10 left in limbo to some extent as well. So when a test  
11 came along, there was a very obvious area to go for to  
12 try and sort these out faster and with better resolution  
13 for the donors and that, I think, was what Dr Cash was  
14 referring to when he wrote to Dr Gunson asking if we  
15 could just get ahead and do that while discussing the  
16 targeted look-back, the big thing -- the numerically big  
17 thing was targeted look-back.

18 Q. You were here for Professor Cash's evidence yesterday?

19 A. I was, yes.

20 Q. And you think that the early correspondence, talking  
21 about around about May 1990, between Professor Cash and  
22 Dr Gunson -- what they were talking about was reverse or  
23 trace look-back?

24 A. I think they were dealing with that as a separate issue  
25 and could this be sort of fast tracked and just done.

1 I'm not sure it was particularly well resolved but  
2 I suspect that those of us on the ground were doing it  
3 on a more informal basis, probably at the same time as  
4 that correspondence was going on, because obviously if  
5 you had such a case and you knew that Eddie Follett  
6 could test all those donor samples, you would do that.

7 Q. Yes.

8 A. I can't remember if there was any specific instances but  
9 it would have been crazy not to.

10 Q. Just to show an example of that correspondence, could we  
11 have a look at [\[SNB0045010\]](#)? It's a letter of  
12 21 May 1990 from Dr Gunson to Professor Cash. The  
13 heading is "HIV look-back", and you say:

14 "I'm not sure that our RTCs will have access to  
15 anti-HCV test material."

16 So they are clearly thinking about Hepatitis C as  
17 well:

18 "I think that it may be worthwhile to carry out the  
19 usual investigations when a transfusion-associated NANBH  
20 case is reported and to ensure that a library sample of  
21 serum is retained from each donor seen."

22 What do you think is being discussed there exactly?

23 A. I think that is the answer to Professor Cash's letter  
24 raising this subject, and I would take that as implying  
25 that if the test was available we should just get on

1           and do it in that situation.

2   THE CHAIRMAN: Mr Gardiner, from the context I think that

3           "HIV" should be "HCV". I think that's right.

4   A. Yes.

5   MR GARDINER: So is that a discussion of reverse or trace

6           look-back?

7   A. That is only about reverse look-back.

8   Q. So that is, as you explain, distinct from targeted

9           look-back, when you are going back to the previous

10          donations and seeing what has been done with those

11          donations, who has received blood components made from

12          those donations. Is that right?

13   A. Yes, and that could only happen once routine screening

14          across the donor population was introduced.

15   Q. Yes, there is a kind of look-back -- maybe I'm using the

16          wrong word but this is a process whereby you would go

17          back to other donations and make sure that, if they

18          hadn't been used, they weren't going to be used,

19          quarantined if you like?

20   A. Yes, that would be part of the targeted look-back. So

21          that if there were -- for instance, in a plasma donor,

22          there may have been material from the previous month

23          still in stock -- FFP or whatever. One of the first

24          things you would do when you identify a seropositive

25          donor -- and again this is predicated on routine

1 screening because you are not going to know this  
2 otherwise -- the first thing you do is quarantine  
3 anything that might still be transfusable, and if that's  
4 out of blood banks and peripheral hospitals, you would  
5 tell them and they would get on with that.

6 Q. Would that not be done if you are not doing targeted  
7 look-back, if you like?

8 A. No, it wouldn't be relevant there because your starting  
9 point is the patient and quite often the transfusion  
10 would have been several years earlier, so it would be  
11 a clinician, say, in 1989 saying, "We have got a non-A  
12 non-B", the person was transfused in 1986, say. So you  
13 are trying to identify the donors of all those donations  
14 that patient got in 1986.

15 Again, one of the first things you would do having  
16 identified those people is look at the donor record, and  
17 if one of them gave and there was still material in  
18 stock, you would take that out of circulation. So you  
19 would make whatever we had safe in that sense.

20 Q. Thank you.

21 THE CHAIRMAN: Mr Gunson refers here to "the usual  
22 investigations", which would appear to distinguish what  
23 he is talking about from the setting up of a new system  
24 in some way.

25 A. Yes, and that's what I described. You would have to

1 look at the donors individually and decide whether you  
2 could identify a culprit, if you like. And I suspect  
3 that different transfusion services did slightly  
4 different things and even within Scotland we probably  
5 had variations on a theme, but broadly speaking we did  
6 the same thing.

7 MR GARDINER: Yes. I think we can put that away now, thank  
8 you.

9 You were asked to provide a statement for this topic  
10 and if we could have a look at that. That's  
11 [\[PEN0180410\]](#). You repeat the questions that you were  
12 asked.

13 A. Yes.

14 Q. So the first question was:

15 "What was Dr Gillon's involvement in the look-back  
16 exercise."

17 Could you just tell us about that?

18 A. What I set out there is, broadly speaking, why it became  
19 my responsibility in Southeast Scotland to deal with  
20 look-back, and initially that was more or less because  
21 of HIV testing, which began very shortly after I was  
22 appointed, and where targeted look-back was agreed  
23 across the UK to be something that we would do right  
24 from the start of testing.

25 Of course, I had also -- as soon as I took up my

1 post -- inherited the files on one or two of the  
2 historical look-backs which -- indeed, some of them were  
3 HIV-related, where clinicians had identified a case and  
4 we had done the reverse look-back thing. But up until  
5 that point there was no real targeted look-back going  
6 on.

7 But once HIV was agreed to be an appropriate case  
8 for look-back, we did it across the country routinely  
9 and I did the Southeast Scotland bit of that. So when  
10 I was asked in 1990 to draw up some documents about  
11 counselling and management of donors and so on by  
12 Professor Cash, as we heard yesterday, one of the things  
13 we addressed in that working party was indeed look-back  
14 and we came to, as I recall, a unanimous decision that  
15 we should do that and included it in that report, which  
16 went to the directors.

17 Q. Yes. Let's have look at the letter that you refer to at  
18 the bottom of the page there, which is [\[SNB0055023\]](#).  
19 This is a letter of 21 June asking you, because it is  
20 a high priority, to produce operational guidelines for  
21 BTS doctors in the context of counselling anti-HCV  
22 confirmed positive donors.

23 By this stage what experience had you had of that  
24 kind of thing?

25 A. Well, of course the numbers of donors found positive



1 with HIV wasn't huge but there were some regular donors  
2 among them. And right from the start -- in fact, when  
3 you introduce a new test, it's likely to be at the start  
4 that you are going to find these things that have  
5 accumulated over the previous, well, two or three years  
6 in the case of HIV, simply because you are dealing with  
7 regular donors who are by and large giving every six  
8 months or so. So within your first six months of  
9 testing, you are going to find a large proportion of the  
10 regular donors and you see that in the charts when we  
11 follow the figures, that you get a hump at the start.

12 So, yes, we had had to go through that process and  
13 identify patients who had been infected by prior  
14 donations and we had experience of doing that.

15 We hadn't had a standardised, national set of  
16 documentation for doing that but I'm absolutely sure we  
17 were all doing exactly the same thing.

18 Q. So you had been involved yourself in counselling in the  
19 context of HIV?

20 A. Yes, yes, I had -- it was shortly after I took up my  
21 post in 1985 in the run up to HIV testing, I had  
22 spent -- I can't remember if it was a week or two weeks  
23 at St Mary's in London with Dr Tony Pinching, who had  
24 the biggest cohort of HIV positive patients in the  
25 country, and visited the GUM clinic and discussed with

1 him and microbiologists and so on, and one of our  
2 doctors, the sessional medical doctor in the centre, Dr  
3 Jan Davidson, did the same thing, she went down to  
4 a counselling course they ran for HIV testing, and  
5 between us we dealt with the counselling of HIV positive  
6 donors.

7 So we had experience of the sort of issues that  
8 would crop up when you are dealing with the donor and  
9 indeed, in dealing with the patients who came through  
10 the look-back -- because by and large -- I guess I would  
11 have done all of that myself in the case of HIV because  
12 the numbers were small. So we had quite lot of  
13 experience there.

14 Q. Just before we move away from it, the last time you were  
15 here, you told us that from 1985, when HIV screening  
16 came in, SNBTS retained samples of blood which had been  
17 donated. That's right, isn't it?

18 A. Yes. The very first archive started in the southeast in  
19 the middle of 1984 and by, I think, early 1986, all of  
20 the Scottish centres were laying down a sample of every  
21 donation, which has continued to this day, and all of  
22 those samples are still there, except the ones that have  
23 all been used up in retrospective testing. But by and  
24 large they are all there, very many millions of samples.

25 PROFESSOR JAMES: "Laying down" sounds like the lessons you

1           must have had from the Scotch whisky industry.

2    A.   In the famous claret links of Edinburgh indeed as well,  
3           yes, it always pays off.

4    PROFESSOR JAMES:   Quite.   Sorry.

5    MR GARDINER:   But you had had experience of counselling in  
6           the HIV context and experience of HIV look-back; do you  
7           think that was why you were asked by Professor Cash to  
8           chair this group?

9    A.   I guess it must have been, yes.

10   Q.   And the other members -- what experience did they have  
11          of that kind of thing?

12   A.   If I remember correctly, it was George Galea,  
13          Bob Crawford and Jan Davidson.   Was that everyone?

14   Q.   Yes.

15   A.   Bob Crawford and George Galea were my exact  
16          counterparts.   Dr Crawford in the west, Dr Galea in  
17          Aberdeen at that stage in the early days, but by the  
18          time HIV came along, I think he was probably still in  
19          Aberdeen as donor consultant in Aberdeen at that stage.

20                Jan Davidson was the doctor I mentioned who had done  
21          HIV counselling training and had a lot of experience in  
22          dealing with donors in this situation.

23   Q.   Yes.   How did you set about that task?

24   A.   Well, I think we were given a pretty short deadline,  
25          so -- I can't remember.   I don't have any notes of those

1 meetings unfortunately but I would have guessed we met  
2 within a month or so.

3 Just before dealing with that, I think probably the  
4 other reason John Cash asked me to do that was from my  
5 background in gastroenterology and indeed, after taking  
6 up my post in BTS, I continued with an interest in  
7 gastroenterology with a weekly clinic. So I was still  
8 kind of plugged into what was going on there.

9 Q. Yes.

10 A. But we had to get this moving quickly. It was a small  
11 group. We would have met, I would guess, at least twice  
12 before we pulled together a draft, and it would have  
13 started with throwing around the ideas -- what comes up  
14 when you talk to donors? -- and that's probably where  
15 the question arose -- what about previous donations?

16 Q. Okay. So if we have a look at [\[SNB0045074\]](#), this is  
17 your letter to Professor Cash, 20 September 1990,  
18 sending the first draft of the document.

19 A. I see in the previous letter the deadline was something  
20 like 14 August and that was in the middle of June.  
21 I don't think that was very realistic and indeed, we  
22 didn't meet that deadline. So September is not bad,  
23 I don't think.

24 Q. That's very quick. I think if we look at [\[SNB0053647\]](#),  
25 and if we could just go to 3656, we see at the bottom of

1           the page the date is 12 September 1990. So that looks  
2           like the draft that was sent with the letter that we  
3           have just seen.

4    A. Yes, there obviously was an earlier draft because in the  
5           previous letter I see that I had sent it to  
6           Harold Gunson by that time. So we must have regarded  
7           this as a fairly final sort of draft.

8    Q. Okay.

9    A. More in optimism than expectation, probably.

10   Q. Right, okay. Could we just go back to the first page,  
11       3647? There we see that it's the report for the  
12       National Medical Director. So you considered that it  
13       was Professor Cash that was asking you to do this?

14   A. Yes -- well, yes, he had written to me as an individual.

15   Q. Yes.

16   A. Yes.

17   Q. So it wasn't the Medical and Scientific Committee that  
18       was asking you to do this?

19   A. I would probably have known that they would have debated  
20       this, I suspect, although I wasn't a member of that  
21       committee.

22   Q. Yes. How much was generally known about the discussions  
23       of the MSC -- by yourself, for example?

24   A. I think Brian McClelland sent all of us, as Consultants  
25       in southeast, a copy of the minutes of all the meetings

1           that weren't in some way regarded as confidential, as  
2           hyperconfidential.  So the directors' meeting, the --  
3           I don't think we saw the coordinating group meetings but  
4           he would have sent us the directors' meetings minutes  
5           and the minutes of the MSC.  So yes, we probably had  
6           seen that.

7    Q.  Did you generally read the minutes of the MSC that were  
8           sent?

9    A.  Oh, yes.

10   Q.  So you felt that you were up-to-date with the  
11           discussions at the MSC meetings?

12   A.  Yes, I think so, yes.

13   Q.  Okay.  Could we just go to the next page?  Who drafted  
14           this document?

15   A.  I'm pretty sure I drafted it.

16   Q.  Yes.

17   A.  In fact I think I initialed it at the bottom.

18   Q.  Right.  So you would have drafted it and circulated it  
19           to the other members of the working party?

20   A.  Yes.

21   Q.  Yes.  Would they have had an opportunity to suggest  
22           revisals?

23   A.  Yes, certainty.

24   Q.  Do you remember if that's what happened?

25   A.  I'm sure that's what happened.  I can't remember how

1 much revision went on in that short time period but by  
2 and large we were in broad agreement.

3 Q. Just to understand, what was the knowledge that you were  
4 drawing on to produce this? Obviously you had your own  
5 experience, all of your own experience, but did you look  
6 further afield to other research?

7 A. Yes, there was already a fairly extensive published body  
8 of work on HIV look-back, and we knew the difficulties  
9 involved. I remember that Herb Peterkin's group in  
10 San Francisco published about their efforts and they, of  
11 course, had a massive problem with HIV and they tried  
12 very hard to find the recipients of previous donations  
13 with very limited success. Even -- they called it an  
14 "extended look-back". They went to great lengths to try  
15 and find people, through public health departments and  
16 just turning over every stone they could to find people.  
17 And the outcome was still disappointing in terms of the  
18 number of people you could identify compared with the  
19 amount of effort they had put in. We knew that. We  
20 knew that it wasn't an easy process. We knew from our  
21 own experience it was going to be difficult.

22 Q. And in terms of the other things that you were  
23 considering, which was counselling and so on, again,  
24 what did you have reference to to help you draft the  
25 document?

1 A. Well, we already, I think, were starting to get a feel  
2 for how the testing would turn out in terms of numbers.  
3 And at that time in the middle of 1990, it was all based  
4 on first generation testing, which had of course been  
5 routinely introduced in several countries by that time.  
6 I think by then probably Eddie Follett and Brian Dow had  
7 had first generation kits to look at and had looked at  
8 some retrospective samples and probably done some donor  
9 samples as well. I can't remember the exact dates of  
10 that but by then we knew that if we were going to be  
11 doing this on the basis of a first generation test, the  
12 numbers were daunting.

13           Initially it was looking something like  
14 0.5/0.6 per cent in Scottish donors who would come up  
15 positive in the first generation test, and we translated  
16 that into the sort of numbers that that would provide,  
17 which would be around ten a day in Scotland. We used to  
18 work on the assumption that we took about 1,000  
19 donations a day on weekdays. And we were looking at  
20 around ten a day across Scotland, which was pretty  
21 substantial and we knew that to do that -- to do  
22 a look-back on those numbers, we would need extra  
23 resource.

24           So that was one of the reasons why I think we felt  
25 we should flag it up early saying, "In principle, we



1 think this needs to be done". I don't think we put  
2 anything about the need for resources in this particular  
3 document. I don't think that would have been  
4 appropriate.

5 Q. So at this time, September 1990, you were proceeding on  
6 the basis that any targeted look-back would involve the  
7 first generation test which was giving you these really  
8 quite high numbers?

9 A. Yes, that's right.

10 Q. Yes, okay. And just to observe, Dr Gillon, that  
11 ultimately, when look-back was introduced in 1995, a lot  
12 of what's in this document here was actually used. Is  
13 that right?

14 A. Yes, yes, it was the basis for the UK documentation.

15 Q. Yes. Could you indicate which bits were ultimately  
16 used? We are looking at the introduction at the moment.  
17 I think if we go to 3651, this is the section which  
18 deals with background information for SNBTS medical  
19 officers counselling anti-HCV-positive donors. Was this  
20 section used in the final look-back documentation?

21 A. I think the final documentation looked pretty like this.  
22 Thinking back to the letter that came from the chief  
23 medical officer. But of course, that was four or five  
24 years later. The figures would have been updated, there  
25 was a little bit more known about natural history and so

1 on, and things like sexual transmission. So it was  
2 certainly completely revised at that stage and that was  
3 done by the working party, which was set up in 1995.

4 Q. Okay, we will come to look at that. What were you doing  
5 in this particular section of the document? What was  
6 the purpose?

7 A. This was very much aimed at the doctors who would have  
8 to sit down with a donor and say, "We have got this  
9 blood test result and here is what it means." It was  
10 specifically about educating the donor doctors.

11 Q. About the nature of the disease?

12 A. The nature of the disease, what it would mean for an  
13 individual, what the natural history was, so far as we  
14 knew at that stage, and what would need to happen to  
15 that individual beyond that.

16 Q. What knowledge did you draw on to draft this particular  
17 bit of the document? Did you have reference to research  
18 papers?

19 A. Yes, and, of course, we all followed avidly the research  
20 output from across the world on non-A non-B Hepatitis.  
21 So, I mean, it was a big issue from the time -- well,  
22 before I came into blood transfusion, but it was a very  
23 hot issue when I came in and was part of the reason why  
24 I was sent off to the United States for three months  
25 before I took up my post, to look at HIV and non-A non-B

1 specifically and talk to the experts.

2 So we had followed that story and we had our own  
3 experience. We had, as we heard earlier, a lot of  
4 research effort going into that in both Edinburgh and  
5 Glasgow, and of course at conferences that we all  
6 attended year in, year out. It was a big topic.

7 Q. Could you remind us about your visit to America for that  
8 three-month period?

9 A. Yes, basically I spent it in Kansas City where there was  
10 a blood centre which was modelled -- well, not modelled  
11 but coincidentally, I suppose, along the lines of what  
12 we had in Scotland and about the same size as the  
13 Edinburgh centre in fact, with a clinician -- a director  
14 who was a clinician -- actually a haemophilia doctor --  
15 who was very interested in keeping up clinical links  
16 between blood transfusion and the clinical  
17 hospital-based transfusion practice.

18 So that was partly to educate me in the sort of  
19 haematological aspects of blood transfusion, which I had  
20 only very limited knowledge of as a gastroenterologist,  
21 but for the last month I travelled extensively, mainly  
22 in the eastern seaboard, Washington DC, and other points  
23 east, including the Centre for Disease Control in  
24 Atlanta, where there was a lot of research going on into  
25 non-A non-B Hepatitis, and in the course of that I met

1 with people like Harvey Alter, I suppose the best known  
2 expert in this area.

3 Q. Yes. Was there anything that you felt that you learned  
4 during that period that you applied to the composition  
5 of this document?

6 A. Not particularly. I think -- when I was there was  
7 almost exactly when they introduced HIV testing and  
8 there was no controversy about doing HIV look-back,  
9 which I saw first hand in the States and reported back  
10 to John Cash, and there was no controversy in this  
11 country about introducing that either.

12 Q. Yes. I see. Okay. Could we have a look at 3654 in  
13 this document. This is headed "Informing the donor".  
14 Could you explain what this section is about?

15 A. This is an attempt to be very practical. These were the  
16 early days of SOPs and I noted yesterday that this quite  
17 rapidly became an SOP -- a standard operating procedure.  
18 In fact we were just trying to describe in very clear  
19 terms what needed to be done to make this work, so that  
20 doctors who didn't have much experience of this would be  
21 able to do it basically, with very little in the way of  
22 additional training.

23 Q. Yes. Was it envisaged that this section would be given  
24 to a patient as a way of explaining the situation or is  
25 it just a way of explaining to the counselling doctor

1 the information he should be imparting?

2 A. I think it's the latter entirely. We would never have  
3 handed this over to a donor or indeed a patient.

4 Q. Yes. Okay. Could we go to 3656? We see the second  
5 question in that page is "What about my previous  
6 donations?" It says:

7 "The recipients of previous donations will be traced  
8 and their consultants or GPs informed. We hope to  
9 obtain results of any tests carried out."

10 Just to be clear, what's that a reference to?

11 A. That is the reference to look-back, to targeted  
12 look-back. And I think partly in response to your  
13 previous question, this was partly angled towards  
14 something we would produce to give to the donor and did  
15 produce on the basis of this. I can't remember if it  
16 was in question and answer format and I think it may  
17 well have been but you can see that the tone changes  
18 after the second sentence to giving background for the  
19 doctor, really. Saying, "However, it may cause distress  
20 to the donor to discuss this in any detail," and  
21 a recommendation about how to approach it. So it was  
22 kind of looking both ways, I suppose.

23 Q. Yes. So we can just put that away now. Do you remember  
24 what happened next in terms of the evolution of this  
25 situation?

1 A. As I recall, John Cash wrote back saying that this was  
2 very well received and the Scottish directors had  
3 accepted it and that he would be discussing it with  
4 colleagues down south and sharing it with them, as we  
5 had already agreed and Harold Gunson had seen it, of  
6 course.

7 Q. I think before that it was discussed at an MSC meeting.

8 A. Yes, I think that's right. I think I attended to speak,  
9 yes.

10 Q. Could we just have a look at the minutes of that? It's  
11 [\[SNB0095513\]](#). If we just look on the first page there,  
12 6 November 1990, so this is just a few weeks after your  
13 letter, and Professor Cash, Dr Mitchell,  
14 Dr McClelland -- could we go to 5516? At the bottom of  
15 the page, paragraph 5(ii):

16 "Dr Gillon's report, which had been previously  
17 circulated, was discussed.

18 "Dr Mitchell pointed out that Dr Gunson was anxious  
19 to take this Gillon document to the national advisory  
20 committee in the near future."

21 Could we go over the page? We see, third paragraph  
22 down:

23 "The committee concluded that a draft standard  
24 operating procedure based on this report should be  
25 prepared by Dr Gillon by 30 November 1990 and submitted

1 to the members of the MSC for their consideration. This  
2 he agreed to do."

3 Do you think that you were at that meeting or have  
4 you got a memory of being there?

5 A. The one that these minutes --

6 Q. Yes?

7 A. -- refer to? Yes, I'm sure I was there.

8 Q. Do you have any memory of the discussions around about  
9 your document?

10 A. I can't say that I do.

11 Q. No. If we could go to 5519, we see point 10, "HCV  
12 look-back":

13 "After discussion it was agreed that Professor Cash  
14 should write to the chairman of the DOH advisory  
15 committee on the virus safety of blood asking that  
16 careful consideration be given to the matter of HCV  
17 look-back of recipients of previous donations."

18 "HCV look-back of recipients of previous donations",  
19 would you say that that's referring to targeted  
20 look-back?

21 A. Yes.

22 Q. Clearly, your draft has raised the question of what is  
23 the policy about targeted look-back?

24 A. Yes, and I can't remember any details about the  
25 discussion. I'm sure there would have been fairly

1           vigorous discussion about the potential difficulties and  
2           whether we would need new resources and so on, but  
3           I think the outcome is clear, that it was accepted that  
4           it should go forward.

5   Q.   Yes. Targeted look-back --

6   A.   Targeted look-back.

7   Q.   Yes. So your recollection is that at that stage the MSC  
8           had a positive attitude to targeted look-back, or was it  
9           stronger than that?

10  A.   I don't think it was stronger than positive. And there  
11           were some people who had reservations about it, I'm  
12           sure, particularly in the west, where the problem  
13           numerically was always going to be greater.

14  Q.   Yes. Can you remember if that was discussed?

15  A.   I'm sure it was, yes. I know that even Bob Crawford,  
16           who was on our group, was very leery of this because of  
17           the amount of work it would create, but the answer to  
18           that was clearly more resources.

19  Q.   So the concern was that necessarily there would have to  
20           be a lot of work to go ahead with targeted look-back and  
21           the question was: well, how is that going to be done,  
22           will there be resources to do it? Is that the  
23           situation?

24  A.   Yes, and I do remember that we discussed this when I was  
25           talking about ten a day in Scotland. We all knew that



1 if that was the outcome, that we were using first  
2 generation testing, we would nearly all have needed some  
3 at least secretarial help, if nothing else. So we  
4 weren't talking about a fortune but we knew we would  
5 need some help to do it.

6 Q. Would you just bear with me? (Pause)

7 Could we go back to 5517? We can see there that you  
8 are being asked to redraft the document that has been  
9 produced but you are not being asked to remove the  
10 question that we looked at, the question that raises the  
11 issue of targeted look-back?

12 A. No, not at that stage, certainly not.

13 Q. Could we go to [\[SNB0018779\]](#)? I'm right in thinking that  
14 your report went through several drafts?

15 A. Yes, it did. I can't remember how many. I think there  
16 was at least a fourth draft.

17 Q. If we look at 8789, we will see that at the bottom of  
18 the page, please, that this draft is dated  
19 23 November 1990. Can you remember what the difference  
20 between the one that was presented to the committee and  
21 this one was?

22 A. I am afraid I can't. I don't think I had been asked to  
23 change it at that stage. I see it says "TTD/39" at the  
24 bottom. Whether this was one that was to be discussed  
25 by that committee, the advisory committee on TTD,

1 I don't know. But I don't think I had been asked to  
2 amend it at that stage.

3 Q. So "TTD" you think might be a reference to the Advisory  
4 Committee on Transfusion Transmitted Infections?

5 A. I would think so, yes.

6 Q. Yes.

7 THE CHAIRMAN: "TTD/39", would that tend to indicate it was  
8 a reference number to their agenda?

9 A. I would think so, yes. It's the only thing I can think  
10 of. It's not a number that I would have used or  
11 recognised.

12 MR GARDINER: Okay, thank you. Could we go to 8788? We can  
13 see that that question, the targeted look-back question,  
14 is still there.

15 A. Yes, and the wording is still the same, yes.

16 Q. Okay. If we could now go to [SNB001 --

17 THE CHAIRMAN: Sorry, just before you do, if we could go  
18 back, please, to the next page, where we were, something  
19 has been scored out. I wonder if you can cast any light  
20 on that. If one looks at the question as it was, does  
21 that reflect your document and then someone has scored  
22 something out?

23 A. It's someone other than me who has done that. I presume  
24 this was part of the papers for a TTD meeting and that  
25 was somebody saying, "I want this taken out ".

1 THE CHAIRMAN: "I want this out", yes.

2 MR GARDINER: I think the next draft we see it's still  
3 there.

4 PROFESSOR JAMES: But there was a discussion, we heard  
5 yesterday, and it ultimately was scored out. This  
6 particular item about informing the dentists was  
7 ultimately scored out, I believe.

8 MR GARDINER: Yes, thank you. So if we could go to the next  
9 draft, which is [\[SNB0018803\]](#), we see that this one is  
10 dated February 1991 and we see "TTD 11/91", and if we  
11 could go to 8809, please -- sorry, just before we go, we  
12 notice there that it's draft number 4.

13 A. Yes.

14 Q. This is the final one; is that right?

15 A. It's the last one that I have seen. I don't remember  
16 seeing one that says "final draft" or anything like  
17 that.

18 Q. Yes. The Inquiry has not been able to find any draft  
19 after this one.

20 A. I haven't either.

21 THE CHAIRMAN: What's the reference at the bottom of that  
22 page Mr Gardiner? "TTD"?

23 MR GARDINER: Yes. Could we now go to 8809, please? If we  
24 look at the bottom of the page, we see the question, the  
25 targeted look-back question, and if we could go to the

1 top of the page, we see that that's on page 9. Are you  
2 able to remember what alterations, if any, were made to  
3 this draft from the November draft?

4 A. I am afraid I don't. In fact I'm pretty sure I had  
5 heard from John Cash by then that the committee --  
6 whether it was this one or MSBT, I can't remember -- was  
7 recommending that look-back shouldn't be done. But  
8 I can't remember if I had been asked to amend it by that  
9 stage.

10 Q. Okay. The next letter I'm going to show you might help  
11 with that. It's [\[SNB0051689\]](#). It's a letter to you  
12 from Professor Cash:

13 "I have pleasure in informing you that the Medical  
14 and Scientific Committee examined your final draft  
15 document at its meeting on 19 February 1991 and found it  
16 to be excellent.

17 "The Committee agrees to the proposal that the  
18 latter pages be used nationally as guidelines in leaflet  
19 form within the RTCs.

20 "It was noted, however, that in the light of  
21 national events with regard to the implementation of  
22 'look-back', that the last question on page 9, ie 'What  
23 about my previous donations', and the answer should be  
24 omitted from the final document."

25 Dr Gillon, when you received that letter, what did

1           you understand by the phrase "in light of national  
2           events"?

3    A.   I think at the time I had no idea.  I think I must have  
4           understood that there was disagreement down south about  
5           doing it and that's the only interpretation I can make  
6           of "national events" in that context.

7    Q.   Was your understanding of why this question was going to  
8           be taken out enhanced by your discussions with  
9           Professor Cash around about this time?

10   A.   No, I don't recall ever being given an explanation.  
11           I think it would have been understood to be largely  
12           a resource issue but I know -- there were people in  
13           London who disagreed with it in ethical terms, if you  
14           like, but largely it was a resource issue, I think.

15   Q.   What would be the basis for that disagreement?  What was  
16           your understanding?

17   A.   Well, we heard yesterday from Professor Cash about the  
18           doubts about doing this when you couldn't offer anything  
19           in the way of specific treatment, although, as I saw in  
20           one of the drafts of the document there, we do refer to  
21           interferon treatment in that background information as  
22           having been done both in the context of non-A non-B  
23           Hepatitis, and the studies where the HCV test was used  
24           initially to confirm that it wasn't HCV they were  
25           dealing with, and we saw yesterday the paper from Makris

1 and others in the north of England and haemophilia  
2 patients. So there was already a body of evidence that  
3 interferon might be used in this condition and might  
4 give some beneficial results. But if there was an  
5 ethical objection to it, it was usually couched in terms  
6 of no treatment being available.

7 Q. Yes. So in draft number 4, you referred to interferon  
8 treatment?

9 A. Yes.

10 Q. Yes. Could we go back to that, please, at page 2 of  
11 [\[SNB0018803\]](#)? Are you able to point us to the section?

12 A. I think, if we could look for page 9 again, I think  
13 I caught sight of it when you went to the top of page 9.

14 Q. That's 8809. Oh, yes. Yes, the first paragraph?

15 A. Yes, so it will have started over the page.

16 Q. So could we go to the page before? So the question is:

17 "Will I die of this?"

18 And the sentence about interferon starts on the page  
19 before:

20 "It is felt by some hepatologists that very few  
21 cases of serious liver disease due to Hepatitis C occur  
22 in the community. So for most people this is an  
23 incidental finding unlikely to cause serious disease or  
24 symptoms of any kind."

25 Going over the page:

1           "Progressive chronic Hepatitis C has been treated  
2           successfully with interferon, and though this treatment  
3           is at present experimental, it holds out considerable  
4           promise for the future."

5           So that's the reference in the document?

6   A.   That's the reference.

7   Q.   Yes, thank you.  Dr Gillon, what was your reaction when  
8           you received that letter from Professor Cash  
9           in March 1991?

10  A.   I was pretty appalled.  I felt strongly that we should  
11           be doing look-back right from the start.  Even if there  
12           was difficulty in coping with the numbers, we should at  
13           least make the attempt.  And at the very least we  
14           should -- if we felt it was ethically desirable to do  
15           that -- and my take on what everybody had been saying at  
16           the meetings was that there was no serious ethical  
17           difficulty, in fact the ethical thing to do was to do  
18           what we had done for HIV, and that if that was the case,  
19           it was our job as doctors to say, "We are going to do  
20           this," and if we couldn't do it because of resources, we  
21           should ask for resources.

22  Q.   Yes.  Was the reason that you were appalled because you  
23           felt, from an ethical point of view, it was the right  
24           thing to do?

25  A.   Yes, I was confident of that.  I was willing to debate

1           that with anybody.

2   Q.   Yes.  Thank you.  Did you have an opportunity to debate  
3           that with Professor Cash?

4   A.   Not that I recall, other than being in the meetings like  
5           the MSC, where, as I say, it seemed to be accepted that  
6           we should be doing it.  It came as a bit of a surprise  
7           that Scotland was not going to be doing this.

8   Q.   If we could go back to your statement, please, could we  
9           go to the second page, 0411?  So the second paragraph,  
10          you have just referred to the letter of 12 March 1991  
11          that we have looked at and you say that you strongly  
12          disagreed with this stance, the stance of not proceeding  
13          with targeted look-back.  The reason that you strongly  
14          disagreed with that, is that just because of what you  
15          have just told us?

16  A.   Yes.

17  Q.   What discussions did you have with the director of  
18          Southeast BTS, Dr Brian McClelland, about this at that  
19          time?

20  A.   I can't remember at what stage it happened but some time  
21          between March 1991 and the introduction of testing  
22          in September.  I remember saying to Brian, "Right, I'm  
23          going to be doing this and I hope you will support it",  
24          and he said, "Yes, I will support it."

25                 How that was fed back to Professor Cash, if it was



1           formally fed back, I can't remember, and I have no  
2           record of me having written back to John Cash about  
3           that, nor of Brian doing so. But I'm sure that we had  
4           that conversation.

5    Q.   Yes. So that would be at some point between March 1991  
6           and September 1991?

7    A.   Yes.

8    Q.   Yes. Do you remember any other discussions you had with  
9           other SNBTS members about this topic?

10   A.   Not specifically in detail but one of the groups that  
11           Professor Cash had set up was the donor consultants  
12           group, chaired by George Galea, and I'm sure that, you  
13           know, we discussed it there and I told him what I was  
14           doing.

15   Q.   Yes, okay. Just focusing on before the start  
16           in September 1991, was this an issue that was being  
17           debated by people in the blood transfusion community?

18   A.   Yes, and it was being debated internationally. As  
19           I said, we went to international meetings every year,  
20           everybody was talking about it and everybody basically  
21           was saying, "No" apart from a few relatively small  
22           countries. Holland was one of the ones who did it right  
23           from the start. But the United States in particular  
24           said they weren't going to be doing it and that  
25           influenced a lot of people, obviously.

1 Q. What was the rationale presented at that time for not  
2 doing it?

3 A. It was largely the numbers, the resources and one of the  
4 problems was the United States were still screening with  
5 first generation kits at that stage, and the debate over  
6 there had been raging since they started testing quite  
7 early in 1990. So by 1992 they would have had a vast  
8 back load of people to follow up if they were going to  
9 do it and the longer it went on, the harder it became to  
10 take that on board, I think, and they were still using  
11 first generation kits up until, I think it was, the  
12 middle of 1992.

13 So they had a vast number of people, most of whom  
14 were false positives. And that was a problem for them  
15 which we didn't have because long before we started  
16 testing, we knew we would have the second generation  
17 test, which was much more specific and more sensitive;  
18 it would have picked up more of the true Hepatitis Cs as  
19 well. Plus, we had the confirmatory test, where we knew  
20 from the turn of the years 1990/1991 that we would have  
21 a second generation test and a confirmatory test, and  
22 with Peter Simmonds's work in Edinburgh, Scotland was  
23 one of the very few countries, possibly the only  
24 country, that had PCR testing as part of our  
25 confirmatory algorithm right from the start. When we

1 identified a donor after testing started  
2 in September 1991 and our virologist said, "This donor  
3 is HCV-positive," we knew they were HCV-positive.

4 So the starting point -- that reduced the numbers  
5 that we would have to follow up from something like 0.5  
6 to 0.6 per cent to something less than 0.1 per cent, as  
7 we discovered when we started testing, and knew indeed  
8 from the exploratory work with the second generation  
9 tests -- we knew that the numbers would come down by  
10 that factor.

11 Q. Just to give us an idea of, you know, the scale of the  
12 work, what difference did it make whether you did  
13 targeted look-back with a first generation test and  
14 targeted look-back with a second generation test and PCR  
15 testing?

16 A. It reduced it almost by a factor of 10, almost tenfold.  
17 Depending on your local population -- and as I say, with  
18 first generation tests we were looking at something like  
19 0.5/0.6 per cent. So five or six per thousand, five or  
20 six per day. And as I said, in the run-up, in our  
21 initial deliberations we were reckoning anything up to  
22 ten a day in Scotland.

23 I'm sure you are going to come on to the paper we  
24 published, but if you look at our first six months'  
25 experience, in Southeast Scotland we had 20 positives in

1 the first six months. So vastly less than the first  
2 generation tests would have thrown up.

3 Q. Yes. Could you give us a ballpark figure for, you know,  
4 infected donors on the basis of the first generation  
5 test?

6 A. Well, infected donors would have been fewer because it  
7 was a less sensitive test but we had no way of  
8 separating out who were the false positives until we had  
9 confirmatory testing, and in fact it was the  
10 confirmatory testing, the RIBA and the PCR, that made  
11 the huge difference. We could eliminate all of the  
12 false positives because even with second generation  
13 testing, you do get false positives.

14 Q. So the point is, if I'm following, Dr Gillon, with the  
15 first generation tests you would have a multitude of  
16 false positives that you would still have to go and  
17 follow up and trace what has happened to previous  
18 donations and so on?

19 A. Yes, and we were geared up psychologically to doing  
20 that, although it wouldn't have been a very satisfactory  
21 thing to do and in fact, when you look at the results  
22 ten years later, from look-backs in other countries,  
23 particularly the United States, I think that in those  
24 situations where they were following up on the basis of  
25 first generation tests, of the patients they then

1 identified, only something like between 10 and  
2 15 per cent turned out to be HCV-positive, whereas all  
3 of ours, all of the patients that we identified through  
4 targeted look-back, had been infected and that's because  
5 we knew that the donors that we were basing this on were  
6 carrying the virus.

7 Q. Yes. So much more than half of the work that would have  
8 to be done was unnecessary?

9 A. Was unnecessary and disturbing no doubt for the  
10 patients.

11 Q. Yes, of course. So --

12 THE CHAIRMAN: Can I just ask one question here? How far  
13 ahead was Professor Simmonds or Dr Simmonds at the time  
14 of the rest in having the PCR available?

15 A. He was -- it's hard to be specific about that because of  
16 course people catch up very quickly once you start  
17 publishing work, and a lot of what he was doing was  
18 based on what we were already doing in developing  
19 genetic trees of viruses and looking at animal models  
20 and so on. But he was certainly ahead of the game  
21 internationally, and I think very few countries had PCR  
22 as part of their confirmatory algorithm for blood  
23 transfusion for a year or two after that.

24 THE CHAIRMAN: A year or two is really quite a long time in  
25 the context.

1 A. It's quite a long time and it's worth pointing out that  
2 south of the border there was no PCR again for at least  
3 a year or two afterwards.

4 THE CHAIRMAN: Sorry, Mr Gardiner, for interrupting your  
5 thoughts.

6 MR GARDINER: Thank you.

7 So if we are talking about March 1991, at that stage  
8 you would be anticipating first generation testing. Is  
9 that right?

10 A. No, by then we knew -- by then in fact we had a second  
11 generation test and we had the RIBA test. So we had  
12 confirmatory tests. I can't remember exactly when we  
13 knew that we would be able to do PCR on all of the  
14 reactive samples, but certainly before September we knew  
15 that Peter Simmonds' laboratory was geared up to do  
16 that.

17 Q. So if you didn't actually have the PCR testing  
18 by September 1991, you knew that it was on its way  
19 fairly shortly?

20 A. We knew that it was in development and they were working  
21 on it and looking at samples, and there were things to  
22 iron out, very great problems of contamination and so  
23 on. So it needed a dedicated laboratory and it takes  
24 a lot of sorting out but they were well on the way by  
25 then, and certainly before September we knew it was

1           feasible.

2   Q.   Yes.  So you take this decision in the context of

3        knowing that you are not going to be using a first

4        generation test --

5   A.   That's true, yes.

6   Q.   We heard from Dr Alexander yesterday and perhaps I could

7        just show you a bit of his report just quickly.  Could

8        we have [\[PEN0181360\]](#)?  This is the first page of his

9        report.  He says:

10                "Screening for Hepatitis C virus (HCV) antibody was

11                introduced in September 1991 through virology

12                laboratories working within public health (largely).

13                This was performed with a first generation ELISA."

14                Is that right?

15  A.   I don't think that's correct.  I don't think in any part

16        of the UK a first generation test was used at that

17        stage.

18  THE CHAIRMAN:  I think that he went on to say that they

19        followed up some 200 people on the basis of these

20        initial tests, who were eventually proved not to carry

21        infection at all.  So ...

22  A.   They would have done that with second generation and

23        RIBA, with no PCR probably because the RIBA can be very

24        difficult to interpret.  There was a category which was

25        referred to as "indeterminate", where there may only be

1 a one band positive, and that band could be anything  
2 from 1 plus positive to 4 plus positives and we, with  
3 Peter Simmonds, did a lot of work on this and some of  
4 these were in fact true antibody with a PCR positivity.  
5 And down south they would have been classified as  
6 "indeterminate", and it may well be that that's they are  
7 referring to.

8 THE CHAIRMAN: I think actually it's the next paragraph that  
9 he mentioned the 200:

10 "... following up equivocal tests, nearly 200 at one  
11 stage."

12 A. Yes, it suggests to me that those were what we labelled  
13 as "indeterminate", and we were able to drill into that  
14 a little bit and find some that were PCR-positive. But  
15 it was likely to be the case that some of those who were  
16 PCR-negative still had true antibody. In other words,  
17 they had not only cleared the virus but had cleared some  
18 of the bands of their antibody as well. But having said  
19 that -- and this is moving on five or six years -- once  
20 we started doing the look-back, after we had got rid of  
21 the backlog of what we knew were true cases, we looked  
22 at the indeterminates, and those that were PCR-negative  
23 had never transmitted to a patient.

24 PROFESSOR JAMES: It is also fair to just note that in the  
25 first of the paragraphs on the screen, he said that PCR:



1            "... often in-house was not introduced until around  
2            1993 and 1994 in most centres in the UK."

3            So first that does show that you were sort of ahead  
4            of the game in that through Peter Simmonds and sort of,  
5            in a sense, in perhaps a privileged position from that  
6            point of view.

7            Second, it suggests where the 200 that the Chairman  
8            referred to came from, because there was obviously  
9            an 18-month or so period in many parts of the UK where  
10           actually they still only had the RIBA confirmatory test,  
11           which, even in the second generation wasn't thought to  
12           be that much of an advance, really?

13          A. Yes, I agree with that, yes.

14          MR GARDINER: It might be helpful, sir, to have a quick look  
15                  at the Preliminary Report about this. Could we go to  
16                  page 314? At paragraph 9.263.

17                  In March 1991 you knew that there were second  
18                  generation tests but also that they were available.

19          A. Well, I think we were using them in some of our  
20                  evaluation studies by that stage. I'm not sure exactly  
21                  when that started.

22          Q. If we look at paragraph 9.263, this is from the  
23                  Preliminary Report, it says:

24                  "On 8 April 1991 Abbott's product manager announced  
25                  the launch of Abbott's second generation anti-HCV ELISA

1 test."

2 And the footnote at the bottom of the page tells us  
3 that this comes from the chronology set out in the  
4 minutes to the ad hoc meeting of the ACTTD.

5 A. That, of course, means that that's when it became  
6 commercially available, and there was a lot of  
7 development work had gone on by then, and I'm sure we  
8 had done some of that.

9 Q. Yes. So you, in March 1991, had no doubt that it would  
10 be on the basis of the second generation test --

11 A. I think that was the assumption that I would have made.

12 Q. Yes, thank you.

13 We heard yesterday about a symposium in October 1993  
14 on Hepatitis C virus infection but just very broadly,  
15 between March 1991 and this symposium, do I take it that  
16 the debate about whether to proceed with targeted  
17 look-back was ongoing in the blood transfusion  
18 community?

19 A. I think it was, but it probably took a back seat to some  
20 extent because, of course, just introducing the testing  
21 was a pretty major preoccupation and getting in place  
22 all that was necessary for the confirmatory algorithms,  
23 for dealing with the false positives, for counselling  
24 the positives, would have kept people pretty busy and  
25 there was lots else going on at the time. I remember

1           there was a war going on in the Gulf in 1991. So there  
2           was lots of stuff. There were huge preparations went on  
3           for the Gulf War. So, yes, I think it took a back seat  
4           but it didn't go away.

5   Q. We did wonder whether the reference to "national events"  
6           might have been a reference to the war.

7   A. It's entirely possible. I remember I was on the  
8           committee locally that was working -- the SHHD had  
9           commandeered a hangar at Turnhouse and we were filling  
10          it with blood and preparations for all these wounded  
11          soldiers. Mercifully it never happened but there was  
12          a huge amount of preparation.

13   Q. When it came to September 1991, you simply went ahead  
14          with targeted look-back in your region, southeast?

15   A. That's correct, yes.

16   Q. Just remind us geographically what that encompassed?

17   A. That encompassed all of the Lothians, the Borders and  
18          Fife.

19   Q. Yes. What did that involve, work-wise, for you?

20   A. For me that meant that -- well, if we look at the  
21          information that was in the paper in the first six  
22          months, we identified 15 regular donors, which is not  
23          a huge number, and based on that, I think, in the paper  
24          we described that that gave rise to 60-odd previous  
25          donations which turned into 83 previous components

1 issued. And it's on the basis of each individual  
2 component issued that you then go through the process of  
3 identifying where that went, to which hospital, which  
4 blood bank, which patient, which consultant was in  
5 charge at the time.

6 Q. Yes. Ultimately, you wrote a paper about this. Can we  
7 have a look at [\[LIT0013802\]](#)? This is:

8 "Risk of Hepatitis C in patients who received blood  
9 from donors subsequently shown to be carriers of  
10 Hepatitis C virus."

11 Could you tell us who the different authors are?

12 A. Yes. The first author was Dr Yasmin Ayob, who was  
13 seconded to us from the blood centre in Malaysia, where  
14 we had had contacts previously. She was a haematologist  
15 in training moving into a career in transfusion medicine  
16 and came here to basically just observe what we do and  
17 I think was with us for about a year.

18 And one of the things that gave her an insight into  
19 the nuts and bolts of how our transfusion service worked  
20 was to take part in this and I offered her the chance to  
21 help with this while she was here. I can't remember if  
22 it was right from the start of testing into 1992 or if  
23 it was at some point during 1992. But largely what she  
24 provided was hands-on experience at looking at medical  
25 records, at sorting out that transfusion did take place

1 on such and such a date and this is the consultant that  
2 needs to be written to and so on.

3 Jan Davidson I referred to earlier, who is on our  
4 initial group reporting to Professor Cash and who was  
5 trained in counselling. Aileen Baxter was my secretary  
6 and she must be one of the few medical secretaries to  
7 get her name on a scientific paper and she did more work  
8 than anybody in this. She was fantastic and she did  
9 a lot of this chasing up of medical records and taking  
10 care of all the correspondence and documentation.

11 Tony Jordan was the lab manager in our local  
12 virology testing laboratory. Peng Lee Yap was a fellow  
13 consultant who had an interest in this area, who was  
14 responsible for the intravenous immunoglobulin service  
15 and had some experience of dealing with their problems  
16 with non-A non-B Hepatitis.

17 MR GARDINER: Sir, before we get into the detail --

18 THE CHAIRMAN: I think it's a good time to stop. We have  
19 seen Dr Yap's name often but not managed to see him.

20 (11.03 am)

21 (Short break)

22 (11.27 am)

23 THE CHAIRMAN: Mr Gardiner?

24 MR GARDINER: Thank you, sir.

25 Just before we go back into the Ayob paper,

1           yesterday we noticed that your report, which was  
2           referred to at various advisory committees down south,  
3           despite the fact that they were often expressing concern  
4           about proceeding with targeted look-back, always still  
5           included that question on page 9, and we just wanted to  
6           ask you: do you remember ever removing that question  
7           yourself?

8    A.    I don't.  It's a puzzle to me what happened after that  
9           draft 4, I think it was, we saw from February/March.  
10           I think I lost ownership of the document.  It took on  
11           a life of its own, circulating round committees.  But at  
12           the same time, you know, I had been asked to draw up  
13           an SOP and we were asked to provide leaflets and so on  
14           for donors and I know we did that.  I haven't got any of  
15           those initial leaflets from that time.

16                 So we worked on that and no doubt, in leaflets for  
17           donors and so on, we dropped that question but that  
18           document, I'm sure, just went off into a parallel  
19           universe of some sort.

20   THE CHAIRMAN:  Because in a real sense the documents weren't  
21           as important to you after you had taken the decision  
22           that you were going to go ahead in the southeast and  
23           do --

24   A.    That's right.

25   THE CHAIRMAN:  -- the testing anyway.  The debate is less

1 significant once you are committed to a line of action  
2 that is independent of the outcome.

3 A. That's true but there were national documents to be used  
4 to give to the donors when we saw them, and the other  
5 four regions, they couldn't have included that question.  
6 So I'm sure it was dropped.

7 MR GARDINER: Yes. Just on that topic, was there any  
8 question that you were hiding what you were doing at  
9 that time?

10 A. No, absolutely not, no. As I have said, I'm sure that  
11 I shared it with the donor consultants' group. They  
12 knew what I was doing. If they asked me any questions  
13 about it, I would have told them.

14 Q. Yes. Mr McIntosh, when he gave evidence, suggested that  
15 a consideration for you and Dr McClelland might have  
16 been the Newcastle experience and that you might not  
17 have been publicising what you were doing with targeted  
18 look-back because you were concerned that the same thing  
19 might happen to you. What's your comment?

20 A. I didn't think it was at the forefront of our minds.  
21 I thought that in doing this we might get some trouble,  
22 I have to say. I didn't anticipate that it would all go  
23 swimmingly.

24 Q. What sort of trouble were you anticipating?

25 A. Well, I thought that Professor Cash probably wouldn't be

1           too pleased and he probably wasn't too pleased, but he  
2           never expressed that directly to me in any way.

3    Q.   Have you ever discussed starting targeted look-back  
4           in September 1999 with Professor Cash?

5    A.   Afterwards, do you mean?

6    Q.   Yes.   Subsequently.

7    A.   After having done it?

8    Q.   Yes.

9    A.   Not that I can remember.

10   Q.   So you never told him, if you like, that that's what you  
11           were doing?

12   A.   I don't remember asking to see him to explain that or  
13           him summoning me and/or Brian to do the same but I'm  
14           sure we must have talked to him about it, Brian and I,  
15           but I have no specific recollection of any discussion.

16   THE CHAIRMAN:  Is it too cynical to wonder whether there are  
17           some topics that are just better not discussed?

18   A.   Entirely possible, yes.

19   THE CHAIRMAN:  Yes.

20   MR GARDINER:  The paper that we looking at at the moment --  
21           this is the Ayob paper -- was received on  
22           23 November 1993, accepted for publication on  
23           21 July 1994.  When would you have produced the final  
24           draft of this or when would it have been produced, do  
25           you think?



1 A. I think that, if it was sent to the journal  
2 in September, we must have started work on that at the  
3 end of 1992, because it would have gone through a couple  
4 of drafts at least and Yasmin Ayob was back in Malaysia.  
5 I drafted the paper and I sent it to her at least  
6 once, possibly twice. So to pull it all together, get  
7 it written, get drafts commented on, I guess it was the  
8 end of 1992/maybe the beginning of 1993 at the latest  
9 that we started doing that.

10 Q. Yes. Do you think by that stage you had had  
11 a conversation with Professor Cash about the targeted  
12 look-back that you were doing?

13 A. It's highly likely. But I don't remember it being  
14 a specific subject of a meeting.

15 Q. Yes.

16 A. One of the questions that arose is how and when did it  
17 become known as a "pilot study", and I have no clear  
18 recollection of that at all.

19 Q. Yes. Do you think it was after it was published or  
20 before it was published that it started to be called  
21 a "pilot study"?

22 A. I think it was before. I think probably it was being  
23 referred to, in correspondence and meetings before then,  
24 as a "pilot study".

25 PROFESSOR JAMES: Could I ask: did you present the data from

1 this, say, at the beginning of 1993, when you and  
2 Dr Ayob had, you know, kind of done the work? Did you  
3 present it at meetings and so on, so actually it was out  
4 there, from, you know, 18 months before it actually got  
5 into print?

6 A. Certainly. I think you may all have been circulated  
7 with this paper, which is the proceedings of the  
8 meetings that Professor Cash referred to at the College  
9 of Physicians in October 1993, and in fact in my  
10 presentation, I gave the results then. So we already  
11 had the results at that stage. We were openly sharing  
12 that.

13 MR GARDINER: So we are going to have a look at that  
14 a little later but do you think that you would have  
15 presented the data publicly at a time before the  
16 symposium?

17 A. I think we probably did a poster to various meetings.  
18 I haven't listed posters in my CV. So I had no easy way  
19 of checking that but I'm pretty sure we had -- the  
20 figures were out there.

21 Q. When you say a "poster", could you explain what that  
22 was?

23 A. For scientific conferences you have the option of  
24 putting in your work either to be presented as an oral  
25 presentation or as a poster, which is where you

1 effectively write the paper and draw up the graphs and  
2 so on and put them on a poster, which is in a hall with  
3 all the other poster presentations for people to go and  
4 look at and read, and you stand beside it and answer  
5 questions. And I'm pretty certain we did that but  
6 I can't remember specifically.

7 Q. Before October 1993?

8 A. Around that time.

9 Q. Around that time.

10 A. The national meeting of the British Blood Transfusion  
11 Society met in September, as many medical organisations  
12 did?

13 PROFESSOR JAMES: Dr Ayob was by this time the other side of  
14 the world, so it would make sense for you to present it  
15 on her behalf as a poster sort of thing at that meeting.

16 A. I regarded it as my work primarily, rather than hers,  
17 I must say, although she was first author.

18 MR GARDINER: Are you able to help us with the question of  
19 who it was who first started to talk about this work as  
20 a "pilot scheme"?

21 A. I am afraid I can't. I can't remember specifically who  
22 came up with the term.

23 Q. Someone at SEBTS or someone external, do you think?

24 A. It was either Brian McClelland and I together or  
25 John Cash with or without input from us. I'm sure he

1           wouldn't have started calling it that unless we knew we  
2           were going to do that. So at some point we decided we  
3           were going to do that but I can't remember who came up  
4           with ... I think we had already used that term, for  
5           instance when we did our autologous transfusion work,  
6           I'm sure we called that a "pilot study". So that had  
7           already been established.

8   Q.   You weren't unhappy to call it that?

9   A.   No, in fact I do remember in a fit of corporate loyalty  
10       referring to it in a meeting as the "SNBTS pilot study"  
11       and being sharply reprimanded by Professor Cash, it was  
12       not to be regarded as the "SNBTS pilot study".

13  Q.   Why was that?

14  THE CHAIRMAN:  It's making more and more sense.

15  A.   Well, either he didn't want to be associated with it or  
16       he felt that it had the potential to damage the  
17       reputation of SNBTS, and if that was the case, I was  
18       happy to go along with that and regard it as our pilot  
19       study.

20  MR GARDINER:  When would that have happened, do you think?

21  A.   It may well have been after this meeting in the college.  
22       It was after a meeting, I think, around that time but  
23       I can't remember specifically.

24  Q.   So around about the time of the symposium  
25       in October 1993?

1 A. Yes, I'm sure it was about that time.

2 Q. Okay, thank you very much. Could we go to the Ayob  
3 paper, and we see in the summary, in the second  
4 paragraph:

5 "In the first six months of routine testing, 42,697  
6 donors were tested. Of 20 confirmed to be HCV-positive,  
7 15 were regular donors. 83 components were prepared  
8 from 63 anti-HCV-positive previous donations from these  
9 donors. In all, nine recipients were found to be alive.  
10 All were positive for anti-HCV."

11 Was that a surprising finding, the amount of  
12 confirmed HCV-positive donors?

13 A. Yes, I think it was a bit surprising that we found so  
14 few who were alive at that stage, having done it as  
15 rapidly as we could really.

16 Q. Yes. Did it accord with your predictions before you  
17 started to do the look-back?

18 A. I don't think we did have a feel for how much we would  
19 turn up really. I don't think we predicted that.  
20 I know that we went on from these data to predict  
21 roughly the numbers we would find in Scotland, which  
22 turned out to be eerily correct, but at that stage we  
23 didn't know what we were going to find.

24 Q. If we look at the methods on the second column, that  
25 talks about the different tests. Could you just talk us

1 through the methods that you used?

2 A. This was exactly the testing that was in place  
3 throughout Scotland at the time, which was that every  
4 donation that was collected was subjected, along with  
5 the other routine tests, to what's known as an ELISA  
6 that is a rapid screening test with fully automated  
7 test.

8 That would tell us which donations were reactive in  
9 that test system. Those were then selected and of  
10 course, as soon as they were regarded as reactive in the  
11 screening test, the actual donations, the bags of blood  
12 and platelets and so on, were taken out of circulation  
13 and put into quarantine, while a sample which was taken  
14 from the pack was sent across to the Microbiology  
15 Reference Unit for further extended testing, which  
16 usually included, where we could, if we had an ELISA  
17 from a different manufacturer, plus what was known as  
18 the supplementary test, the RIBA-2 -- is what we were  
19 using, which just tells you about antibody and breaks it  
20 down into various different sub-portions of an antibody,  
21 and these appear as bands on a strip.

22 It's a very visual thing and two bands or more was  
23 regarded as positive, a single band, as I described  
24 earlier, was described as an "indeterminate test", and  
25 of course it was negative if nothing showed up. And

1           there were control bands as well, which tell you that  
2           the test was done properly, and in addition we had the  
3           PCR, which looked directly for the genetic material of  
4           the virus.

5   Q.   What did you do with the indeterminates?

6   A.   We regarded them as potentially positive and would not  
7        have cleared a person with an indeterminate result to go  
8        back on to the panel of donors who were able to donate.

9           Eventually that policy was revised, once we knew --  
10         the data I gave you earlier -- that in fact, if the PCR  
11         was negative, these donors did not transmit. And some  
12         years later we raised this subject and -- I think it was  
13         agreed at UK level, in fact, rather than just Scottish  
14         level, that those donors could be reinstated in fact.  
15         But we were very cautious initially about that.

16  Q.   Yes. The next paragraph talks about donor call-up and  
17        counselling. Could you just briefly describe how that  
18        was done?

19  A.   We had agreed that we would send out a letter with  
20        standardised wording to the donor, which was really  
21        pretty bland, and this was not an easy thing to decide  
22        on in fact because if it was too bland, there was  
23        a danger the donors wouldn't take it seriously and come  
24        back to see us, which would not be good for the donor.  
25        In a sense it wouldn't matter to us because obviously we

1 would never recall them to donate and if they did come  
2 back in, we would not allow them to donate. But we  
3 wanted them to come back.

4 So it had to give enough information to make them  
5 think, "We had better go and see these people and see  
6 what this is about". And we also wanted to get a second  
7 sample to confirm the findings and make sure that that  
8 person got proper medical care thereafter.

9 Q. Yes. If we go over the page to the second paragraph on  
10 the left-hand column, the heading is "Recipient  
11 identification"; could you just explain to us what you  
12 did with that?

13 A. The first sentence ties in with what Professor Cash was  
14 saying yesterday. What we say is we identified from  
15 blood bank records -- and he was right in saying that in  
16 the Southeast of Scotland we had very direct access to  
17 the majority of the relevant records because we were  
18 sited in the Royal Infirmary of Edinburgh. We had the  
19 blood bank under our control, and I could in fact just  
20 ask for medical records in the Royal Infirmary, for any  
21 patient's records, and get them usually within 24 hours  
22 or so.

23 In fact where he was wrong yesterday was in  
24 suggesting that made it easier for us. It gave us more  
25 work because we were doing the part that in an outside



1 hospital -- say, if we identified a donation that had  
2 gone to the Western General hospital, I would have  
3 written to the consultant there saying, "We sent you  
4 this unit on [such and such a date]. We now know that  
5 donor is HCV-positive and we have to regard this one as  
6 potentially positive; can you tell us what happened to  
7 it?"

8 And he would have to do that bit of work identifying  
9 what happened to what unit of blood, who the patient  
10 was, who the consultant was in charge of the patient and  
11 then report back. So in fact it gave us more work but  
12 of course it was faster, because we could do it  
13 ourselves without correspondence and so on.

14 So for a large slice of them we could get that  
15 information relatively quickly. Otherwise I had to  
16 write to whoever it was at the Western General or in  
17 hospitals in Fife and the Borders or West Lothian or  
18 wherever, and ask them to do the same.

19 Q. So that was more work for you but it allowed the  
20 operation to be concluded quicker because you had more  
21 control over the medical records. Is that right?

22 A. Yes, it undoubtedly speeded it up a bit because there  
23 were certain steps that were vital to know about: had  
24 the unit been transfused? Who was the patient? Is the  
25 patient still alive? And you could often tell that from

1 the hospital records.

2 Q. Dr Gillon, I wonder if you could move your microphone  
3 a little bit closer, I'm not sure that it's picking you  
4 up.

5 If we go on the left-hand column, we see "Results"  
6 and again we see:

7 "Between 1 September 1991 and 29 February 1992,  
8 42,697 donors were screened routinely."

9 It then lists all the results. Could you just  
10 broadly tell us what the results were that you got back  
11 from this exercise?

12 A. Well, what we saw was that, I think these 15 donors had  
13 given 60-odd donations that we knew about -- sorry, 70  
14 previous donations, and that led to 80-odd components,  
15 which we had to establish the fate of in the way that  
16 I have just described to you.

17 Q. Yes.

18 A. So although the number of donors looks modest, of  
19 course, because they have been donating for many years,  
20 the number of components you have to chase up was not  
21 inconsiderable, manageable but not inconsiderable.

22 Q. Yes. If we could go to the top of the right-hand  
23 column, there is a figure 1, "Plan of Investigation".  
24 Could you just explain to us what that is?

25 A. This is just trying to make it easily accessible, this

1 system that we had in place, which was screening,  
2 leading to the reactive donors being identified and the  
3 confirmation of those who were genuinely infected with  
4 Hepatitis C, what we did about the donor. And then,  
5 beyond that, is the look-back process itself, when we  
6 review the record, if there are frozen samples, retrieve  
7 them and test them. If we could identify the date of  
8 seroconversion, that could cut things down considerably,  
9 because if we could show that, say, a donor had been  
10 regularly donating from, let's say, 1984 to 1991, and in  
11 Edinburgh, we might well have had samples for all of  
12 that time, we would pick out initially the first and the  
13 most recent test there. If they were both positive, we  
14 would assume everything in between was capable of  
15 transmitting infection. If the earlier one was  
16 negative, we would then dig out the intervening  
17 samples -- depending on how many, we might do them one  
18 at a time, we might do them all at once for convenience.

19 If we could then establish that at a certain point,  
20 the donor had gone from seronegative to seropositive,  
21 particularly valuable if that coincided with what the  
22 donor was telling us about risky activity, we would  
23 usually in fact go back and trace the recipients of the  
24 previous negative donation, in case it was what was  
25 called a "window period donation". But anything prior

1 to that we can discount and not trouble the patients  
2 with that information.

3 Q. What does the dotted line represent?

4 A. Just the start of the look-back process.

5 Q. Right. So that's the look-back?

6 A. Yes.

7 Q. The targeted look-back portion? Thank you.

8 If we could go down to the bottom of the second  
9 column, you say in the conclusion:

10 "The workload was assessed as approximately 60 hours  
11 each of secretarial time and medical time."  
12 60 hours each?

13 A. Yes, I mean, that was a best guess at what Yasmin Ayob  
14 and my secretary had put in to that first six months'  
15 work. It would have spanned a longer period than the  
16 six months because, you know, these donors would have  
17 been coming back through that period and some of them  
18 towards the end of it. We would not have been getting  
19 the look-back completed for at least six months after  
20 that probably, which was around the time we started  
21 writing this up, I think.

22 Q. So 60 hours of secretarial time and 60 hours of medical  
23 time?

24 A. Yes.

25 Q. Okay. Then microbiology staff, small amount of

1 consultant time. Was that an important conclusion in  
2 terms of the feasibility of targeted look-back?

3 A. As far as blood centre work was concerned, it was better  
4 than nothing, I guess. I can't pretend that we did  
5 a work study on this and measured all the time that went  
6 into it but it was guesswork, but guesswork based on  
7 experience, just to try and give people an idea with  
8 that number of donors, this is how much effort would  
9 need to go into it.

10 Q. Yes. But what you were telling us previously was that  
11 your particular circumstances in the southeast didn't  
12 make the process easier or, rather, didn't mean that you  
13 were spending less time than if it had been elsewhere in  
14 Scotland?

15 A. It's true that with the exception of Dundee and  
16 Aberdeen, and Inverness in fact, this would not have  
17 been applicable to the West of Scotland in the sense  
18 that I reckoned we had more work to do for each  
19 individual than they would.

20 PROFESSOR JAMES: But somebody else would have had to do the  
21 work, wouldn't they?

22 A. And that's where the hospital blood bank would have  
23 felt --

24 PROFESSOR JAMES: Precisely, just a transfer of the work  
25 from you to other colleagues in other hospitals?

1 A. That's right.

2 MR GARDINER: In terms of the question of whether targeted  
3 look-back should be pursued nationally, how did this  
4 paper assist determination of that question in your  
5 opinion?

6 A. I think at least gave it a nudge. You know, when we  
7 presented it at the meeting in the college -- I can't  
8 remember but there probably was a poster -- there would  
9 no doubt have been talk about it and it must have been  
10 one of the factors that revived discussion at the  
11 various committees.

12 Q. Yes. I'm just wondering if it was more than that. Is  
13 it putting it too high to say that before your report  
14 people were unsure whether look-back was feasible  
15 without massive resources being put into it and after  
16 your report it was clear that that wouldn't necessarily  
17 be what was required?

18 A. I don't know. I would hesitate to read too much into it  
19 because, I mean, I think people saw me as -- I certainly  
20 wasn't an enthusiast for look-back but somebody who felt  
21 strongly that we should be doing look-back. So they  
22 might have looked at these data and thought it's all as  
23 John Cash presented, others might have thought, "Well,  
24 it's all right for them, it's easy for them but we can't  
25 do that, we don't want to do that," or, "We don't

1 believe that's the right thing to do". I don't know  
2 that the paper would have had that much influence but it  
3 must have had some.

4 But it wasn't the only factor. There were media  
5 stories beginning to appear around about that time and I  
6 think -- was it the Sunday Mail or one of the Scottish  
7 papers, made it a bit of a crusade in the early part of  
8 1994, I think it was.

9 Q. Thank you. If we maybe just look at the next page of  
10 this report, there is a diagram that sets out really the  
11 results of the exercise.

12 A. Yes, and broadly speaking -- well, almost exactly, this  
13 became the format adopted by the monitoring that was in  
14 place after look-back was introduced universally in  
15 1995, and this is the format in which we reported data  
16 in the MSBT eventually.

17 Q. Yes, thank you. Could we go to table 1. These are the  
18 results of the different tests that you did. Is that  
19 right?

20 A. Yes, it shows the RIBA pattern. So each of these  
21 columns, the C100, C33C and so on, these bands are  
22 described in the RIBA, whether the PCR was positive or  
23 negative. And the duration is, as I see from the  
24 asterisk, the time from the last reported risk  
25 behaviour, so how long we thought the donor had had that

1 infection. And then comparing that with the results we  
2 found in the recipients.

3 Q. Yes. If we could go over the page, we see there that  
4 under the heading of "Discussion", you discuss papers  
5 about look-back. At the bottom of the page you note --  
6 this is five lines up:

7 "It is the policy of the UK transfusion services not  
8 to carry out HCV look-backs. If we assume approximately  
9 one infected recipient per donor, we estimate that  
10 around 3,000 patients may be alive and infected with HCV  
11 as a result of transfusion in the UK, based on the  
12 prevalence of HCV in Scottish blood donors and excluding  
13 haemophiliacs."

14 Could you just explain that, please?

15 A. I'm sorry, explain why we excluded haemophiliacs or ...?

16 Q. Well, just if you could explain the numbers --

17 A. The extrapolation is based simply on what we then knew  
18 about the prevalence of Hepatitis C in the donor  
19 population, as compared with our first six months. And  
20 if we extrapolated what we found then to the whole donor  
21 population, we came up with a number of roughly 300 --

22 Q. Yes.

23 A. -- for Scotland, 3,000 for the UK. It wasn't too far  
24 off the mark, given that ultimately the UK total  
25 look-back produced over 2,000 in England and 133,



1 I think it was, in Scotland; who were still alive at  
2 that time. And of course many of those patients might  
3 have died in the intervening --

4 Q. Yes, thank you. In the second column at the top you  
5 refer to treatment in the form of A interferon. You say  
6 that:

7 "This compels us to suggest that we have a clear  
8 ethical responsibility to these patients to identify  
9 them and offer counselling, testing and, if necessary,  
10 treatment."

11 There is a reference there to Kolins 1990. What was  
12 that paper?

13 A. I can't remember the details of that particular paper.  
14 I see it was a review article in Transfusion, which was  
15 the leading blood transfusion journal published in the  
16 United States. So this looks as if it was a leader in  
17 Transfusion which made the same point.

18 Q. Yes. So you are agreeing with what has been said  
19 previously about the --

20 A. As I say -- sorry, I think in retrospect that was  
21 a letter published in Transfusion. I don't know the  
22 author; Kolins was not known to me.

23 Q. Yes. In any event, you conclude by saying that in your  
24 view:

25 "This problem should not be ignored on logistical

1 grounds when in each case there is an overwhelming  
2 responsibility to the individual patients."

3 Is that what your group felt at that time?

4 A. Yes, certainly our group in southeast were committed to  
5 this, yes, and we saw it as a responsibility to the  
6 patients.

7 Q. Yes, thank you. Could we just go back to 3802? It's  
8 the results page, the second column, the sentence that  
9 starts:

10 "Samples were received ..."

11 I just noted there at the bottom of that paragraph:

12 "No recipient was alive and traceable more than five  
13 years after transfusion."

14 I just wonder if you thought, Dr Gillon, that that  
15 was an important finding in terms of carrying out  
16 targeted look-back?

17 A. Yes, I think that's very much the case. I mean, I think  
18 there was already information from the HIV look-backs  
19 that something of the order of 50 per cent of patients  
20 will have died within the first year or two of having  
21 a transfusion and that is, of course, because of the  
22 severity of the disease for which they were transfused.  
23 And this confirms that, you know, if you go back more  
24 than five years, you are not going to find many patients  
25 who are still alive. You do find some and we found one

1 or two in our HIV look-back, as we reported in the  
2 statistics paper, and indeed in the comprehensive  
3 look-back there were some patients identified from, say,  
4 the early 80s, but not many.

5 Q. Yes. Would you say that that supports the argument that  
6 look-back should be started as soon as possible?

7 A. Yes, I mean, I think broadly speaking, yes. If you are  
8 going to have a chance of doing anything about it  
9 anyway, you need to identify the patients sooner rather  
10 than later.

11 Q. Thank you. I would like to have a look now at the  
12 symposium that we have heard about. The flyer for that  
13 is at [\[PEN0180553\]](#). So that's the first page.

14 We see that it was October 1993. If you could go to  
15 the next page, please, we see that at 10.30 you are  
16 scheduled to deliver a paper on the epidemiology of HCV.  
17 I think you have kindly produced a copy of that paper  
18 today and we have got that in court book now at  
19 [\[PEN0181420\]](#).

20 I think this is the introduction to the workshop and  
21 your paper is on the next page, 1421. We have got it on  
22 the screen now. Is that the paper that you delivered at  
23 the symposium?

24 A. Yes.

25 Q. Could you just summarise what you told the symposium

1           that day?

2    A.   What I tried to do was give a fairly comprehensive  
3           overview of what was known about the epidemiology of  
4           Hepatitis C at that stage from a non-epidemiologist's  
5           point of view.  And that probably skewed the  
6           presentation a little bit in favour of what we knew  
7           about blood donors and that particular section of the  
8           community.

9           But I tried to cover, for instance, the geography --  
10          HCV is a worldwide problem and so on.  And later on in  
11          the paper I covered what was known about sexual  
12          transmission and other facts.

13   PROFESSOR JAMES:  Just to note that as a matter of fact this  
14          was updated to 1995, so say the editors.  So what's  
15          written here is perhaps very largely what you presented  
16          in 1993 but it will have been modified by information  
17          you had, and it's in your references, for example, up to  
18          1995.  Would that be correct?

19   A.   I think that's correct, yes.  I think this was produced  
20          from tape recordings of the presentations.  It was  
21          organised by Dr Gordon Scott, who is a consultant in  
22          GUM, and I have a letter from him saying that, you know,  
23          "It's taking me a while to deal with these transcripts  
24          and, you know, given that it's a couple of year, do you  
25          want to look at your numbers and see if anything has

1 changed?"

2 PROFESSOR JAMES: Thank you.

3 A. That's more or less what happened.

4 MR GARDINER: So we see on that first page that you talked  
5 first of all about historical perspective and then  
6 geography: HCV is a worldwide problem. If we go over  
7 the page, we see on page 585 that you talk about the  
8 situation in the United Kingdom, and if we look about  
9 two thirds of the way down that paragraph, that sentence  
10 starting:

11 "Nonetheless, some information has been obtained.  
12 In the two years since testing began in our service, we  
13 have identified approximately 300 seropositive donors.  
14 We have also tried to extrapolate from this rate of  
15 donor, seropositivity, the number of transfusion  
16 recipients who have been infected in the past by these  
17 donors. In a small study in southeast Scotland, looking  
18 at the first 20 HCV seropositive donors to be  
19 identified, we found that over 70 potentially infectious  
20 units of blood had been donated by these individuals.  
21 However, many of the recipients of these units of blood  
22 died of their primary disease. Some are untraceable and  
23 there remained fewer than ten live patients."

24 Is that you presenting the data that we have seen in  
25 the Ayob paper?

1 A. Yes, exactly.

2 Q. Okay. Then you make an estimate of the 150 infected  
3 recipients in footnote 9 on page 588 in the Ayob report;  
4 that's right?

5 A. Yes, and that would have gone in subsequently, yes.

6 Q. Subsequently?

7 A. It hadn't been published at that stage.

8 Q. Of course, yes. So do you think that this was the first  
9 time that you were publicly presenting the data that  
10 ended up in the Ayob report?

11 A. Yes, I think it probably was, unless we had a poster at  
12 the BBTS meeting in September, which was possible, but  
13 certainly it was around that time.

14 Q. Are you able to remember how much time was spent on this  
15 data?

16 A. In that conference?

17 Q. In your particular talk. How much of your talk was  
18 concerned with your experience in the southeast?

19 A. A relatively small part of it. Mainly I was concerned  
20 with the broader epidemiological issues, and in fact at  
21 the end of the proceedings there is a transcript of the  
22 discussion and nobody asked a question about look-back.

23 Q. Yes. Okay. Could we go back to the flyer at page 2 of  
24 [\[PEN0180553\]](#)? At the bottom half of the page, the  
25 afternoon session, we see there is a talk from

1 Dr Dusheiko and so at the end of your talk there was no  
2 question or discussion about targeted look-back. That's  
3 right?

4 A. There was no discussion at the end of the talks; it was  
5 all held over to the final session at 3.30.

6 Q. I see.

7 A. And Gordon Scott tried to focus on what he thought were  
8 the big questions really and as I say, it just didn't  
9 come up in that part of the proceedings.

10 Q. Really? We got the impression from Professor Cash's  
11 evidence that Dr Dusheiko would have mentioned the  
12 question of targeted look-back. Is that your  
13 recollection?

14 A. It was but I fished this out last night and I was  
15 surprised to find that in his talk he doesn't refer --  
16 not in his talk, he wouldn't have referred to it but  
17 that it didn't come up in discussion. But I have to  
18 say, I have the same recollection as John Cash, that  
19 Geoff Dusheiko was interested in this and asking us,  
20 "Why isn't this happening?" He was coming from a very  
21 clinical standpoint and was very interested in the topic  
22 obviously.

23 Q. So your recollection is that by the end of the symposium  
24 the question of targeted look-back had been publicly  
25 discussed?

1 A. It had been aired and it certainly stimulated -- I'm  
2 sure it interested Geoff Dusheiko and maybe one or two  
3 others there.

4 Q. Okay. Thank you. Could we go back to your statement,  
5 page 2 of [\[PEN0180410\]](#)? In the middle of the second  
6 paragraph you refer to the Ayob paper and you say:

7 "Our conclusion stated in the paper was that  
8 look-back was feasible with little in the way of extra  
9 resource and justified in terms of outcome and as  
10 described in the Preliminary Report, this chapter was  
11 instrumental in the decision reached by the committee  
12 for the Microbiological Safety of Blood and Tissue  
13 (MSBT) at its meeting on 15 December 1994 to recommend  
14 to ministers that look-back should be undertaken  
15 UK-wide."

16 I think, if we could have a quick look at the  
17 Preliminary Report at page 322. It's paragraph 9.299.  
18 What it says is:

19 "On 15 December 1994 the ACMSBT met. The Committee  
20 decided to recommend to ministers that a UK-wide  
21 look-back exercise be introduced to identify those blood  
22 transfusion recipients infected with Hepatitis C prior  
23 to the introduction of Hepatitis C screening  
24 in September 1991."

25 If we could go back to Dr Gillon's statement. You



1 then narrate what happens subsequently:

2 "The recommendation was accepted on 11 January 1995.  
3 On 3 April 1995 the CMO, Dr Kenneth Calman, wrote to all  
4 doctors announcing look-back and an identical letter was  
5 issued by the CMO in Scotland to all doctors working in  
6 Scotland."

7 If we could go over the page, you refer to, at the  
8 top, a working party set up under the chairmanship of  
9 the Deputy CMO and then in the next paragraph you talk  
10 about implementation in 1995 and that formal monitoring  
11 of the look-back ceased in 1998. At this point I would  
12 like to look at the report that you prepared for the  
13 Inquiry at -- which is at [\[PEN0172220\]](#).

14 Dr Gillon, could you tell us what this document is,  
15 please?

16 A. This is a paper which I prepared, with input from one or  
17 two others, in the run-up to the Inquiry starting, when  
18 we had a team established in SNBTS to try to get  
19 together our materials in preparation for the Inquiry  
20 itself. And one of the things we did was identify one  
21 or two areas that would merit, effectively, a review  
22 paper, which is what this was.

23 Q. Yes. If we go over the page, we see that this is in  
24 response to a question from Mr Tullis, the Inquiry  
25 solicitor, on 21 April 2010, about what the SNBTS policy

1 was in relation to HCV look-back.

2 Could we go to page 2224? These are the contents of

3 the paper. Is that right?

4 A. Yes, that's right.

5 Q. Paragraphs 1 to 2.2 are primarily concerned with HIV.

6 Would that be fair?

7 A. Well, initially just describing the different types of

8 look-back, as we have discussed today, and some of the

9 experience, particularly in the United States, with HIV

10 look-back and then saying what we found when we did HIV

11 look-back in this country.

12 Q. Yes. So if we could just go to the section on HCV

13 look-back, which is at 2231, this is a paper that you

14 drafted primarily, Dr Gillon. Is that right?

15 A. Yes, Dr McClelland and Professor Franklin had some input

16 to it.

17 Q. Yes. In the first paragraph there you talk about

18 retrospective analysis in the USA and you talk about the

19 labour-intensiveness of the process, and I think the

20 footnote at the end of that paragraph is a reference to

21 a paper by Busch MP. Was that paper important in the

22 approach to look-back?

23 A. I think it was. Mike Busch worked in San Francisco with

24 Perkins, who had written his report on the outcome of

25 the HIV look-back and was the head of the department

1           there, and, as I described earlier, they put a huge  
2           amount of work into it and got not that much back out of  
3           it at the end, in terms of identifying patients. To  
4           tell you the truth, I can't remember exactly how  
5           enthusiastic or unenthusiastic Mike Busch was in that  
6           review paper that he wrote -- I think around the end of  
7           the 80s, was it, the 90s?

8    Q. We can have a look at it, [\[PEN0172307\]](#). Perhaps if we  
9           could just go to the last page of that, please. This is  
10           the end of his article. If we could go to the second  
11           column at the top, the paragraph that begins:

12                    "In light of the data showing the very limited  
13                    efficacy of previous look-back efforts ..."

14                    Just reading that again there, Dr Gillon, do you  
15                    recall what he was advocating?

16    A. He seems to be advocating a public education campaign  
17           for physicians and the lay public. Good luck to him,  
18           that's what I would say. I can't make out if he is  
19           saying that this would be more effective or just a way  
20           of doing something. In fact experience should have  
21           shown them in San Francisco that general appeals to the  
22           public to come forward for testing do not work. That is  
23           something that we considered in the working party set up  
24           by the MSBT. To some extent we did that in the press  
25           conferences and press releases, when the CMO's letter

1           came out. And indeed included in the letter to doctors  
2           was the statement that any patient with a history of  
3           transfusion who expressed any concern about HCV should  
4           receive a test.

5   Q.   Yes.

6   A.   And in the press releases and so on, patients were  
7           encouraged to come forward if they were worried, but  
8           very few did.

9   Q.   Okay. Thank you. If we could go back to the report,  
10           the exposition. In the next paragraph you talk about  
11           extrapolation that was done and we have discussed that.  
12           If we could go over the page, you talk about HCV  
13           look-back in Scotland and the pilot study, and we have  
14           also discussed that. If we could go over the page, the  
15           second paragraph, you say:

16                 "The outcome of all of this ..."

17                 In reference to the work that you did:

18                 "... all of the living recipients tested in the  
19                 initial period were able to be confirmed to be  
20                 HCV-positive in marked contrast to reports based on  
21                 first generation tests. The number of donors identified  
22                 as truly infected with the virus was approximately  
23                 tenfold less ..."

24                 And you have told us about that already. In the  
25                 next paragraph you talk about early papers, which are

1 listed in table 1. I wonder if we could have a look at  
2 table 1, please, which is at 2236. Could you just  
3 explain to us what this table shows?

4 A. At around that time we weren't the only ones that  
5 started publishing reports of our own local look-back  
6 and what I tried to do was compare the various reports  
7 that were appearing around that time in terms of the way  
8 they had gone about look-back, which tests they were  
9 using at the time, what the outcome was in terms of the  
10 number of components and recipients traced and  
11 recipients not traced and deceased and so on, and some  
12 studies are better than others.

13 I mean, I think that comes across very clearly just  
14 looking at some of the gaps in the Swedish study, for  
15 instance, which is even smaller than ours and very  
16 little detail given in the paper. But some are very  
17 helpful. The Netherlands study was bigger than ours,  
18 broadly similar results, and in fact everything that has  
19 been published subsequently really reflects the same  
20 outcome in terms of the proportion of patients who are  
21 deceased by that time, the proportion who are not  
22 traceable, and that at the end of it you end up with not  
23 that many alive, testable and Hepatitis C-positive  
24 recipients.

25 So I think it broadly confirmed our experience and,

1 as I say, these were appearing around the same time and  
2 must have been influential at that time too.

3 Q. Yes. Thank you. Could we now have a look at the  
4 question of cost-effectiveness of the targeted  
5 look-backs, if we could go back to page 15, please, two  
6 pages back. At the bottom of the page, you first of all  
7 talk about the situation in the San Francisco area.  
8 Could you tell us a little bit about that?

9 A. Well, I have alluded already to the amount of work they  
10 put into it and I don't know that they ever costed that.  
11 I can't remember. But they estimated that of the total  
12 number of patients who had been infected by transfusion  
13 in their area, they only managed to trace about  
14 3 per cent of them, so they were saying that this is not  
15 a particularly effective way of identifying people who  
16 have been infected by transfusion, which nobody would  
17 dispute.

18 They put an exceptional amount of effort into it, we  
19 put a fair amount of effort into it and others have  
20 tried to cost that. I think there was a Canadian study  
21 which estimated the blood transfusion service bit of it  
22 at something like \$6,000 per patient identified, which  
23 seems cheap.

24 Q. I think if we go over the page, we see that.

25 A. But there is a lot more to cost-effectiveness than just

1 totting up how much time and effort and therefore money  
2 it took us to identify the patients we identified.

3 Q. Yes.

4 A. If you are going to do proper cost-effectiveness, you  
5 need to look at the outcome beyond that and the impact.  
6 First of all, we didn't look at the hospital blood  
7 banks; it was tracing, tests and so on. The GPs would  
8 have had to put some effort into it. Then the patients  
9 were referred to specialists. That all cost money. And  
10 if they had gone to interferon treatment or a liver  
11 transplant and so on, that's even more expensive. And  
12 you have to say whether that's cost-effective in terms  
13 of the outcome, in terms of mortality, morbidity and  
14 prolongation of life and so on. So it's complicated.  
15 There aren't any really comprehensive studies that  
16 address that satisfactorily.

17 Q. Yes. What studies are there on the question of  
18 mortality and morbidity, as far as targeted look-back is  
19 concerned?

20 A. The best data have appeared quite recently, both from  
21 the outcome of the UK look-back, which gave rise to what  
22 was known as the "National HCV Register", which was set  
23 up by the NBS, in conjunction with the Health Protection  
24 Agency down south, to which we contributed. And what  
25 they decided to do and was a tremendous idea was, as we

1           were doing this look-back, to try to register as many of  
2           those patients as possible in a way that could allow  
3           prospective follow-up on the basis that we knew the date  
4           of infection because, of course, we knew the date when  
5           they had been transfused. And this is a uniquely  
6           valuable cohort. It is starting to give long-term  
7           outcomes in very precise terms.

8           At, I think, about ten years they reported some  
9           preliminary findings that round about 20 years, on  
10          average, since the time of transfusion, the mortality  
11          was no different between patients who had been infected  
12          by transfusion and patients who had had a transfusion  
13          but had not been infected by Hepatitis C.

14        Q. Yes.

15        A. So they couldn't demonstrate any benefit in terms of  
16          length of life. And they have continued this work up  
17          until now and I don't think there has been a subsequent  
18          report from that group yet but that would give us  
19          tremendous data. Meanwhile, a year or two ago the  
20          Danish published similar experience.

21        Q. I think you talk about that in your statement. So  
22          perhaps we should just look at that section. It's page  
23          4 of [\[PEN0180410\]](#). This is in the context of the  
24          question:

25                "How useful do you think the look-back exercise



1 was?"

2 I think you are addressing the best measure of  
3 benefit is mortality, and half way through that  
4 paragraph you refer to the Danish report. I'm sorry  
5 I interrupted you. Could you just carry on?

6 A. As I say, this is fairly recent and unlike the study  
7 I have described, which is in progress in this country,  
8 this is retrospective. So two or three years ago the  
9 Danish researchers looked back at the outcome of their  
10 look-back, which was done around the same time as ours  
11 actually, and found out what the outcome for those  
12 patients was. And again, they could really demonstrate  
13 no significant benefit in terms of mortality compared to  
14 non-infected transfused patients but they have shown  
15 very considerable morbidity in the HCV infected  
16 patients, which is really quite significant, I think.

17 I see at the bottom of the page there that not many  
18 patients were in fact treated with interferon but of  
19 those who were treated, they got nearly 50 per cent cure  
20 rates. So there was beginning to emerge evidence of  
21 benefit from that group of patients anyway.

22 THE CHAIRMAN: I wonder if I could follow the mortality  
23 point just a little. There is a shift towards  
24 liver-related cause of death --

25 A. There is.

1 THE CHAIRMAN: -- reported.

2 A. But not enough to affect or cause mortality.

3 THE CHAIRMAN: My concern is that while there perhaps is no  
4 change in the balance between those infected and those  
5 not, if there is a growth in the numbers dying from  
6 liver disease, does that not have some significance?

7 A. Indeed, but you would hope that can be affected by the  
8 fact that they have been identified and, as we see at  
9 the bottom of the page, offered treatment that might  
10 cure them.

11 THE CHAIRMAN: I see that as a second stage in the argument,  
12 as it were.

13 A. Yes.

14 THE CHAIRMAN: But the mortality risk has been increased by  
15 infection and that can be offset by treatment but of  
16 course the risk is there first, is it not?

17 A. Yes, indeed. It's a question of whether you would want  
18 to identify that in advance and potentially be able to  
19 do something about it.

20 THE CHAIRMAN: Sorry, Mr Gardiner.

21 MR GARDINER: I think that Danish study is at [\[PEN0180507\]](#).  
22 Is that it?

23 A. Yes, that's it.

24 Q. So this contains information about mortality but does it  
25 contain information about morbidity as well?

1 A. Yes, it does, I'm sure this is the paper that has  
2 morbidity included.

3 Q. When we talk about morbidity, we are talking about  
4 living with the disease?

5 A. Living with the disease, having cirrhosis and the  
6 implications of cirrhosis, which are very severe and in  
7 themselves life-threatening.

8 Q. Yes. So that's a treatment for people who are living  
9 with the disease and benefit from that is an indication  
10 in favour of targeted look-back, I think. That's what  
11 you are saying.

12 A. Yes, I think that's true, yes.

13 Q. Okay. We can put that away now. Could we go back to  
14 Dr Gillon's statement, please? Again, this is still in  
15 the context of the question of how useful targeted  
16 look-back was and in the third paragraph you talk about  
17 your own personal experience of counselling. Could you  
18 tell us a bit about that, please?

19 A. From the outset, when we did the look-back -- and this  
20 became standard practice in the UK general look-back --  
21 I offered the clinician responsible for the patient  
22 first chance to talk to the patient and counsel them if  
23 they wanted. If they didn't want to do that, we went  
24 through the GP and the GP in some cases took that on  
25 board. For instance if they were out in Fife or down in

1 the Borders, they might well do that. But most of the  
2 patients in fact ended up being seen by me and I saw  
3 most of them in the clinic I was still doing in the GI  
4 unit at the Western General Hospital, rather than in the  
5 donor centre. I think I may have seen one or two in the  
6 donor centre but I did the initial counselling of quite  
7 a few of these patients and followed them up for a short  
8 time afterwards. And I never had any negative feedback  
9 from patients that we shouldn't have done this, they  
10 would prefer not to have known. That didn't happen.  
11 Small numbers obviously.

12 Q. And you say in the next paragraph:

13 "However, since clearly measurable benefit has not  
14 (yet) been demonstrated, a cost-effectiveness analysis  
15 cannot be undertaken."

16 So are you suggesting that maybe in the future, when  
17 we have more data, that exercise will be able to be  
18 carried out?

19 A. I would hope. So I would hope that's what comes out of  
20 the HPA study and from the Danish work as well, that  
21 they will extend these studies long enough to show one  
22 way or the other.

23 Q. Yes.

24 A. You could argue it's a bit late now. Everybody has  
25 caught up and done look-back, even the Americans, but to

1 do a proper cost-effectiveness study you have to do  
2 that. You have to demonstrate benefit and then cost  
3 that benefit.

4 Q. Yes. The next question that we asked you at the bottom  
5 of that page was what you thought had been achieved and  
6 the answer is on the next page. I think one of the  
7 major benefits you have identified is that the UK  
8 transfusion services regained a measure of trust. Could  
9 you just explain what you mean there, please?

10 A. I think I have already said there were various media  
11 campaigns going on around the time when the decision was  
12 taken to start and the headlines that appeared were  
13 really quite toxic at times and damaging to the  
14 reputation of the transfusion service, and none of us  
15 stand to gain from the reputation of the transfusion  
16 service being harmed.

17 So I think the fact that, although the delay was to  
18 my mind unjustified and regrettable, it was turned round  
19 very quickly and still was one of the very earliest  
20 comprehensive look-backs in a large population, which  
21 the UK is, worldwide. And I think that that was  
22 important to calm down the atmosphere at the time and  
23 show that really we took it on board, we did something  
24 about it and we hope we have learned from it. And we  
25 can demonstrate we have learned from it by our response

1 to CJD, HTLV-I and other problems that have cropped up  
2 since then.

3 Q. You have mentioned donor support. I imagine that that  
4 is crucially important?

5 A. Absolutely, yes, and if donors see headlines criticising  
6 the transfusion service, week in, week out, they are  
7 going to question whether donating blood is something  
8 they want to do, and that's a disaster.

9 Q. Yes. So you would see that in itself as an important  
10 reason for having done targeted look-back. Is that  
11 right?

12 A. Well, it would have been better to have been preventive  
13 rather than reactive but it's better to have reacted in  
14 the right way rapidly, when we eventually accepted that  
15 that's what had to be done.

16 Q. Yes. The next question, final question, that we asked  
17 was an important question:

18 "What, if anything, would you have done differently  
19 in hindsight?"

20 You say that you don't regret the stance that you  
21 took on look-back and you don't think there is anything  
22 that you could have done that would have hastened the  
23 change in policy. Could you explain why you think that?

24 A. Well, I didn't really have a locus to change anything in  
25 any other way than doing what I did, which was stick to

1 my view that I thought we should do it and then go ahead  
2 and do it and show what that resulted in.

3 Q. Yes. We asked you to comment on an article that you  
4 wrote "Look back on Hepatitis C look-back", and that's  
5 at page 2 of [\[PEN0180822\]](#). We see that that is under  
6 the heading "Reader's Opinion":

7 "Look back on HCV look-back."

8 Can you just explain to us what the context of this  
9 piece was, Dr Gillon?

10 A. Yes, this was the Journal of the International Society  
11 of Blood Transfusion, of which Fereydoun Ala, who is the  
12 director in Birmingham, was editor at the time. And  
13 it's a magazine rather than a scientific journal. It's  
14 disseminated worldwide, obviously to transfusion  
15 services and -- I mean it's not a serious peer-reviewed  
16 journal or anything, and Fereydoun asked me to do this  
17 short opinion piece, which I wasn't keen to do.

18 I really couldn't see the point in 1999. Was it  
19 worthwhile? In a word, yes, and to fill the space  
20 I went on to speculate about why we hadn't done it  
21 sooner.

22 Q. I see. Okay. Let's just have a look at the article.  
23 I think you are taking an overview here of whether HCV  
24 look-back was worthwhile and in the second column at the  
25 top, the paragraph that starts "I think", you talk about

1 a particular problem. I think if we could all just take  
2 a minute to read from that paragraph to the end of the  
3 piece. So could I just ask you to read that again,  
4 Dr Gillon, just to yourself. (Pause)

5 Now that we have all had a chance to read that, you  
6 talk about the problem being one of psychology, rather  
7 than logic. I wonder if you could just explain to us  
8 what you mean by that?

9 A. I think there was a bit of group-think that went on,  
10 actually. I think there may be something in this shying  
11 away from the past and avoiding difficult things that  
12 might reflect badly on us. I just couldn't understand  
13 why my colleagues just didn't get on and do it,  
14 basically. I couldn't see what was -- apart from these  
15 minor resource issues, which I think were somewhat  
16 overplayed. And the only conclusion I can come to is  
17 that it was a group-think type of phenomenon, and once  
18 that gets established, it's very hard to turn round.  
19 I'm sure we have all had experience of that.

20 Q. The group-think would be, "Let's not do this because" --  
21 well, as much as anything else, it's going to be an  
22 unpleasant exercise to carry out?

23 A. Yes, and it's unpleasant. It's a very difficult thing  
24 to grapple with. It's not just time-consuming, each  
25 case sort of rumbles on for a long time and it's very



1 hard to keep it all together. We started before there  
2 were databases and computers to do this, and Excel  
3 spreadsheets and what not. It was all bits of paper,  
4 massive bits of paper all taped together, with lists of  
5 who had been contacted, where we had got to with this  
6 one, that one, the other one. Very hard to  
7 cross-reference, very hard to pick up the pieces when  
8 a new piece of information came in. It really is not  
9 fun to do. So anybody who had had any experience of  
10 that would shy away from it obviously, and when there is  
11 a collective tendency to think that, it's very easy to  
12 go along with it, I think.

13 Q. Yes. I mean, as you put it the not fun aspect of it  
14 there that you are referring to is the logistics, the  
15 difficulty of continuing to keep on top of it. But you  
16 also mention the fact that no one relishes the task of  
17 telling patients that they were harmed by interventions  
18 that were meant to help them. I imagine that that  
19 exercise of counselling a patient and effectively  
20 telling the patient, that is something that no doctor  
21 would really ever want to do, if they could choose?

22 A. No. It's the definition of "not fun". It's a very  
23 unpleasant thing to have to do.

24 Q. Do you think that was also a factor in the group-think?

25 A. It may well have been. We were telling the donors -- we

1 had experience of giving people bad news, we had been  
2 through it with HIV. If that was a reason, it shouldn't  
3 have been but as I say, nobody would look forward to  
4 having to do it.

5 Q. Yes. Despite the fact that this was an opinion piece  
6 that you didn't relish writing, does it still represent  
7 your view?

8 A. Yes, I think it does really, yes.

9 THE CHAIRMAN: Can I ask you this about the scheme: of the  
10 nine people who were tested, found positive and who were  
11 still alive, do you know whether any of them did have  
12 treatment as a result of that identification?

13 A. Not during the time when I was following them up, which  
14 would have been a relatively short time, and then  
15 I referred them on to a hepatologist experienced in the  
16 field.

17 THE CHAIRMAN: Yes, indeed.

18 A. I don't know. I didn't get feedback from the clinics  
19 that I referred them to in fact, saying this patient has  
20 been treated and failed or was unsuccessful. Once  
21 I referred them, the communication was between the  
22 clinic and the GP rather than me. I had no locus. So  
23 I am afraid I can't answer that question. Of course,  
24 our look-back didn't stop at that six month point and it  
25 has been ongoing ever since, so it's not just nine

1 patients that we have experienced --

2 THE CHAIRMAN: I appreciate that. I was simply looking for  
3 some indication of a particular positive outcome that  
4 might have resulted had you known about it.

5 A. That will come out of the work that Helen Harris and HPA  
6 are doing, and I know that Peter Hayes, who is the  
7 hepatologist who runs the HCV clinic in the Royal, has  
8 already made use of that resource for research.

9 THE CHAIRMAN: I can't remember if Professor Hayes said  
10 anything about that.

11 MR GARDINER: We will have to look back and see.

12 PROFESSOR JAMES: A targeted look-back.

13 THE CHAIRMAN: A targeted look-back on the evidence, yes.

14 MR GARDINER: If we go back to your statement, please,  
15 Dr Gillon, there were two final, practical questions  
16 that you have answered about how look-back was taken  
17 forward and then if we could go over the page, the  
18 question about how the procedures attached to the CMO  
19 letter of 3 April 1995 were implemented in practice.  
20 You cover that in that answer.

21 Dr Gillon, I don't have any more questions for you  
22 about look-back but obviously you have had experience of  
23 look-back, first of all HIV and then HCV, and I suppose  
24 look-back in a way never ends.

25 A. That's right.

1 Q. Is there anything else that you would like to tell the  
2 Inquiry about your experience of look-back?

3 A. I think we have pretty well covered it and I would only  
4 extend my observation about the way the patients respond  
5 to recent experience with CJD, which we were very  
6 nervous about because there were four cases of  
7 transmission of CJD through transfusion and that  
8 resulted in a sort of reverse look-back, if you like,  
9 and putting donors off, but then it extended --  
10 a reverse look-back -- I hesitate to mention this but  
11 a reverse look-back, of course, if you identify the  
12 donor who transmitted, then maybe it kicks off  
13 a targeted look-back from that donor to the previous  
14 donations. And there was a decision made to do that  
15 with absolutely no prospect of treatment for  
16 a potentially very nasty disease, and the fact that  
17 these -- I was going to say "patients", they are not  
18 patients yet in this sense, but their medical records  
19 would have -- I can't remember the exact wording but "at  
20 risk of BCJD, treat as public health risk" with, you  
21 know, destroying instruments when you have to have your  
22 teeth out whatever, and those patients didn't complain,  
23 extraordinarily. They accepted that information, which  
24 I think is an indication that, if you turn the ethics  
25 round and look at it from the patient's point of view,

1           which, of course, is the point of view you should be  
2           taking, they think they should have the information.  
3           They don't resent it and don't say, "You shouldn't have  
4           told me". And I think that is an ultimate ethics test  
5           for what we have been doing.

6   Q.   Yes. Thank you very much.

7           I don't have any more questions, sir.

8   THE CHAIRMAN: Mr Di Rollo?

9   PROFESSOR JAMES: Could I ask one thing, please? This is  
10          about the estimate that's in your 1994 paper, that you  
11          think that roughly, in Scotland, there would be around  
12          about 150 individuals who would have been, as an  
13          extrapolation from the data that you produced at that  
14          time, alive and who would have been infected at that  
15          time. You and I have discussed the fact that as  
16          a matter of fact, in the year before you started your  
17          look-back in Southeast Scotland, the criteria for  
18          acceptance or the discouragement of potential donors who  
19          might think that they might be at risk, was increased by  
20          information leaflets and so on and, of course, we know  
21          in the Inquiry that for the preceding eight or nine  
22          years, largely consequent upon HIV testing and  
23          discouraging donors from coming forward who might be HIV  
24          positive, the proportion of individuals who are  
25          HCV-positive would have decreased really very

1 significantly.

2 So I'm concerned that it has been used in some  
3 places, your estimate of only 150 "in Scotland", and you  
4 are aware that, for example, Dr Soldan, who works or  
5 worked with Dr Harris, produced some other modelling  
6 estimates, which would be very considerably higher than  
7 that. I don't think it's published but her estimate for  
8 Scotland, which she gave to SEBTS, was probably in the  
9 range of about 2,000 and for the UK was probably in the  
10 range of, from memory, 20,000 plus.

11 So we don't get this rather small 150 sort of in our  
12 minds too much, I wonder if you could comment on what  
13 I have just said.

14 A. Certainly. I think that's a very important point and  
15 I'm very aware that those figures are out there of the  
16 highest -- to my mind the highest -- to anybody's mind  
17 surely, they would be alarming figures.

18 I would make two points, I think, really. One,  
19 first of all, it depends crucially on how many infected  
20 donors were coming through the door year on year up to  
21 the onset of testing, and in my view the estimates in  
22 those papers were too high and we have been working with  
23 Professor Goldberg for the Inquiry, as you know, to try  
24 to come up with a model for Scotland that better  
25 reflects what actually happened and was happening in the

1 population in respect of Hepatitis C, and how that might  
2 have translated into the numbers of blood donors who  
3 were allowed to donate.

4 In other words, we have built in the factors that  
5 you mention, from donor selection in particular, but  
6 other factors about the changing prevalence, the sort of  
7 dynamics of the prevalence in the population, which is  
8 largely related to the drug using population in Scotland  
9 on which David Goldberg and his colleagues have done  
10 a huge amount of work.

11 I'm not sure if the Inquiry has seen any draft of  
12 that latest paper but I have seen it in draft and the  
13 numbers are much smaller than projected by Kate Soldan  
14 and colleagues.

15 PROFESSOR JAMES: I think it has been requested and some  
16 summary of it has been produced but the summary was  
17 effectively written on the back of a postage stamp, and  
18 I think the Inquiry would be very grateful to receive  
19 Professor Goldberg's fuller examination. Perhaps  
20 I could briefly just comment on that, which is that in  
21 your own paper, the 1994 paper, you noted that half  
22 a dozen of those nine had had transient IV drug  
23 exposure, sort of a mean -- just glancing at them -- of  
24 12 or 13 years previously. So that suggests that  
25 actually at risk behaviour was going on, you know, in

1 1980, 1981, 1978 and so on and I think one should be  
2 very careful indeed of just allowing this 150 to float  
3 in the air. Do you see --

4 A. I sympathise with that and the other point I would make  
5 is that the look-back, even our look-back, which started  
6 online, was starting 10/15 years after the risk activity  
7 and a lot of the patients will have died by then. So  
8 what we are finding is not that many patients alive and  
9 infected, but that's not to deny that a much larger  
10 number of patients were exposed, and extending back from  
11 that, that a very large number of blood components over  
12 the years might have had Hepatitis C in them.

13 What we have also been able to show is that  
14 particularly in Scotland, where we were driven by the  
15 need to maintain plasma self-sufficiency, and that  
16 resulted in a huge outdateding of red cells in particular  
17 in the mid 1980s, a lot of those components were never  
18 transfused.

19 PROFESSOR JAMES: Thank you very much, sir.

20 THE CHAIRMAN: Can I just enter one word of caution, that  
21 gratitude for Professor Goldberg's work is likely to  
22 suffer exponential decay as the process of writing the  
23 report continues and would eventually disappear if we  
24 didn't get it in good time.

25 Mr Di Rollo?



1 Questions by MR DI ROLLO

2 MR DI ROLLO: Sir, I just want to ask Dr Gillon one point  
3 about the stance that Professor Cash took.

4 You have indicated, I think very clearly, that you  
5 strongly disagreed with the stance that was taken at the  
6 time, and obviously your actions speak louder than words  
7 because you went off and did what you did.

8 What you have indicated, I think, in your evidence  
9 is that it was for you a question of an ethical view,  
10 and my learned friend referred to "look back on  
11 look-back", you say at the end of your article:

12 "These aspects, however, must not be allowed to  
13 cloud the essential ethical issue, which is about the  
14 responsibility of an individual doctor to an individual  
15 patient."

16 I just want to ask: the reason for your strong  
17 disagreement, to the stance that was taken by  
18 Professor Cash, is it an ethical issue. Can you just  
19 explain how you saw the ethical position at that time?

20 A. Yes. I saw it very clearly as a dilemma about what to  
21 do about a piece of paper landing on my desk with  
22 a result which says "donation [such and such], confirmed  
23 HCV-positive", and by the following day I would have the  
24 donor's record on my desk with that information, showing  
25 that there were previous donations, and that, to my

1 mind, translated into previous recipients and I couldn't  
2 in all conscience ignore that information. So I saw it  
3 as my duty of care to the recipients of that blood that  
4 their clinicians should have that information.

5 Q. Is that irrespective of the fact that treatment may or  
6 may not be available for those individuals?

7 A. Yes, obviously it is given more impetus if there is  
8 treatment available but I would point out there was no  
9 treatment available for HIV when we started doing that.  
10 It was seen as a much more serious disease, and that may  
11 be arguable, but at the time that was the perspective,  
12 and that it was a much more serious public health  
13 problem. And again, that may be arguable in retrospect,  
14 but even allowing for that, we did go into HIV look-back  
15 without specific treatment.

16 Q. Thank you.

17 THE CHAIRMAN: Mr Anderson?

18 Questions by MR ANDERSON

19 MR ANDERSON: Dr Gillon, Mr Di Rollo just now used the  
20 phrase "the stance taken by Professor Cash". I wonder  
21 if I can ask about that. After you had started your  
22 look-back exercise in September 1991, which became  
23 thereafter known as the "pilot study", whenever it was  
24 that Professor Cash discovered what you were doing, did  
25 he ever suggest to you that you must stop this, or that

1           you mustn't do it or whatever?

2    A.  No, not at all.

3    Q.  In his evidence to the Inquiry, David McIntosh, in  
4           relation to the policy of look-back, described  
5           Professor Cash as:  
6                 "... fighting a rear guard action to stop  
7           implementation of look-back when it couldn't be done  
8           universally in the UK."  
9           He went on to say he was trying to stop it.  Do you  
10           think that's right?

11   A.  No, I don't think he was trying to stop it.  We have  
12           certainly got no evidence that he was trying to stop it  
13           as such and in fact, as we have seen, he and the MSC  
14           agreed with the policy and put it forward to the UK  
15           committees.  
16           I mean, he was obviously very keen that it should be  
17           a UK-wide thing but he certainly didn't try to stop me  
18           and I didn't hear him or read anything from him that  
19           suggested he was trying to stop it in any active sense.

20   Q.  Thank you very much.

21   MR JOHNSTON:  Nothing from me, sir, thank you.

22                         Further questions by MR GARDINER

23   MR GARDINER:  Can I just clarify one thing with Dr Gillon?

24   THE CHAIRMAN:  Yes.

25   MR GARDINER:  My learned friend, Mr Di Rollo, asked you

1 about the look-back and you mentioned HIV look-back.

2 I was just wondering if you would accept that there was  
3 and is a difference in the infectivity of the two  
4 diseases, and whether that would also be a factor in  
5 doing look-back, you know, finding recipients of  
6 donations that had been infected to, from a public  
7 health point of view, avoid further spread of the  
8 disease?

9 A. From the point of view of avoiding secondary spread?

10 Yes. I think there is a degree of difference in  
11 infectivity and there was a lot of doubt about the exact  
12 extent of sexual transmission with Hepatitis C, but by  
13 the time we wrote our report, I think we were writing  
14 correctly that sexual transmission does occur, not  
15 efficient and not as bad as with HIV and nowhere near as  
16 with Hepatitis B, which is very much more infectious.  
17 But nevertheless it was there.

18 But, yes, I think there was a different perception;  
19 it was seen as less serious, less infectious and less of  
20 a risk to the community at large.

21 Q. I mean, the two diagnoses for the two diseases at that  
22 time were very different in terms of health  
23 implications?

24 A. Yes, I would accept that.

25 Q. Yes. Thank you very much.

1 THE CHAIRMAN: Dr Gillon, thank you very much indeed.

2 A. Thank you.

3 (1.07 pm)

4 (The short adjournment)

5 (2.00 pm)

6 DR AILEEN KEEL (sworn)

7 Questions by MR GARDINER

8 THE CHAIRMAN: Mr Gardiner?

9 MR GARDINER: Thank you, sir.

10 Good afternoon, Dr Keel.

11 A. Good afternoon.

12 Q. The topic that we are considering in this section of the

13 Inquiry is the topic of C5, which is to do with tracing

14 and testing of patients, and we are particularly

15 interested in at the moment in look-back. You have very

16 kindly provided the Inquiry with a statement in response

17 to certain questions. Is that right?

18 A. Yes.

19 Q. Thank you. So could we have a look at your statement,

20 which is [\[PEN0180396\]](#). I think you have a hard copy in

21 front of you.

22 What's your current position, Dr Keel?

23 A. I'm Deputy Chief Medical Officer for Scotland.

24 Q. Yes. What did you do before you joined the SHHD?

25 A. I trained in haematology and was working as a consultant

1 in London immediately prior to coming back to Scotland  
2 to the job as a Senior Medical Officer in SHHD.

3 Q. Yes. I think we have a copy of your CV, which is at  
4 PEN0180383. So this is a brief curriculum vitae?

5 A. Yes.

6 Q. If you go to the second page, please. Honorary  
7 Consultant Haematologist, Royal Infirmary of Edinburgh.  
8 If we could go down, we see the heading "Professional  
9 Qualifications/Membership", could you just take us  
10 through those please?

11 A. The MBChB is the basic medical degree. MRCP is  
12 membership of the Royal College of Physicians. MRCpath  
13 is membership of the College of Pathologists. The next  
14 two are fellowships at the Glasgow College and the  
15 College of Pathologists respectively. In 2004 I was  
16 awarded membership of the Faculty of Public Health in  
17 recognition of the job that I had been doing, and in  
18 2006 I was made a fellow of the Royal College of  
19 Physicians of Edinburgh.

20 Q. Thank you. Could you give us your career resume,  
21 please?

22 A. As it says on the screen, I trained in general medicine  
23 first of all and then in 1979 went up to Aberdeen to  
24 begin training in haematology and progressed through  
25 various jobs, sat the exam and qualified as

1 a consultant.

2 Q. Yes.

3 A. Then in 1992 moved back to Edinburgh and to a job in the  
4 Civil Service and was promoted to Principal Medical  
5 Officer in 19 -- gosh, I can't remember -- 1998 and then  
6 in 1999 was promoted to Deputy Chief Medical Officer,  
7 and I have been in that job ever since.

8 Q. Yes. On the second page we see a list of your previous  
9 appointments.

10 A. Yes.

11 Q. So between 1987 and 1989, Consultant Haematologist and  
12 director of pathology, Cromwell Hospital in London. Was  
13 that purely clinical?

14 A. I was -- well, in that post it was mainly running the  
15 laboratory, a multidisciplinary laboratory, but I also  
16 had -- that was a private hospital, so I was doing  
17 private practice in haematology as well.

18 Q. Yes. So it was mainly laboratory-based, was it?

19 A. At the Cromwell but I was still doing a lot of clinical  
20 work. As you can see, there is overlap between that and  
21 the post above, of Honorary Consultant Haematologist at  
22 the Central Middlesex, and I also worked at the  
23 Middlesex in a clinical role.

24 Q. Yes. Okay. Could we go a bit further down the page?  
25 We see before the Cromwell Hospital, various locum

1 posts, St Mary's Hospital, Middlesex Hospital, before  
2 that registrar in haematology at the Royal Infirmary,  
3 Glasgow, and lecturer in medicine at the University of  
4 Aberdeen between 1979 and June 1981.

5 A. Hm-mm.

6 Q. Yes, thank you. Okay. I think we can back to the  
7 statement now, please, [\[PEN0180396\]](#). So paragraph 2 is  
8 just really repeating what we have seen on your CV and  
9 what you have just told us.

10 I don't know, Dr Keel, if you have been following  
11 the transcripts of the Inquiry?

12 A. Not religiously but I have read some of them.

13 Q. Yes. Did you read the recent transcript from  
14 Professor Cash's evidence?

15 A. From yesterday?

16 Q. Yes.

17 A. I have read part of it.

18 Q. Yes, okay, thank you. I don't know if you saw the bit  
19 where I referred him to Lord Fraser's letter but I would  
20 like to ask you to have a look at that. It's  
21 [\[SNB0084848\]](#). Have you had an opportunity to read this  
22 recently?

23 A. Yes, I have got a hard copy in front of me.

24 Q. We have seen it fairly recently and what I would like to  
25 draw to your attention is the second paragraph, where



1 Lord Fraser is talking about a pilot research study,  
2 which he says:

3 "... has established that a look-back exercise for  
4 Scottish patients would be feasible and practicable."

5 Then at the bottom of that paragraph he says that  
6 a failure to implement look-back:

7 "... may result in a liability for loss or injury."

8 Then starting on the first page, in the last  
9 paragraph on that page he refers to the Advisory  
10 Committee for the Microbiological Safety of Blood and  
11 Tissue for Transplantation committee, the MSBT, and over  
12 the page he talks about what their advice is,  
13 recommending that guidance should be drawn up but this  
14 leaves unresolved the question of timing.

15 It's the next sentence which I would like to  
16 concentrate on. He says:

17 "The advice which I have received from my medical  
18 and legal staff is such that I consider it's no longer  
19 a matter of policy but of legal liability, and that the  
20 look-back should take place as soon as possible in  
21 Scotland. I am informed that the SNBTS is ready to  
22 carry out such an exercise ..."

23 Just before we go back and look at some of the  
24 documents from the past, Dr Keel, I just wondered if you  
25 could help us with the question -- it's fairly

1           obvious -- who decided at this point to proceed with  
2           look-back in Scotland?

3    A.   Well, the Minister ultimately decided, but he was given  
4           advice by a variety of policy colleagues, myself on the  
5           medical side, and clearly -- we had taken advice from  
6           legal colleagues at that point as well.  So collegiate  
7           advice to the Minister.

8    Q.   Yes.  It's really just as Lord Fraser says in the  
9           letter, that his decision has been taken on the basis of  
10          advice from SHHD staff, if you like, medical and legal.  
11          Is that a fair way of looking at it?

12   A.   Yes, I mean -- I was the main medical adviser in this  
13          area at this point.  I wouldn't have given advice on  
14          legal liability but I certainly gave advice as to the  
15          medical/clinical aspects and, of course, my view was  
16          informed by perhaps meetings that we will be coming to  
17          shortly, that happened in the months preceding this  
18          letter.

19   Q.   Yes.  So your view would have been informed by the  
20          advice that you were getting from the SNBTS?

21   A.   Yes, particularly around the Southeast Scotland pilot  
22          study, which had demonstrated for the first time that  
23          a look-back in this area was feasible.  Up until then  
24          part of the reason that it hadn't taken place was that  
25          it was just perceived to be logistically too difficult

1 and the pilot look-back in Edinburgh had demonstrated  
2 that it was feasible; it was difficult but it was  
3 feasible. So that totally changed the context in which  
4 we were having these discussions.

5 Q. Yes. We have heard evidence about the Medical and  
6 Scientific Committee, MSC, of the SNBTS. We have heard  
7 evidence about the Advisory Committee for Virological  
8 Safety of Blood, the ACVSB, which then became the  
9 Microbiological Safety of Blood and Tissue committee, so  
10 the Metters committee, MSBT. Then separately we have  
11 heard about the Advisory Committee On  
12 Transfusion-transmitted Infections.

13 In Lord Fraser's letter he is referring to one of  
14 those Advisory Committees but notwithstanding their  
15 advice, he is proceeding with look-back. I'm just  
16 wondering to what extent SHHD staff or yourself would  
17 have been relying on the advice from these two Advisory  
18 Committees?

19 A. Well, MSBT was the principal UK Advisory Committee,  
20 which was run out of the Department of Health and as you  
21 have said, by the then DCMO down there, Jeremy Metters.  
22 That was the committee that the health departments  
23 collectively looked to for advice. The other committee  
24 didn't have government representation on it. It was  
25 a group of professional advisers, whose views were

1 clearly very important, but MSBT was the Health  
2 Department's Advisory Committee and that would have been  
3 the one that we would have looked to for a steer on this  
4 look-back.

5 Q. Yes. Okay, thank you. Could we have a look at the  
6 letter that the Inquiry sent you, which is [\[PEN0172511\]](#)?  
7 This is the letter which contains the questions which  
8 you answer in your statement. Is that right?

9 A. Yes.

10 Q. Thank you. Could we go over the page? We see there  
11 that the Inquiry has included a schedule which sets out  
12 the historical context, and if we could go down to the  
13 bottom of the page, we start in 1990 with a description  
14 of events and the first thing that's mentioned is the  
15 working party to advise on policies and procedures.  
16 Could we go over the page? We note that the authors  
17 advise that look-back should be instituted from the  
18 onset of testing.

19 Then the next paragraph:

20 "The proposal for look-back underwent further  
21 discussion by both SNBTS and NBTS directors and was  
22 finally rejected after referral by the SNBTS, national  
23 medical director to the Department of Health, London."

24 Could we have a look at [\[SNB0018934\]](#)? We see that  
25 these are the minutes of the Advisory Committee on the

1 Virological Safety of Blood and it's the minutes of the  
2 ninth meeting of 25 February 1991. So this is the  
3 Inquiry that became the MSBT, if you like. I don't know  
4 if you have had a chance to look at these before, have  
5 you?

6 A. I may have. I mean, I have looked at lots of documents  
7 but, of course, this pre-dates my appointment to  
8 Scottish Government. So ...

9 Q. I realise that. We see that the chairman is Dr Metters  
10 and one of the observers is Dr McIntyre.

11 A. Yes.

12 Q. So could you remind us who Dr McIntyre was?

13 A. Dr McIntyre was the Principal Medical Officer when  
14 I joined the department back in 1992, who had  
15 responsibility for laboratories and blood transfusion,  
16 and when I was appointed, I took over these areas from  
17 him. So he clearly was attending ACVSB in advance of my  
18 appointment.

19 Q. Yes. So if you had been in post at that point, you  
20 probably would have been at this meeting?

21 A. Yes, and indeed I attended a couple of meetings of ACVSB  
22 before it morphed into MSBT.

23 Q. Yes. No doubt, when you joined, you would have been  
24 briefed about previous meetings?

25 A. I have no strong recollection of being briefed

1 specifically about ACVSB but probably Archie would have  
2 briefed me.

3 Q. Could we go to page 6 in that document? You see at the  
4 top of the page, paragraph 14, it's recorded that:  
5 "The committee discussed the problems of look-back  
6 and recommended that it should not be undertaken as  
7 a service, leaving the option for those carrying out  
8 research. However, all cases of post-transfusion  
9 hepatitis should continue to be investigated."

10 So the Advisory Committee there seems to be saying  
11 that they are not advising ministers to pursue  
12 look-back. Would you agree?

13 A. I would agree.

14 Q. Thank you. The next document I would like to show you  
15 is [\[SGF0012163\]](#). This is an SHHD memo from Dr McIntyre  
16 to Mr Panton. Who was Mr Panton?

17 A. He was one of my policy colleagues, who reported to  
18 George Tucker, who was the assistant principal at that  
19 point. So Rab Panton would have been a key policy  
20 colleague in taking these matters forward.

21 Q. Yes. Have you seen this before?

22 A. I think I have.

23 Q. Yes.

24 A. I can't be quite sure but I think I have.

25 Q. Yes. Well, if you want to take a moment to just remind

1           yourself. (Pause)

2           So we see there that he is referring to a copy of  
3           recommendations for counselling of HCV seropositive  
4           donors. He says:

5           "As you know, I'm particularly concerned about  
6           paragraph 3.4 at page 6, which states 'in the case of  
7           regular donors, the fate of previous donations is  
8           determined and look-back initiated in accordance with  
9           SNBTS policy'."

10          A. Can I ask what the date of this policy is?

11          Q. Sorry, it's at the bottom of the page.

12          A. 10 July 1991.

13          Q. Yes, the minutes I have just shown you are February 1991  
14             and this is July 1991.

15          A. Yes.

16          Q. So he seems to be talking about look-back here, would  
17             you agree?

18          A. Yes.

19          Q. And the third paragraph:

20             "In the present state of knowledge, donors who are  
21             only HCV seropositive donors without evidence of antigen  
22             may not be infectious. What purpose is served by going  
23             back. Will it cause the recipient of the blood (the  
24             50 per cent who are still alive after two years)  
25             unnecessary worry and possibly distress?"

1           So he seems to be raising a question about whether  
2           it's a good idea. Do you agree?

3   A. Yes, I would.

4   Q. Then he says:

5           "In certain circumstances, it could also give rise  
6           to litigation and it may be that you would wish to  
7           discuss this particular point with our solicitors before  
8           this policy is put into effect."

9           I'm just wondering, that seems to be a hint that  
10          there is a concern that look-back might give rise to  
11          litigation one way or the other. I'm just wondering  
12          whether, when you joined the service, you thought that  
13          was something that was being considered in the whole  
14          context of look-back?

15   A. Well, clearly from Archie's minute, this is a concern of  
16      his. I can't honestly remember it being an issue that  
17      was particularly stressed in our discussions around  
18      Hepatitis C and the possibility of look-back. I think,  
19      as I said earlier, the main memory I have is that  
20      look-back wasn't considered feasible, that logistically  
21      it would be too difficult to undertake, rather than any  
22      major concerns around litigation.

23   Q. Yes. Could we now go back to the schedule to Dr Keel's  
24      letter, please? So in the chronology we are coming to  
25      paragraph 6 at the top of the page and there is



1 a reference there to the look-back that had been  
2 commenced in Edinburgh and Southeast Scotland regional  
3 transfusion, then we move to 1993 and by this stage you  
4 have joined the service.

5 A. Yes.

6 Q. That's right. Just to get the historical context, again  
7 paragraph 7:

8 "5 October 1993, Dr Cash wrote to the SNBTS  
9 directors raising the issue of HCV look-back ... he  
10 intended to raise the matter at the ... MSC ...

11 "On 18 November 1993, Dr Cash wrote to Dr Gunson  
12 informing him of ... discussions ..."

13 The next paragraph:

14 "The ACTTI ..."

15 Which is the Advisory Committee On  
16 Transfusion-transmitted Infections:

17 "... met on 18 January 1994 ..."

18 Could we go over the page:

19 "Various members of the committee were to look into  
20 the issue further and report back at the next meeting."

21 Then we come to 16 May 1994:

22 "An SNBTS issues meeting was held at St Andrew's  
23 House."

24 We have the minutes of that at [\[SGH0040847\]](#). Have  
25 you had an opportunity to look at this, Dr Keel?

1 A. Yes, again I have a hard copy with me.

2 Q. Okay, thank you. We see that you are in attendance  
3 there.

4 A. Yes.

5 Q. What is an issues meeting?

6 A. Well, blood transfusion is an area that is never quiet.  
7 There are always lots of things going on and I think, as  
8 can be seen from other minutes around this area, Medical  
9 and Scientific Committee minutes, for example, there are  
10 a lot of various activities being undertaken by the  
11 transfusion centres, which give rise to issues which  
12 government need to be aware of. So these meetings,  
13 I think, were set up with a view to providing a forum  
14 for discussion of issues of mutual concern.

15 Q. Yes. So is it an ad hoc meeting in response to events?

16 A. We have these meetings nowadays and we have them  
17 regularly. Going back to 1994, my recollection is they  
18 were more sporadic than they are now, but they weren't  
19 just ad hoc; it was, I suppose, perhaps when policy  
20 colleagues in particular felt there was enough on the  
21 agenda to make a meeting worthwhile.

22 Q. Before we look at the detail of this meeting, can you  
23 remember, casting your mind back, from the time that you  
24 joined the service up until this point at the beginning  
25 of 1994, what was the general attitude at SHHD to

1 implementing look-back in Scotland?

2 A. I think it was as I have already outlined, that we  
3 shouldn't be proceeding with it because of the view that  
4 it wouldn't be feasible and the other relevant point is  
5 that at that point there was no really evidence-based  
6 treatment which would be effective for individuals  
7 identified with the virus. Treatments were beginning to  
8 emerge around about this time but up until 1994, there  
9 were no effective treatments.

10 Q. So shouldn't be proceeding because it wasn't thought to  
11 be feasible and, number two, there wasn't any treatment  
12 in any event?

13 A. Yes.

14 Q. Yes. In reaching that view, to what extent did you and  
15 your colleagues at SHHD rely on advice from the SNBTS?

16 A. Well, I think our view was informed by SNBTS's view,  
17 obviously, but more widely by the view which had been  
18 expressed by committees south of the border, in  
19 particular MSBT, over a period of time and also by  
20 expert opinion, you know, across the UK and more widely  
21 because there hadn't been any look-back exercise in any  
22 other parts of the world, for example.

23 THE CHAIRMAN: Could I ask a question. Before this meeting  
24 that we were coming to, did you know that there was  
25 a study of the nature of look-back going on in Edinburgh

1           and the Southeast of Scotland?

2    A.   I did not.

3    THE CHAIRMAN:   You had no information about this at all?

4    A.   No specific information.   It may have been mentioned.

5           I would use the phrase "in passing" but I had no detail  
6           of what was going on until the meeting of the Medical  
7           and Scientific Committee of SNBTS on 18 May, which was  
8           two days after this meeting.

9    THE CHAIRMAN:   Information in passing can still spark  
10           interest, Dr Keel.   Do you have any recollection of  
11           anything that did spark any interest in you in such an  
12           event?

13   A.   There had in late 1993 been a conference in the college  
14           in Edinburgh around Hepatitis C, which I attended, and  
15           there was interest then in the emerging treatment, which  
16           was Alpha interferon.   So, yes, I mean, obviously, I was  
17           aware of this developing area and the idea that we might  
18           at some point be able to offer treatment to patients,  
19           although it was by no means 100 per cent recognised,  
20           even by experts, such as Harry Zuckerman, that Alpha  
21           interferon was a particularly effective treatment.

22           So I suppose round about this time, yes, there were  
23           various things happening, the conference that I have  
24           mentioned being one of them.   There was also a meeting  
25           of the MSC in late November, where look-back was on the

1 agenda, but I have no clear recollection from that  
2 meeting of any detail around the Southeast Scotland  
3 pilot, nor of any particular emphasis being given by  
4 Professor Cash and his colleagues to the need to get on  
5 and do this, and certainly there was no detail revealed  
6 at that meeting of the Southeast Scotland pilot. That  
7 did follow at the later meeting, on 18 May.

8 THE CHAIRMAN: Yes. I'm sure that Mr Gardiner will want to  
9 fill in a lot of this detail but do you have no  
10 recollection of data from the pilot study being made  
11 available at the symposium?

12 A. No, I don't, no, I am afraid.

13 THE CHAIRMAN: Mr Gardiner, I wanted just to go back  
14 a little but I'll leave it to you to develop.

15 MR GARDINER: Yes. Let's go back to the symposium, if you  
16 wouldn't mind, Dr Keel. Could we have a look at  
17 [\[PEN0180553\]](#)? This is a flyer for the symposium  
18 "Hepatitis C virus infection". Does it ring any bells?

19 A. I know that I was there, yes.

20 Q. Yes. Could you go to the next page, 0554? We see on  
21 the right-hand side the speakers, Dr Follett,  
22 Dr Simmonds, Dr Gillon.

23 A. Yes.

24 Q. I know it's a while ago but do you have any memory of  
25 being present for the morning speakers?

1 A. Well, given that I attended, I imagine I was there in  
2 the morning but I have no recollection. I mean, these  
3 speakers, it looks from the titles that they have been  
4 given that they are setting the scene for, you know,  
5 outlining the basic epidemiology, the tests that are  
6 available. So, no, I can't remember the presentations  
7 on my feet.

8 Q. Can you remember any of the speakers on that day?

9 A. I remember Professor Dusheiko talking about treatment.  
10 I imagine he is further down the --

11 Q. Yes, he was in the afternoon at 2 o'clock, we can see.

12 A. Yes.

13 Q. But you don't have any memory, as you sit there today,  
14 of Dr Gillon's talk?

15 A. No, and I'm interested that there is no mention of  
16 look-back in Jack's title.

17 Q. Yes.

18 A. So I would infer from that that he did not talk about  
19 the look-back but perhaps I'm wrong.

20 Q. Well, Dr Gillon told us this morning that he did talk  
21 about his experience of look-back in the southeast and  
22 he has actually provided a copy of the paper that he  
23 gave, although it was subsequently revised. I'll just  
24 let you have a look at that. It's at page 4 of  
25 [\[PEN0181420\]](#). Actually could we go to page 2 first of

1 all? I appreciate that this is all new for you,  
2 Dr Keel, and it's a long time ago but what Dr Gillon  
3 told us this morning is that this is the paper that he  
4 spoke about. These are the things that he covered in  
5 his talk.

6 So on the first page we see "Epidemiology of  
7 Hepatitis C", "Historical perspective" and then  
8 "Geography". If we go over the page, at the bottom of  
9 the page, just about two thirds of the way down, there  
10 is a paragraph that begins:

11 "In a small study ..."

12 If you could see that?

13 A. Yes, I can see that.

14 Q. If you want to just read from there to the bottom, just  
15 take your time to read that. (Pause)

16 A. Can I ask if this is an abstract that Jack produced  
17 after the meeting perhaps, for publication, because  
18 I mean, he wouldn't have stood up and delivered this.  
19 He would have used a Powerpoint presentation, I imagine.

20 Q. Yes.

21 A. With selected headings.

22 Q. Yes, well, I don't think he was suggesting that the text  
23 of his talk was given out and also he told us that it  
24 was revised subsequently to a certain extent, footnotes  
25 were inserted and so on. But he did tell us that at his

1 talk he presented this data to the audience.

2 A. Well, I have no recollection of that part -- or any part  
3 of his presentation, I am afraid. I mean, if I could  
4 just comment, it doesn't say "in a look-back in  
5 Southeast Scotland", it says "in a small study", so the  
6 term "look-back" isn't even being used by him. If he  
7 had said "look-back" then maybe that would have lodged  
8 in my memory more than it clearly has.

9 Q. Yes, I understand. You would accept that what he is  
10 describing there is looking back to the recipients of  
11 donated blood?

12 A. Indeed, yes.

13 Q. So he is clearly describing a look-back exercise. Would  
14 you agree?

15 A. Yes.

16 Q. Thank you. We got sidetracked there. Could we go back  
17 to [\[SGH0040847\]](#)? Could we go to 0849? We see there  
18 under the heading "Hepatitis C -- look-back":

19 "Mr McIntosh indicated that when Hep C testing of  
20 donations was introduced in 1991 it was not thought  
21 appropriate to look back over previous donations.  
22 Mr Panton confirmed that any claims for compensation  
23 following infection with Hepatitis C should be refuted.  
24 After discussion it was agreed that Mr McIntosh would  
25 send a draft policy statement about look-back to the



1 department for clearance. This would then be used in  
2 response to any newspaper/media enquiries received by  
3 SNBTS."

4 So the first question, Dr Keel, is: do you think  
5 that it was at this meeting that you first became aware  
6 of the Dr Gillon data about look-back?

7 A. My clearest recollection of Jack Gillon's work was at  
8 the meeting two days after this at the MSC. In relation  
9 to this meeting, I really have no strong recollection of  
10 the discussion around the look-back. Clearly it was  
11 discussed. But the meeting two days later had a much  
12 bigger impact on me.

13 Q. Yes. We are going to come to that. But the other thing  
14 I wanted to ask you about was Mr Panton referring to  
15 claims for compensation in the context of look-back, and  
16 I'm just wondering again, does this represent a concern  
17 that was about in the SHHD at that time, that proceeding  
18 with look-back could precipitate claims?

19 A. I can only repeat what I said earlier in answer to this  
20 question: to me it was not a major element in our  
21 thinking around why look-back should not go ahead. That  
22 related to the other factors that I have already  
23 outlined.

24 Q. Yes. The other thing I wanted to ask you about was this  
25 reference to newspaper and media enquiries. Would we be

1 correct in getting the impression that at this point the  
2 media/newspapers are becoming interested in the question  
3 of look-back?

4 A. Well, that sentence would certainly give that impression  
5 but I'm not quite clear why that should have been at  
6 this particular juncture, that there should have been  
7 media interest, just de novo. So I don't quite  
8 understand where the media interest might have been  
9 coming from or why it had been stimulated.

10 Q. Do you have a memory at that point of media interest in  
11 the look-back question?

12 A. Not at this point, no.

13 Q. Thank you. So do we take it then that when you left  
14 this meeting, you didn't think that look-back was  
15 a particularly hot issue?

16 A. I think that would be a fair thing to say, yes.

17 Q. Okay. Thank you. Could we go to the 18 May minutes,  
18 which are [\[SNB0099331\]](#)? We see present Professor Cash,  
19 Dr Gillon, yourself, Dr Mitchell, Dr McClelland,  
20 Dr Perry, Mrs Thornton. First of all, Dr Keel, could  
21 I just ask: was it normal for you to attend MSC  
22 meetings?

23 A. My recollection is that it was normal. I wouldn't  
24 perhaps be there for the whole event but I would attend  
25 for part of the meeting, depending on other diary

1 commitments.

2 Q. Yes. How would you decide which bits of the meeting you  
3 would stay for and which bits you wouldn't be present  
4 for?

5 A. I suppose I would look at the agenda in advance but  
6 I think more often than not I tried to be there at the  
7 beginning and stay for as long as I could.

8 Q. Yes. Professor Cash told us, I think I'm right in  
9 saying, that he had specifically arranged for you to  
10 attend this meeting because look-back was going to be  
11 discussed and he thought it would be important for you  
12 to be there. Does that ring any bells with you?

13 A. No, I read that in Professor Cash's evidence yesterday  
14 and that doesn't tally with my recollection of fairly  
15 routine attendance at these meetings. I certainly have  
16 no recollection of him approaching me and saying,  
17 "Look-back is going to be on the agenda, you need to be  
18 there".

19 Q. Yes. Hypothetically, if that had been the case and you  
20 had known that look-back was going to be discussed, what  
21 would you have seen as your role at the meeting?

22 A. Well, I suppose it would have depended on whether John  
23 or SNBTS had told me they wanted to go ahead with a  
24 look-back exercise. Had that been the case, I would  
25 definitely have spoken to policy colleagues before I set

1 off for the meeting.

2 Q. Yes. Why was that? Why would that have been? If you  
3 had been getting that advice, why would you need to  
4 speak to policy colleagues?

5 A. Well, because this would have been a change in view on  
6 look-back. We have had a lengthy discussion up until  
7 now about the reasons why Scottish Government and other  
8 bits of the UK Government didn't want to proceed with  
9 look-back. So that was the policy which was in my mind.  
10 So if I had been given advance notice that SNBTS were  
11 going to present me with evidence that suggested we  
12 should be moving towards a look-back, then I would  
13 have -- well, it would have been obvious that I should  
14 have discussed it with policy colleagues because no  
15 decision in government is ever taken unilaterally; it's  
16 always, as I said earlier, a corporate decision and  
17 advice is developed by a number of people before we go  
18 to ministers.

19 Q. Yes. So, to the best of your recollection, you arrived  
20 at the meeting thinking SHHD policy is we are not going  
21 ahead with look-back, but if you received advice from  
22 the SNBTS, which would be advising that look-back should  
23 be proceeded with, then that would be a change of policy  
24 and so you would want to check first with colleagues  
25 about that?

1 A. Yes, and I think that's the way that the meeting is  
2 minuted. Obviously, if there is new evidence, then that  
3 has to be taken into account in terms of developing  
4 policy and possibly changing it.

5 Q. Yes. I mean, am I right in thinking that it would still  
6 be ultimately a question for SHHD to decide on the basis  
7 of that new evidence whether to change policy?

8 A. Well, I think I know where this is heading because the  
9 minutes clearly indicate that I suggested that it might  
10 not be a matter for SHHD and the reason behind that  
11 is -- I think that the words -- I expressed a view that:

12 "SHHD may not have a locus in this matter and the  
13 SNBTS should make a decision on look-back for HCV that  
14 was based on their professional judgment."

15 The minutes are perhaps not as explicit as they  
16 might be but I think what I was trying to convey to  
17 SNBTS was that if in their professional -- by that  
18 I meant clinical -- judgment, a look-back was feasible,  
19 as Jack Gillon had clearly demonstrated, then they,  
20 because they have a duty of care to donors and  
21 recipients of blood, might feel the necessity to proceed  
22 with it on professional grounds.

23 You have to remember that I was a relatively new  
24 recruit to government at that point. I knew that  
25 I unilaterally should not be taking any decisions in

1 this area about changes in policy and, as is clearly  
2 minuted, I said I would like to discuss it back at base  
3 with colleagues before SNBTS did anything.

4 And what isn't minuted here is the fact that  
5 Jack Gillon gave a presentation at this meeting, which  
6 for the first time -- well, the first time that I  
7 remember -- very explicitly laid out how they had gone  
8 about it, how many people they had identified and how  
9 successful they had been, in a limited way, in tracing  
10 recipients of blood, blood components.

11 So at that meeting, as I say, I was really conscious  
12 in a very powerful way of what had been going on, which  
13 had not been visible to us, certainly not overtly, prior  
14 to that. So this was absolutely, as far as I was  
15 concerned, new evidence that I needed to discuss with  
16 colleagues. But I felt that this was really a clinical  
17 judgment as to whether to go ahead with it.

18 Now, clearly, SNBTS needed help with organising it  
19 and the look-back exercise was announced by the Chief  
20 Medical Officer, by the Secretary of State, and all of  
21 that had to be behind it to make it a success but in  
22 purely professional terms, they had identified that they  
23 could do it, that they were identifying recipients of  
24 blood that was infected and therefore they had a duty of  
25 care to those individuals. So that was why I said what

1 I said.

2 Q. Yes. Just to take it step by step, Dr Keel, without  
3 looking at what was discussed at the meeting, just to be  
4 clear about what you thought the position was when you  
5 arrived at the meeting, was it that SHHD policy was, no  
6 look-back, and would only be changed or may be changed  
7 if new evidence was presented by the SNBTS? Or was it  
8 that SHHD policy was no look-back but that policy could  
9 be changed by SNBTS advising you that in their clinical  
10 judgment, you should go ahead with look-back? Do you  
11 see the distinction? Whose decision is it ultimately?  
12 Is it the SNBTS? If they say, "You go ahead", and you  
13 have to go ahead, or they present this new evidence and  
14 you take account of that and then make the decision?

15 A. Well, probably the former is the way that, you know, the  
16 process should work. I mean, the way it's minuted,  
17 I come over as perhaps conveying the idea that this is  
18 SNBTS's decision and that may reflect the fact that  
19 I had not been the Senior Medical Officer for all that  
20 long at that point. But I come back to the fact that  
21 I said very clearly, "I need to discuss this with  
22 colleagues," and that is minuted. And indeed, I left  
23 the meeting and went straight back to St Andrew's House  
24 to speak to Rab Panton.

25 Q. So just before the meeting, just to be clear, are you

1           saying that it wasn't a decision for SNBTS; it was still  
2           a decision for SHHD?

3    A.   Well, it wasn't at that point because SNBTS hadn't  
4           presented us with this new evidence, which, as I say,  
5           changed the entire context of the debate around should  
6           there or should there not be a look-back exercise.  
7           Government policy is always informed by information from  
8           various sources and in this situation SNBTS clearly were  
9           a key source of information and provided evidence that  
10          the context had changed because they had demonstrated  
11          that the look-back was feasible.

12   Q.   Yes.

13   A.   So that had to inform government policy and indeed it  
14          did.

15   Q.   Yes.   But ultimately, no matter what happened at the  
16          meeting, it was your view before you got there that it  
17          was the SHHD's decision; it wasn't a question of the  
18          SNBTS making the decision, it was still your decision?

19   A.   Well, it would be a UK government decision ideally  
20          because the major Advisory Committee, MSBT, was set up  
21          to advise all four UK governments at that point.   So  
22          I would have been aware of that at the back of my head.  
23          So, yes, it would not have been SNBTS's decision to  
24          proceed unilaterally with a look-back.

25   THE CHAIRMAN:   Mr Gardiner, can you keep an eye on the time?



1 MR GARDINER: Yes, indeed.

2 Let's have a look at what's in the minutes? Could

3 we go to 9335? You have had an opportunity to read

4 these minutes. That's right, isn't it, Dr Keel?

5 A. Yes.

6 Q. Under "Any other competent business":

7 "HCV look-back.

8 "This very complex and extremely important issue was

9 discussed at length. The committee unanimously agreed

10 that on finding a 'known' (or regular) donor who was now

11 anti-HCV-positive, the SNBTS should ..."

12 Then on the next page we have (i), (ii), (iii) and

13 (iv). That really describes look-back, would you agree?

14 A. Yes.

15 Q. So the committee is suggesting that look-back should be

16 pursued. That's correct, isn't it?

17 A. Well, as I say, what's missing from these minutes is the

18 fact that Jack Gillon gave a presentation. So the

19 committee's views would have been formed on the basis of

20 the evidence that he presented. So the committee was

21 expressing the view that look-back should proceed.

22 Q. Would you consider yourself to be a member of the

23 committee that day?

24 A. No, I'm an observer.

25 Q. So that's not you when it says "the committee"?

1 A. No, that's not me.

2 Q. I'm sorry, I have not given you a chance to tell us  
3 about Dr Gillon's presentation. Would you like to tell  
4 us about that?

5 A. Well, my recollection -- and it's a long time ago but my  
6 recollection is of Jack standing up and showing various  
7 slides on how they had gone about the pilot and  
8 providing to me, and clearly to the other people round  
9 that table, convincing evidence of the feasibility of  
10 undertaking this exercise and of tracing infected  
11 donations to recipients.

12 Q. Yes.

13 A. It made a powerful impression on me.

14 Q. Yes. The message was: look-back is feasible.

15 A. Yes.

16 MR GARDINER: Sir, I think that might be a good moment.

17 THE CHAIRMAN: I think so.

18 We have to allow the stenographer time to recover,  
19 Dr Keel.

20 (3.04 pm)

21 (Short break)

22 (3.21 pm)

23 THE CHAIRMAN: Yes, Mr Gardiner?

24 MR GARDINER: Thank you, sir.

25 Dr Keel, could we go back to the minutes that we

1           were looking at beforehand. This is on page 9336. We  
2           have just looked at the bit where the committee is  
3           recommending look-back and then at paragraph 5 it says:

4                 "From an SHHD perspective, AK expressed a view that  
5           the SHHD may not have a locus in this matter."

6                 I take it that "matter" there is referring to the  
7           question of whether to proceed with look-back.

8   A. Yes.

9   Q. Okay. Please correct me if I'm wrong but I'm just  
10        surmising from your previous evidence that you would  
11        probably accept now that SHHD did have a locus in that  
12        matter and if that's correctly recorded there, about  
13        what you said, then it's maybe just because you were  
14        relatively new in your post. Is that right?

15   A. Yes, I would accept that.

16   Q. Yes. Okay. So just reading on:

17                 "... SNBTS should make a decision on look-back for  
18        HCV and that was based on their professional judgment.  
19        However, before SNBTS took any action, AK asked to be  
20        given the opportunity to discuss the issues with SHHD  
21        colleagues to seek their views and ask that the SNBTS  
22        take no formal action until she had subsequently  
23        contacted JDC."

24                 Then:

25                 "Once AK had communicated the SHHD position to JDC

1 and provided SHHD were in agreement that the SNBTS  
2 should implement this policy, JDC would write to  
3 [David McIntosh] to provide details of the SNBTS policy,  
4 thereby allowing a decision to be taken on a starting  
5 date for the process. JDC would also formally advise  
6 NBA, NIBTS, SACTTI and MSBT of the SNBTS policy."

7 Are the minutes accurate, as far as you can  
8 remember, about what was discussed?

9 A. I honestly can't recall this part of the discussion. As  
10 I said before, we stopped for tea, Jack Gillon's  
11 presentation is the thing that I remember most clearly  
12 because it made a powerful impact on me and convinced me  
13 as a clinician that this was the right thing to be  
14 doing. I don't think even in my then current relative  
15 newcomer state I would have accepted that John Cash  
16 would inform MSBT of a change in policy of this  
17 magnitude. So I don't think I wouldn't agree with that  
18 bit of the minute.

19 Q. He is saying changes of SNBTS policy.

20 A. Yes, but even so, I would have expected him to use the  
21 department or indeed one of the SNBTS members of MSBT to  
22 convey the SNBTS change in view in this area, rather  
23 than him doing it directly.

24 Q. Yes.

25 A. So I honestly don't know whether that is accurate, but

1 clearly MSBT was not a committee on which he sat and  
2 therefore it would not have been appropriate for him to  
3 be conveying any view to them.

4 Q. Even if he is expressing the view of the SNBTS?

5 A. MSBT was the vehicle of the government health  
6 departments. I was sitting round this table, being part  
7 of this discussion. So I think perhaps John would have  
8 expected me or my colleagues to convey that view to MSBT  
9 that SNBTS had come up with this new evidence.

10 Q. Yes. Then just reading on, we see:

11 "If SHHD agreed that SNBTS should develop and  
12 implement a look-back policy for HCV, AK subsequently  
13 would communicate this to the [Department of Health]."

14 That last bit, would you say that was an accurate  
15 note of what was agreed?

16 A. Yes, I mean, whether it was me as an individual or SHHD  
17 conveying this view to DH is a moot point. One way or  
18 another we would have had to let the Department of  
19 Health know about it. All of this was predicated on the  
20 discussion that I was going to have with my policy  
21 colleagues.

22 Q. Yes. Did you have that discussion after this meeting?

23 A. I did. I think the minutes say that I -- perhaps no.  
24 I left the meeting -- we broke for tea, I have  
25 a recollection of breaking for tea, probably around

1 about 3 o'clock, and I also have a recollection of  
2 someone from SNBTS saying to me that John Cash was  
3 phoning Harold Gunson to relay my views expressed in the  
4 meeting and that SNBTS would be going ahead with the  
5 look-back.

6 Well, at that point I thought I had better get my  
7 skates on and get back up St Andrew's House and discuss  
8 all of this with policy colleagues as a matter of  
9 urgency, and as I said earlier, that's exactly what  
10 I did because clearly John, for -- well, if the person  
11 who said that he was on the phone to Harold Gunson is  
12 correct, John was rather jumping the gun on this.

13 Q. What do you say he was representing to Dr Gunson about  
14 your position?

15 A. Well, this is hearsay because it's through a third party  
16 but my recollection is that it was clearly conveyed to  
17 me that John was saying Government, SHHD, had said they  
18 could go ahead with the look-back.

19 Q. Right. So he was --

20 A. So it would be happening in Scotland.

21 Q. Right. So Professor Cash was representing that you, as  
22 representing SHHD, had said at the meeting that the  
23 SNBTS could go ahead with look-back?

24 A. Yes, that is my recollection of what was said to me at  
25 the tea break during this MSC meeting.

1 Q. Yes. Professor Cash is on the phone to Dr Gunson and he  
2 is saying that you are saying that they can go ahead  
3 with look-back?

4 A. Yes.

5 Q. Yes. But that wasn't correct?

6 A. It certainly wasn't correct and the minutes reflect  
7 that.

8 Q. Yes. But Dr Gillon's presentation had made a very big  
9 impression on you?

10 A. Indeed it had, and I was convinced as I left that  
11 meeting that whatever previous views of SHHD had been,  
12 it was my job to convince policy colleagues that the  
13 right thing to do now was to go ahead with the look-back  
14 because Jack's pilot had demonstrated its feasibility.

15 Q. Yes. Because you personally had been persuaded?

16 A. Indeed, I had been.

17 Q. Yes. Which colleagues did you discuss this matter with?

18 A. I think I went to see Rab Panton immediately.  
19 I think -- again my recollection is rather hazy but  
20 having told him the tale, I think we probably went along  
21 to his senior, George Tucker, and I think we had  
22 a collective discussion, but I can't be absolutely sure  
23 about that but I certainly briefed Rab.

24 Q. Yes. So the message that you gave to Mr Panton was,  
25 "I'm persuaded that we should be going ahead with

1 look-back and we should be doing something about it."

2 A. Yes.

3 Q. Okay. What was his reaction to that?

4 A. I don't have a very clear recollection but I'm sure he  
5 took what I was saying very seriously and I think  
6 I would also have said to him, "And by the way, I think  
7 John Cash has already been on to Harold Gunson at the  
8 NBA so we need to do something about this very quickly,"  
9 but I can't be absolutely clear about that.

10 Q. You were persuaded by Dr Gillon's presentation because  
11 it was clear that look-back was feasible. Was that the  
12 main point of his presentation?

13 A. I think that was the main point but allied to that was  
14 a growing awareness that treatment was becoming  
15 available for infected patients.

16 Q. Yes. So Dr Gillon's presentation covered the treatment  
17 aspect as well?

18 A. I don't know that it did but at the back of my mind --  
19 and you know, given the Hepatitis C conference that we  
20 have already discussed and Dr Dusheiko's presentation on  
21 treatment, I mean, all of that would have been quite  
22 fresh in my mind. But I think the main thrust of Jack's  
23 presentation and why I was convinced by it was his  
24 demonstration of the feasibility because that had been  
25 one of the major arguments against proceeding with



1 look-back up until then.

2 Q. Yes. We have seen from other references in the minutes  
3 that Mr Panton has previously referred to liability,  
4 concern about liability. Do you remember if that was  
5 something that featured in your discussions?

6 A. On this day, when I went back to ...?

7 Q. Yes.

8 A. I don't recall that being an element of the discussion,  
9 no.

10 Q. Just trying to think about, I know it's a long time ago  
11 but did your thinking go: well, I know there is  
12 treatment, I have now been told that it's feasible to do  
13 look-back and the implications of that are that if we  
14 don't do it, there may be some legal liability because  
15 there is a breach of duty of care? Did that part of the  
16 equation feature in your thinking?

17 A. I can't be clear about that but I suspect it formed part  
18 of our collective thinking, as over the next couple of  
19 days we put our views together and we obviously sought  
20 legal advice on the issue of liability. So it must have  
21 been an element of, if not my thinking, our collective  
22 discussions around that time.

23 Q. Yes. So that was the sequence of events: you went to  
24 somebody for legal advice?

25 A. My policy colleagues would have sought that legal

1           advice, yes.

2   Q.   On the basis of this new information that look-back was

3           feasible?

4   A.   Yes.  And it had been demonstrated as feasible in a part

5           of Scotland.

6   Q.   Yes.

7   A.   So that made us different from the rest of the UK.

8   Q.   Yes.  So who would organise obtaining that advice?

9   A.   I imagine Rab Panton did.

10  Q.   Right.  Okay.

11  A.   I can't be sure.  I haven't seen any -- the files

12           relating to this period are not available in many cases.

13           So I can't be sure.

14  Q.   Yes.  Do you know who provided that advice, if anyone?

15  A.   I can't recall, I am afraid.

16  Q.   No.  Do you know when it was provided?

17  A.   Lord Fraser's letter refers to it and I spoke about it

18           at MSBT, so some time between May and September we had

19           obviously obtained that advice but I can't recollect how

20           quickly we went about it.

21  Q.   Yes.  This would be from a Scottish Office solicitor?

22  A.   Yes.

23  Q.   Do you remember what the advice was?  Could you describe

24           it?

25  A.   Well, I think it's as captured in the text in

1 Lord Fraser's letter, that, having demonstrated the  
2 feasibility of the look-back exercise, Scottish  
3 ministers would be vulnerable if the look-back was not  
4 proceeded with across the country.

5 Q. Yes. Do you have a memory of reading the advice?

6 A. Not really, I am afraid.

7 Q. No.

8 A. I'm sure I did read it but I can't recollect.

9 Q. Yes. Okay, thank you. So by the end of this meeting of  
10 18 May, what did you think had been decided? Was it  
11 SNBTS were to wait until you had conferred with  
12 colleagues before confirming their policy?

13 A. Yes.

14 Q. Right. Could we have a look at [\[SNB0084779\]](#)? This is  
15 a fax from Mr David McIntosh to Mr Panton. Have you  
16 seen this before?

17 A. Yes, I have got a copy in front of me.

18 Q. Okay. So we see that what it says is:

19 "The MSC has now formally recommended to me that  
20 service should implement a look-back policy ..."

21 He says:

22 "This is sufficient grounds for immediate acceptance  
23 ..."

24 And he is intending to give colleagues in England,  
25 Wales and Northern Ireland, prior warning of an

1 intention to activate look-back with effect to  
2 1 June 1994. Do you remember seeing that document at  
3 the time?

4 A. No, I don't recollect seeing it at the time.

5 Q. No.

6 A. The annotations don't copy me in but colleagues probably  
7 made me aware of it. I don't recollect seeing it at the  
8 time.

9 Q. Would you have been surprised to see that standing the  
10 discussions at the meeting?

11 A. Yes.

12 Q. Yes. Okay. The next document I would like you to look  
13 at is [\[SNB0084783\]](#). This is a letter which records  
14 a meeting, Professor Cash, Brian McClelland,  
15 Jack Gillon, at SOHHD on 24th. Do you remember that  
16 meeting?

17 A. No, I don't remember it. I imagine that we established  
18 it to try and work through the logistical issues around  
19 this matter.

20 Q. Yes. But you were at the meeting?

21 A. I believe I was but I really have no recollection of the  
22 discussion, I am afraid.

23 Q. Okay. I would like to jump forward to September 1994.  
24 Could we go to [\[SGH0040840\]](#)? This is a meeting about  
25 SNBTS general issues, Mr Tucker. He is your superior at

1           this point?

2   A.   Not strictly speaking.  He was, as far as grades were  
3       concerned at that point, my equivalent on the policy  
4       side.

5   Q.   Yes.  And so we see that he is present, Dr Keel,  
6       yourself, Mr Panton, Mr Wildridge.

7   A.   Yes.

8   Q.   Do you remember this meeting?

9   A.   No, I am afraid not.

10  Q.   Okay.  Let's have a look at 0841, please.  We see under  
11       the heading "Hepatitis C look-back":

12           "Glasgow Royal Infirmary had written seeking funding  
13       for the costs of treatment with Alpha interferon for  
14       patients with transfusion acquired Hepatitis C and  
15       pharmaceutical services had replied to the effect that  
16       whoever was in charge of clinical care was also in  
17       charge of prescribing.  The position of the department  
18       was that the source of the infection was, in this case,  
19       irrelevant and that no additional funding would be made  
20       available."

21           If we go over the page, at the top, again in the  
22       context of look-back:

23           "Dr Keel had attended a meeting of hepatologists and  
24       their view was that a look-back was necessary as part of  
25       a general duty of care.  It was noted that SNBTS had

1 still not produced suitably detailed papers on the costs  
2 and consequences of a look-back but that in any case the  
3 issue was now being taken forward by ..."

4 Should that be "not being taken forward" or "now  
5 being taken forward," do you think?

6 A. I imagine it's "now".

7 Q. Okay:

8 "... the department would continue to monitor the  
9 situation."

10 So at this stage, Dr Keel, what is the plan about  
11 look-back as far as SHHD is concerned?

12 A. I think there was general agreement that it should go  
13 ahead.

14 Q. Yes.

15 A. The meeting of hepatologists, I don't recall, but what  
16 I have said reflects my own view that the look-back had  
17 to proceed because this was part of a duty of care that  
18 SNBTS had to their donors and recipients.

19 Q. Yes. Had any discussions taken place with the  
20 Department of Health colleagues about look-back by this  
21 stage?

22 A. I imagine they would have but I can't remember what the  
23 substance would be other than sharing with them the  
24 evidence that SNBTS had demonstrated that look-back was  
25 feasible, our view in SHHD that it should therefore go

1 ahead and our desire for it to be discussed in MSBT, in  
2 particular, so that a collective view could be taken  
3 across the UK about proceeding.

4 Q. Yes. Okay. Could we go to [\[SNB0099176\]](#), please? These  
5 are the minutes of the MSC for 9 and 10 November and  
6 again, do you think you have been specifically invited  
7 along to discuss look-back?

8 A. No, I have no recollection of a specific invitation.

9 Q. Okay. If we could go to 9185, we see at the bottom of  
10 the page under "New Items":

11 "look-back: HCV":

12 "After a full discussion in which the principles of  
13 look-back of HCV PCR positive donor archive samples and  
14 appropriate communication with recipient's GPs were  
15 agreed, it was felt that the position concerning PFC  
16 products required further consideration. The committee  
17 felt it would be inappropriate to make a policy decision  
18 at this time and that further discussion was required.

19 "DB McClelland to circulate look-back information  
20 ..."

21 That was back in 1993. So do you have  
22 a recollection of having that information circulated to  
23 you?

24 A. No, I have no recollection of having information  
25 circulated by Brian McClelland and I suppose that's why

1 the subsequent MSC meeting in May, Jack Gillon's  
2 presentation, came as a revelation because I had nothing  
3 written down about the look-back and, you know, the  
4 discussion here, it comes half way through a very, very  
5 lengthy meeting, minuted on page 10 of 18. It doesn't  
6 convey to me that SNBTS were attaching a great deal of  
7 priority to this, amongst all the other issues that they  
8 were discussing on that day, but I certainly don't  
9 recollect receiving any written information about the  
10 pilot exercise. I'm sure I would have remembered that.

11 Q. Thank you. Could we go to October 1994 now?

12 [\[SGH0040803\]](#).

13 This is another general issues meeting at which you  
14 are in attendance with Mr Tucker, Mr Panton and also  
15 members of the Common Services Agency. If we could go  
16 to 0805, this is about Hepatitis C look-back:

17 "Mr Tucker advised that the MSBT was examining  
18 proposals for a look-back and was returning to the  
19 subject in December."

20 So it looks as though you are waiting for a decision  
21 from the Advisory Committee?

22 A. Yes.

23 Q. Then it's recorded:

24 "Dr Keel and Dr Perry awaited the decision but  
25 pointed out that MSBT had no real locus in this since it



1 was not a matter of blood safety."

2 Could you just explain what's recorded there,  
3 Dr Keel?

4 A. Yes, I think actually with hindsight it's a kind of  
5 nitpicking point on my and Bob Perry's part, and  
6 probably not terribly material to any of the discussions  
7 that were going on. But in strict terms the committee  
8 is about the microbiological safety of blood for  
9 transfusion; it's not about tracing recipients of blood  
10 transfusion; it's about ensuring that the blood supply  
11 is safe before it's issued.

12 But, I mean, whether -- I can't remember the  
13 discussion but it seems to me a rather immaterial point  
14 that I was making, quite frankly.

15 Q. That doesn't represent a change of view at SHHD that  
16 meant that you didn't have to, if you like, pay too much  
17 attention to what the Advisory Committee was telling you  
18 about look-back?

19 A. Well, I think that the view in SHHD was very much  
20 coloured by what had happened locally in Southeast  
21 Scotland. That's point number 1. And it may have been  
22 that by then we had the legal advice to which we have  
23 referred. So that's, I suppose, what's to the forefront  
24 of our minds when we were having these discussions. So  
25 the idea that a committee -- MSBT -- even though it was

1 set up as a UK Advisory Committee, might step in and  
2 decline to implement this policy, I suppose -- well, it  
3 would have been undesirable from a Scottish perspective.  
4 I think both in SHHD and in SNBTS.

5 Q. Yes.

6 PROFESSOR JAMES: Could I just ask you: were you by this  
7 time attending the meetings of the MSBT?

8 A. Yes, I was.

9 PROFESSOR JAMES: You mentioned earlier that it was your  
10 recollection that it was Professor Zuckerman who had  
11 said that in his view, interferon treatment was really  
12 not likely to be very helpful in the treatment of  
13 Hepatitis C.

14 You may well have the minutes of those two meetings  
15 here but reconstructing events, do you believe that this  
16 may have been a sort of delaying tactic to take  
17 Professor Zuckerman's point and say, "Oh, well, we will  
18 have to come back to that, so we will delay making  
19 a decision about this issue for another three months  
20 until another meeting"? Is that the impression you are  
21 trying to give us?

22 A. No, that's not the impression I'm trying to give. My  
23 recollection of discussions in MSBT were that the main  
24 factor in influencing their view was the demonstration  
25 of the feasibility of undertaking the exercise. The

1 issue of effectiveness of treatment was a secondary one  
2 and I think even at that point there was recognition  
3 that Alpha interferon was only the first of what were  
4 likely to be many forms of effective treatment, and it  
5 was recognised, notwithstanding Professor Zuckerman's  
6 views, that it was effective in a number of patients.  
7 So I don't think that MSBT were trying to stall because  
8 of what Harry Zuckerman said.

9 PROFESSOR JAMES: I'm very pleased to hear it, thank you.

10 MR GARDINER: We can look at the minutes for December 1994  
11 at [\[SNB0084820\]](#). Before we do, I just want to ask you,  
12 Dr Keel: one gets the impression reading the documents  
13 that having come very close to making the decision about  
14 going ahead with look-back at the previous meeting,  
15 after the presentation from Dr Gillon, things are  
16 starting to get delayed, and one gets the impression  
17 that the urgency is starting to go out of the question.  
18 Is that the wrong impression?

19 A. I think it is the wrong impression because even if we  
20 had been in a position in Scotland to unilaterally say  
21 there is going to be a look-back across the whole  
22 country, the day after that meeting on 18 May, other  
23 bits of the country would have had to do the kind of  
24 preparatory and planning work that Southeast Scotland  
25 had undertaken over a period of many months. In fact it

1           may have run on for years. I can't really remember the  
2           detail.

3           So there was a desire that we should proceed on a UK  
4           basis in this and in other blood transfusion-related  
5           matters. That was always a recurring theme and a focus  
6           for us.

7           So if we were slightly ahead of the game in  
8           Scotland, having done this pilot exercise, and there was  
9           a bit more awareness in Scotland of what might be  
10          required in terms of undertaking it, the rest of the UK  
11          were not as up to speed even as we were. So there  
12          needed to be a lot of planning and advance warning of  
13          the blood transfusion services in other parts of the UK  
14          before they could have possibly undertaken it.

15        Q. Was the situation south of the border holding you up at  
16          this point?

17        A. I don't think at this point but clearly Lord Fraser  
18          indicated in his letter to Tom Sackville that, because  
19          we had demonstrated the feasibility in Scotland of doing  
20          look-back, he felt, based on the advice he had received,  
21          that we needed to get on with it.

22        Q. I should have said what I meant by "at this point"  
23          because, you see, these minutes are 15 December 1994 and  
24          Lord Fraser's letter is 22 December 1994. So it's very  
25          close.

1 A. Yes.

2 Q. But let's have a look at them. On the first page we see  
3 who is there: Dr Mitchell, Dr Mortimer, Dr Perry, you  
4 are there as an observer. This is, as I said,  
5 15 December 1994. If we could go to 4824, under the  
6 heading of "HCV look-back", it starts at paragraph 7.1,  
7 and just to get an overview, if we could go over the  
8 page, paragraph 7.4, 7.5, 7.6, 7.7 all look-back. Then  
9 over the page, 7.8, 7.9, 7.10, 7.11, 7.12. Over the  
10 page, please, there are three pages of notes about  
11 look-back.

12 So was the discussion about look-back particularly  
13 extensive at this meeting?

14 A. Clearly it was, yes.

15 Q. Yes. Do you remember how long you talked about it for?

16 A. No, I can't tell how long.

17 Q. An hour? More than an hour?

18 A. I honestly can't remember. I would imagine an hour  
19 would be a reasonable guesstimate of how long we spent  
20 on it.

21 Q. What was the mood of the meeting? Were there forthright  
22 views expressed?

23 A. I infer from the earlier paragraphs that MSBT had set up  
24 a subgroup. I imagine to think about the logistical  
25 difficulties this might present to England in

1 particular.

2 Q. I was just wondering what you could remember of the  
3 meeting in terms of --

4 A. I think a lot of it -- the discussion was therefore  
5 based on next steps, you know, in practical terms.  
6 I think what I read from the minutes and what I can  
7 remember, which is not very clear, is that we were  
8 moving forward on a UK basis, very much so at this  
9 point.

10 Q. Yes. Could we go to 4825? If you look at  
11 paragraph 7.6:

12 "Dr Robertson said that four writs had been issued  
13 against the NBA and its legal advice was that the duty  
14 of care existed in this case."

15 Then at the bottom of the page, paragraph 7.7:

16 "Professor Zuckerman, sharing the view of  
17 Dr Mortimer, that the question of look-back was driven  
18 by lawyers."

19 Then if you could go over the page, at 7.10, it  
20 records one of your contributions:

21 "Dr Keel said that the view in Scotland was that the  
22 Secretary of State was vulnerable as look-back was  
23 feasible since donors could be identified and traced,  
24 and advice from Scottish Office lawyers was that  
25 look-back should start immediately."

1 I'm just wondering whether what you were referring  
2 to there as the Secretary of State being vulnerable, was  
3 that vulnerable to actions of negligence? Is that what  
4 you are referring to there?

5 A. Yes, in not proceeding with a look-back that had been  
6 demonstrated to be feasible in a part of Scotland.

7 Q. Yes. I'm just wondering how important the concern about  
8 the liability was in reaching the decision?

9 A. Well, it was a material issue. There is no doubt about  
10 it, because once you have got legal advice of that  
11 nature, you have to take that seriously. But it wasn't  
12 there at the beginning, the outset, as far as I can  
13 recall, as a substantive issue, as the most important  
14 issue that needed to be taken into account in deciding  
15 whether the policy should proceed as it has proceeded.

16 Q. So it would be wrong to think that that was the main  
17 determining factor in the decision?

18 A. I think so.

19 Q. Okay. If we go down to the bottom of the page, we see  
20 the conclusion:

21 "In the committee's view there is a duty of care  
22 towards those infected with HCV as a result of NHS  
23 treatment. It follows that procedures should be put in  
24 place to identify those patients at risk.

25 "Whatever is done should be done equally and

1 uniformly throughout the UK."

2 Over the page, please:

3 "Guidance should be drawn up as soon as possible on  
4 procedures for identifying those at risk and ..."

5 7.13:

6 "The committee agreed that these conclusions would  
7 be passed on to the Secretaries of State of all four  
8 health departments."

9 Dr Keel, when you left that meeting, what was your  
10 impression about what was likely to happen next as far  
11 as UK-wide look-back was concerned?

12 A. That the various bits of the UK, the health departments,  
13 would advise their ministers separately that look-back  
14 should be undertaken across the UK and informing  
15 ministers that the detail was being worked on by various  
16 groups and that this would be based on the results from  
17 the Southeast Scotland pilot.

18 Q. So what was your impression about how quickly a decision  
19 would be made about that?

20 A. It's difficult to recollect at this length of time after  
21 the event but I think that my impression would have been  
22 that we were going to get on with this pretty quickly --  
23 well, as soon as the blood transfusion services could  
24 get the guidance developed and then in place in the  
25 different parts of the UK. That would be a plan and it



1 would be progressed quickly.

2 Q. Yes. If we could go to [\[SNB0084847\]](#). So the meeting  
3 that you went to was on 15 December. A week later.  
4 This is Mr Tucker sending a copy of Lord Fraser's letter  
5 to David McIntosh. Lord Fraser's letter was dated  
6 22 December 1994. Can you remember what happened at  
7 SHHD between 15 December and 22 December?

8 A. No, I can't. I mean, I can speculate, if that would be  
9 helpful?

10 Q. I think that would be.

11 A. I would have come back from MSBT and briefed colleagues.  
12 Probably I would have done a note of the meeting, that  
13 was my usual habit, and noted that I had suggested that  
14 our ministers were vulnerable because of the legal  
15 advice that we had received. I can't recollect whether  
16 I met with colleagues -- I suspect I probably did -- to  
17 discuss getting on with this from a Scottish point of  
18 view. And I suspect there was a collective view that we  
19 needed to inject a degree of urgency into this; hence  
20 the letter from Lord Fraser to Tom Sackville.

21 Q. Yes. I mean, that is notwithstanding your impression at  
22 that meeting that things were going to progress fairly  
23 quickly at a UK level?

24 A. Well, the minutes suggest that there is a lot of  
25 activity underway, that a group had been set up, that

1           they were talking about developing algorithms and  
2           guidelines for clinicians who were going to be in  
3           contact with patients. So the minutes give an  
4           impression, at least to me, of activity but I don't know  
5           whether there were other impressions, reading between  
6           the lines, that I brought back to Scotland, which  
7           suggested that perhaps things were not going to move as  
8           quickly as we might have desired. I honestly cannot  
9           recollect.

10        Q. But putting it all together, that seems the most likely  
11           scenario, does it not, that you have formed the  
12           impression one way or the other that things aren't going  
13           to move as quickly as SHHD would like?

14        A. Well, given our different position and in view of the  
15           legal advice that we had, clearly there was more  
16           pressure on Scotland to move forward here than might  
17           have been felt in the other parts of the UK. But allied  
18           to that was the fact, as I have already said, that we  
19           had some practical experience of running the look-back,  
20           even if it was only in part of Scotland. The rest of  
21           the UK didn't have that. They were coming new to it.  
22           And, you know, England is a much bigger country than  
23           Scotland for a start. So the scale of the look-back  
24           exercise and all the multifarious strands and hurdles  
25           that it encountered were always going to be greater

1           there. So I don't think we should underestimate the  
2           task that the blood transfusion services, particularly  
3           in the other parts of the UK, were being asked to  
4           undertake.

5   Q.   Yes. Thank you. Just to clarify a point, I would like  
6           to go back to the statement that you gave us. Could we  
7           have a look at page 3 of [\[PEN0180396\]](#). This is the  
8           statement that you gave us, isn't it?

9   A.   Yes, it is.

10  Q.   And you have answered in your evidence most of the  
11           questions that you have covered in your statement but  
12           there is just one thing I would like to ask you about  
13           here. The question number 5 is:

14           "Dr Keel said that the view in Scotland was that the  
15           Secretary of State was vulnerable as look-back was  
16           feasible since donors could be identified and traced and  
17           advice from Scottish Office lawyers was that look-back  
18           should start immediately. Please explain this comment  
19           in more detail."

20           You say:

21           "I was quoting the advice received from the  
22           solicitor's office and do not either have a copy or  
23           a clear recollection of the precise terms of the advice.  
24           However, I think that the legal advice would have been  
25           based on the fact that the SEBTS pilot project had

1 demonstrated the feasibility of conducting a look-back  
2 exercise and therefore the position in Scotland was  
3 different from the position in England ..."

4 I think that's what you have told us earlier today?

5 A. Yes.

6 Q. Then you say:

7 "We could no longer argue that it would not be  
8 feasible to conduct the exercise in Scotland."

9 What I wanted to ask you, Dr Keel, is why would you  
10 be wanting to argue that position? Why would your  
11 inclination be that way? Why would you be looking for  
12 arguments?

13 A. Well, I was reflecting the previous argument that had  
14 been deployed, not necessarily a desire to redeploy it  
15 in this new situation. We had argued, or Government had  
16 argued from the introduction of Hepatitis C testing that  
17 a look-back exercise should not be undertaken, mainly  
18 for reasons of logistics and the perception that it  
19 would not be feasible. The world had moved on by the  
20 time of the Southeast Scotland pilot, which demonstrated  
21 the feasibility. So that argument, that it wasn't  
22 feasible, could no longer be deployed.

23 Q. What I'm getting at is were you making that argument  
24 because that was the position or were you deploying it  
25 as an argument because your inclination was not to start

1 look-back for some other reason? I'm really focus --

2 A. No, no, no, I hope I made it clear in my earlier  
3 evidence that, having heard Jack Gillon present, I was  
4 absolutely convinced that proceeding with look-back was  
5 the right thing to do for a whole raft of reasons.

6 Q. I'm talking about before that.

7 A. I suppose I share the collective mindset of the time,  
8 that the look-back would not be feasible, that  
9 logistically it would be impossible to conduct  
10 a look-back.

11 Q. Yes. Okay. Thank you. Question 7. I'm nearly  
12 finished:

13 "What steps, if any, did the SHHD take to draw  
14 doctors' attention to the availability of testing and  
15 implications of HCV for patients before April 1995?"

16 You say:

17 "It is not normal practice to issue circular letters  
18 to the whole profession in relation to new tests. The  
19 introduction of new diagnostic tests is a fairly regular  
20 occurrence; hepatologists would have been aware of the  
21 availability of the Hepatitis C test as a diagnostic  
22 tool and introduction of HCV testing would not have been  
23 treated differently from any other diagnostic test."

24 I'm just wondering if there is an analogy that we  
25 can draw with HIV. The Inquiry has heard about booklets

1 that were sent to doctors when HIV testing came in.  
2 Perhaps I could just show you a letter about that,  
3 [\[SGH0027079\]](#). You won't have seen this before.

4 A. No.

5 Q. So just take your time and read it. (Pause)

6 So this is 1 October 1985, the Chief Medical Officer  
7 is asking for a booklet to be sent to all doctors and  
8 that's at the time of introduction of a test for  
9 HTLV-III, later called HIV. If you could have a look at  
10 [\[SGH0027081\]](#), that's a booklet that was sent out. If  
11 you look over the page, it talks about introduction of  
12 the screening test. Further down this page "Procedure"  
13 and if we could go over the page, "Interpretation of  
14 results".

15 I'm not going to take up more time with this  
16 booklet, but would you accept, Dr Keel, that what was  
17 being suggested in the question has been done before?

18 A. Well, clearly it has but I would suggest that the  
19 situation around the discovery of the AIDS virus and the  
20 context in which this booklet was issued are radically  
21 different from that in relation to the Hepatitis C  
22 virus. I mean, I can remember, as a clinician, these  
23 viruses being discovered and the growing awareness of  
24 the devastating consequences of being infected with that  
25 virus, and of course it was many, many years before

1           there was anything like effective treatment to deal with  
2           AIDS. There was enormous lack of awareness and great  
3           fear of the virus within the general population and  
4           I suspect that the decision to issue this guidance was  
5           as a result of that lack of awareness of this new, very,  
6           very strange and worrying virological entity.

7           As I say, the situation with Hepatitis C was by no  
8           means the same. For example, up until, one might say,  
9           the late 80s/early 90s, there was still a widespread  
10          view that non-A non-B Hepatitis, later to be defined as  
11          Hepatitis C, was a fairly benign virus, which did not  
12          have many adverse effects on individuals' health.  
13          Absolutely the opposite from HTLV-III/HIV. So I think  
14          we are talking about two very different situations here.

15        Q. Would you accept that it could have been done?

16        A. What could have been done?

17        Q. A booklet, which explained about the new test and the  
18          implications and so on.

19        A. Well, certainly the guidance that went out on the  
20          look-back contained a great deal of detailed information  
21          for general practitioners and other doctors on the test,  
22          the implications of a positive test, the management of  
23          patients with the virus. So I suppose one might argue  
24          that that was guidance of a sort, mirroring this.

25        Q. I'm suggesting that that could have been done earlier,

1           maybe September 1991.

2       A.   With what end in view?

3       Q.   Well, information to medical practitioners about the new  
4           test.

5       A.   But as I said in my statement, the advent of this new  
6           test was not perceived as being different from any other  
7           virus and other types of blood test that come along  
8           daily. The Chief Medical Officer would never be done  
9           writing out to doctors if we had adopted that as  
10          a general principle. Which I think reinforces what  
11          I said earlier about AIDS being a very, very different  
12          scenario.

13      Q.   I have just got two more questions, Dr Keel, and the  
14           second last one is a very general question. I would  
15           like to ask you to answer this question based on your  
16           considerable experience of the Medical Civil Service.

17                 At the beginning of your evidence this afternoon you  
18           described the MSBT and by implication its predecessor,  
19           the ACVSB, as the principal UK Advisory Committee and as  
20           being run out of the Department of Health. You said it  
21           was the committee that the health departments  
22           collectively looked to for advice and later you  
23           described it as the vehicle of the government health  
24           departments.

25                 I just wondered if that isn't a bit circular because



1           it sounds like it's the department advising the  
2           department effectively?

3    A.   Well, certainly the Deputy Chief Medical Officer at that  
4           point chaired that Advisory Committee. That is no  
5           longer the case. Its equivalent is chaired by an  
6           independent expert clinician. But round that table,  
7           under the chairmanship of the DCMO, were a wide range of  
8           experts: virologists, clinicians from other backgrounds,  
9           haematologists, blood transfusion experts. I certainly  
10          think that the Department of Health, as well as the  
11          other UK health departments, placed great store on that  
12          independent expert advice, which formed the collective  
13          view coming from that committee.

14   Q.   Yes.

15   A.   So I wouldn't accept that it was the department advising  
16          the department.

17   Q.   Right. Okay. And my last question. Could we have  
18          a look, please, at [\[PEN0181410\]](#)? This isn't a very good  
19          copy and you won't have seen this before. It's a letter  
20          to Roseanna Cunningham to the Minister for Health and  
21          Community Care, Andy Kerr MSP. Do you remember seeing  
22          this?

23   A.   No, but I probably did see it but I don't recollect it,  
24          I am afraid.

25   Q.   Just to get some context, we see it's 16 June 2006 and

1           it's a letter to Roseanna Cunningham as the convener of  
2           the health committee of the Scottish Parliament.

3    A.   Yes.

4    Q.   It says:

5           "Dear Roseanna, I'm writing in response to your  
6           letter of 19 April on the decision of the health  
7           committee to call for a full judicial inquiry into  
8           infection with Hepatitis C through NHS treatment with  
9           a particular focus on the efficacy of the look-back  
10          exercise."

11          If we go down to the bottom of the page, under the  
12          heading of "Look-back exercise":

13          "Concerns have been expressed by the committee  
14          that some patients did not know for long periods that  
15          they had been infected with Hepatitis C, in particular  
16          through blood transfusions, and that there should have  
17          been a more thorough and comprehensive strategy for  
18          tracing and counselling patients."

19          If could we go over the page:

20          "As my earlier letter explained, a UK look-back  
21          exercise was started in 1995 to trace as many patients  
22          as possible who had contracted Hepatitis C through blood  
23          transfusions. This exercise was agreed by UK ministers  
24          on the basis of medical and scientific advice, and the  
25          different options for carrying out the look-back were

1 carefully considered. I set out below the detail of how  
2 the look-back exercise was developed and the basis for  
3 the decisions taken."

4 It's the next few lines that I would like you to  
5 concentrate on:

6 "These were decisions taken by the UK Government,  
7 based on advice from the relevant professional Advisory  
8 Committees, before devolution. I do not think that  
9 there can be any strong basis for seeking to reopen  
10 these issues and revisit these decisions now, ten years  
11 later."

12 Dr Keel, I just wanted to ask you to agree with me  
13 that that is not a correct statement of the position, is  
14 it?

15 A. Which particular part is it?

16 Q. "These were decisions taken by the UK Government based  
17 on advice from the relevant professional Advisory  
18 Committees."

19 A. Well, the look-back proceeded on a UK basis -- was  
20 a decision for UK Government, informed by the evidence  
21 that Scotland had presented to it.

22 Q. Was it not a decision taken by Lord Fraser in the letter  
23 of 22 December?

24 A. Well --

25 Q. 1994.

1 A. I think if we hypothesise and if the Department of  
2 Health had decided against proceeding with the look-back  
3 exercise, I suspect that Lord Fraser would have wanted  
4 to proceed in Scotland. So if that answers your  
5 question, then, I believe that would have been the case.

6 Q. Well, what I'm getting at is that he made the decision,  
7 the Scottish Office made the decision, not the UK  
8 Government. Was that not right?

9 A. Well, for Scotland, yes, but we didn't make the decision  
10 for the UK.

11 Q. For Scotland? Indeed.

12 A. Yes, but we didn't go ahead on a Scotland-only basis; it  
13 was a UK look-back exercise. As I said, things might  
14 have been different had DH decided not to proceed. But,  
15 as it turned out, the whole of the UK went ahead with  
16 it, based on Scottish experience.

17 Q. Hm-mm.

18 A. And I think the views in the Department of Health would  
19 have been very strongly informed by what we were saying  
20 in Scotland was possible.

21 Q. Would you not agree that the decision to go ahead with  
22 look-back was taken by Lord Fraser?

23 A. For Scotland, yes.

24 Q. Indeed, for Scotland.

25 A. Yes.

1 Q. Would you agree with that?

2 A. I would agree.

3 Q. Thank you. Thank you very much, Dr Keel.

4 THE CHAIRMAN: Mr Di Rollo?

5 MR DI ROLLO: No, thank you, sir.

6 THE CHAIRMAN: Mr Anderson?

7 MR ANDERSON: Thank you, sir, I have no questions.

8 THE CHAIRMAN: Mr Sheldon?

9 Questions by MR SHELDON

10 MR SHELDON: Just a couple of matters of detail, if I may.

11 Dr Keel, we heard some evidence about the symposium  
12 on HCV in October of 1993, I just wanted to ask you how  
13 you came to be there?

14 A. I have no clear recollection but I imagine I received  
15 a flyer, as I very often do for conferences, at what is  
16 my local college and decided that this would be of  
17 interest and applied to go to it.

18 Q. All right. You weren't specially invited to it or  
19 something of that sort?

20 A. No, certainly not.

21 Q. All right. The only other matter I wanted to ask you  
22 about was about the MSC committee meeting of 18 May,  
23 which we have heard about in some detail. I think it  
24 would be fair to say that there was a fairly lengthy and  
25 detailed discussion of look-back at that meeting. Is

1           that correct?

2    A.   Yes.

3    Q.   Do you recall whether look-back was an item on the  
4           agenda for that meeting?

5    A.   My recollection from the minutes -- and having revisited  
6           them recently, I was rather surprised to see that  
7           look-back was under any other business rather than  
8           a substantive agenda item.

9    Q.   Can you help us then whether there was any mention of  
10           look-back per se on the agenda that was issued prior to  
11           the meeting?

12   A.   I can't remember, I am afraid.

13   Q.   All right. Thank you.

14           I have nothing else, sir.

15   THE CHAIRMAN: Dr Keel, thank you very much. We are asking  
16           you to dredge your memory, I appreciate, but we are  
17           grateful for all the help you have given.

18   A.   Thank you.

19   MR GARDINER: Sir, there are no more witnesses today.

20   THE CHAIRMAN: Until tomorrow.

21   (4.25 pm)

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

23

24

25

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