Friday, 30 September 2011

(9.30 am)

DR RUTHVEN MITCHELL (continued)

Questions by MS DUNLOP

THE CHAIRMAN: Good morning.

MS DUNLOP: Good morning.

THE CHAIRMAN: Yes, Ms Dunlop?

MS DUNLOP: Good morning, sir. We have Dr Mitchell with us again this morning.

Good morning, Dr Mitchell.

A. Good morning.

Q. We wanted to ask you some questions about the introduction of screening of donated blood for what later became known as the HIV virus.

So could I ask firstly that we have your statement on this topic in front of us? That's [PEN0171002].

Could we look at the first page? We can see in bold an extract from our snapshots and landmarks document and then a question, which is in bold and in italics. We are actually already rather familiar with the correspondence in Scotland in January 1985 and then the coordinating group meeting on 19 February. The question we posed was:

"What particular steps had the SNBTS taken with regard to the introduction of HTLV-III screening in

Scotland as at 24 January 1985?"

You say in your answer that:

"Major steps were being taken by the SNBTS well before January 1985."

I just wondered what the major steps were.

A. Yes, well, we had lots of contact with many other people throughout the world who were interested in this problem. We were aware that through the MMWR reports there was this new disease, mainly in America but some other places, and we began to get information that there might well be a transfusion-transmitted element to it.

That was the reason we began to consider the possibility of doing individual testing of donations for this virus, provided we could get sufficient materials in which to do it. So far as I know there was no test available in Europe at that time and the Americans were only just beginning to start their various test systems, mainly Abbott Laboratories and one or two others. There were many American commercial companies who obviously saw tremendous commercial advantage in introducing such a test.

So they were very keen to liaise with Dr Gallo in order to obtain samples of his materials, to develop various types of detection system. So certainly we were well aware of that but how we could fit into it was

another problem because we really didn't have access to any of the materials at that time.

Q. Right.

A. We were aware that Dr Tedder of course, having tried also unsuccessfully to get samples in order to evaluate them in the UK, had been unable to do this with Gallo, and he and Robin Weiss, of course, had prepared a eluate themselves from a known patient in London. And so that was the position, as I understood it, just before January 1985.

Q. Right. Do you remember a point when Dr Crawford went to visit Dr Tedder?

A. No, I don't actually, no, no, I'm sorry. It's not unusual. Certainly there were lots of contacts throughout that time.

Q. Yes. Don't worry at all. It's a very long time ago.

A. Many of us were attending meetings in various places, including North London and elsewhere, with Dr Contreras and John Barbara and many other people who were involved.

Q. Perhaps you could just have a look at a letter which Dr Crawford sent to you on 20 December 1984. It's [SNB00488803]. This is, as you can see, Dr Crawford writing to report on a visit to Dr Tedder on 18 December.

A. Yes.
Q. If you don't really remember the event, then I suppose you won't remember what had triggered it or why or how Dr Crawford came to be making the visit?
A. Well, I understand why Bob would go because clearly he would go with my blessing. Bob was very interested in the whole question of AIDS and its transmission and so on. He had a special interest in that and it was only right and proper that he had been involved with counselling of donors and that kind of thing.

It's quite natural that Bob would wish to do that. He was also, of course, interested in the science of the subject and this was just an example of trying to determine how close we were to obtaining a suitable test. I think the early work of Gallo was -- he was, of course, a Glasgow alumni. He had spent some time with the virology department at Glasgow University, which in those days, I think there were only about eight people in the whole world who knew much about retrovirus.

So I believe -- I think I remember that Gallo came to Glasgow to give a talk on his interesting information and one of the professors in Glasgow, I remember, coming through Glasgow Airport and saying that -- at the time of customs declaration -- he had many millions of virus in his top pocket. Whether he was stopped or not,

I don't know. But that was really part of the beginning of this, how this all came about, and it was not unusual that Bob should go down to Richard Tedder and try and find out just what was going on.

I think other people were doing the same thing but naturally Richard was a bit reluctant to say too much about it having had difficulties with Dr Gallo and the question of rights of access. It is difficult to share information in that kind of climate.

Q. Certainly, Dr Mitchell, we have heard tales of people bringing virus in a flask from Paris and leaving it at Waterloo Station and I have also seen a reference to somebody flying across the Atlantic with virus packed in dry ice. So I can imagine that people travelled around at this point with their samples of virus, but you have a memory of Dr Gallo being in Glasgow?

A. I tried to think back to these days and I have a feeling that he did come to Glasgow, and the professor that went to get some of the material and bring it back, he was interested in possibly producing a vaccine to the virus at that time. We actually invited him to speak at one of our first Scotblood meetings, which is the annual meeting of the Scottish National Blood Transfusion Service in those days, of which I was the originator of the scientific meetings. And it's interesting just

looking back over many, many years that that's the sort of position we were in at that time.

We knew about this, we knew it was going on, we knew that people were interested, mainly in the States, because they had a bigger -- a huge problem, as far as the literature would indicate, so perhaps -- I don't know if that answers your question?

Q. Actually I think we are slightly off the track but it's interesting, so if you don't mind, I'll pursue it a little bit. Which professor in Glasgow are you talking it?

A. Jennett, Professor Jennett.

Q. Brian Jennett?

A. Yes. He is unfortunately not still with us.

THE CHAIRMAN: Just get it into the notes what his discipline was.

MS DUNLOP: Actually he was a neurosurgeon.

A. It was his brother. I think he was the veterinary professor in Glasgow. Brian was the chap who did the head injury studies, yes.

Q. So he was at the vet school in Glasgow?

A. That's right, yes, as I remember it.

THE CHAIRMAN: How much did you have to do with the vet school? I'm interested in their knowledge of retroviruses.

A. Not a lot.
THE CHAIRMAN: Not a lot?
A. Not a lot because as I say, in Scotblood it was in its early days at that time. We had only started just briefly before that, and we knew that Professor Jennett [sic - Jarrett] had an interest in other oncogenic viruses, and he had written about this, mainly in cattle.

So in just general terms for the interest of the audience and people in blood transfusion, it was interesting just to talk about viruses and the activity in general terms. We had other people who spoke. We had one lady who spoke about cervical cancer and the papillomavirus and so on. It was a scientific meeting but also a meeting of colleagues --

Q. Yes.
A. -- from various disciplines.
Q. I understand. Thank you.

So in that light you weren't at all surprised to be reminded that Dr Crawford had made a visit to see Dr Tedder to find out exactly what was happening at the Middlesex Hospital?

A. Yes, yes.
Q. And just to look at the letter, Dr Crawford is setting out some information about the two different tests,

first of all Dr Tedder's test, and he is saying that in the Tedder test, if we just call it that for the moment:

"Unknown serum and labelled antibody compete."

A. Yes.

Q. Actually it does look as though it's still a radioimmunoassay he is describing at this point.

A. That's right.

Q. I think that must be right with the reference to counts per minute?

A. That's right.

Q. Then the American test, which we understand is not the same kind of format, solid, phase, purified antigen, unknown specimen, presumably, and then an enzyme labelled anti-immunoglobulin. It can be made sensitive or specific but not both.

A. Yes, there are all different ways of doing it.

Q. Yes, and then a reference in the section headed "Source of Antigen" to the growing of the Gallo isolate in the cell line, H9?

A. Yes.

Q. We understand that in due course that actually led to some problems with false positives?

A. Yes.

Q. Yes. I don't need you to you explain that to us because we have had some explanations of it but you were aware

of that, were you?

A. Yes, I think the American literature was absolutely clear on that. All the technical information from the various companies in the States who had been looking at it, always were reporting large amounts of false positive information. And what was more worrying was the false negatives.

Q. Yes. I think we understand that for a transfusion service, both cause problems; both false positives and false negatives, obviously.

A. Oh yes.

Q. Then we can see Dr Crawford reciting the names of the five firms -- four firms actually -- who are working to develop tests and that Dr Tedder had asked American companies for antigen with which he could work and that he wasn't able to do that, and he explained to us that he thought that was really to do with the legal position.

A. Yes.

Q. Then mention of industrial culture facilities. That's CAMR Porton?

A. Yes. Certainly I knew this bit of information, yes.

Q. This material is all quite familiar information?

A. Oh, yes.

Q. Then the reference on the second page in that second

paragraph to the possibility that given cells and virus and support from Middlesex, Scotland might go it alone.

A. Yes, that's right.

Q. What do you think he was meaning by "go it alone", do what alone?

A. I think we could have helped considerably with the development of a test.

Q. Right.

A. I think that's the important aspect of this. There is no use having a test that would work in a test tube --

Q. Yes.

A. -- with half a dozen specimens. We have got 100,000 specimens to do.

Q. Yes. Then Dr Crawford, maybe with that in mind, has turned his attention to talking about safety for those working with the virus.

A. Hm-mm. That's right, that's very important.

Q. Yes. Then on the final page we can see that he has also addressed what I think was a live topic around this time, which is trying to ascertain from laboratory testing if the heat treatment that PFC were carrying out was being effective.

A. Yes. That's correct.

Q. Right.

THE CHAIRMAN: Dr Mitchell, what would have been the basis

for confidence at that time that Scotland might go it alone? Was there some relevant experience or a body of skill or whatever, that would instruct that view?

A. Well, we certainly had a lot of experience from mass screening in terms of the Hepatitis B virus. We had done a lot of work on that. We had a lot of knowledge and experience of doing those kind of work-ups for these tests, and so if conjugate had been available, then I'm pretty sure that the West of Scotland would have played a very considerable part in developing a suitable test.

It was important to have a test which would be reliable and would answer the question of: did it have specificity and sensitivity? You wouldn't buy a car from someone without doing a test drive. That's my answer really.

MS DUNLOP: Yes, indeed.

A. We would have been most interested in doing it. Again, for many reasons but mainly because we had a staff who were particularly good at doing these kind of evaluations.

As you probably saw from the hepatitis studies, Glasgow was very instrumental in making sure that many of these tests that were being used were in fact up to speed and up to standard. That was the case in the States. I mean, many of the tests developed there were

miles out. I mean, 1986, I think it was, that I read, they were still talking about 90 odd per cent false positives.

THE CHAIRMAN: That's a sidetrack.

A. I'm sorry, that doesn't answer your question.

THE CHAIRMAN: I wonder if I could ask my second question and let you decide where you are going to go.

I probably should have known but wasn't aware until now that Gallo was one of the Glasgow mafia.

A. I don't think that's true.

THE CHAIRMAN: Do you know when he graduated?

A. No, I think he was doing a PhD at the time.

THE CHAIRMAN: You don't know who his contemporaries might have been?

A. I think the professor in virology was Scharpey Schaffer.

THE CHAIRMAN: Not someone who figures in --

A. No, Scharpey Schaffer is dead now. That's how I remember it, but it's a long, long time ago.

MS DUNLOP: Just before we leave Dr Gallo, are we talking about Gallo actually being a student in Glasgow?

A. No, I think he was doing part of his PhD. I wasn't involved with that department. So I really couldn't answer that question.

Q. Right.

A. As far as I know -- it was said at the time that one of

the reasons he came back to say hello to Glasgow was because he was coming back to thank his mentor, ie the professor of virology. That was what was said at the time.

Q. I see.

A. Because as I said to you, I think at the time there were only about eight people in the world who knew anything about retroviruses.

Q. And one of them was in Glasgow?

A. Well, one of them was a professor of virology in Glasgow, yes.

Q. Yes. Right.

THE CHAIRMAN: Was he in the vet school --

A. No, no, no. He was in the university department of virology, which is a separate organisation.

THE CHAIRMAN: I'm just conscious, you see, that I have heard already that information tended to be exchanged rather readily between people who had historic contacts with each other.

A. That's right.

THE CHAIRMAN: And I was wondering whether there was any significance in Gallo's association here.

A. I don't think -- as I say, I was only an observer at that time. I wasn't involved.

MS DUNLOP: Do you remember Dr Forbes --

A. Charles Forbes?
Q. Yes. Having contacts in America as well?
A. Not personally. I didn't know of that. I had a feeling that perhaps he did have information from again, haemophilia colleagues in the States. That would not be at all unusual because reports had been received in his speciality as well. And of course he had worked over in the States.
Q. Yes.
A. So he was aware of people who were there, and no doubt kept in touch with them.
Q. Just going back, if we could, to the idea of what might have been possible in Scotland in early 1985, can we go back to the statement, please? We are still on the first page, [PEN0171002]? You say that you were aware of the refusal of Dr Gallo to agree that the DHSS would have access to his isolate and then you have told us that in fact there was a British isolate anyway. So that gap was plugged by the research work, I think, mainly of Professor Weiss, whose forte this was?
A. But it didn't go simultaneously. The Weiss isolate was really in desperation not being able to get the American one.
Q. But perhaps focusing a little more closely on what was happening in the West of Scotland, we do have some

information about the idea that there could be evaluation of commercial kits in the West of Scotland, and can we just look at a pair of letters on that topic? The first is [SNB0059715]. This is a letter from you to Dr Cash.

A. Hm-mm, yes.

Q. And you are thinking that you and he have had a process of thought transfer?

A. Hm-mm.

Q. And you have already had a visit from Abbott Laboratories.

A. Yes.

Q. This is as at 21 January 1985. You had had a visit from somebody at Abbott. Did you have contacts within Abbott?

A. Only with the representatives who came from time to time.

Q. Yes.

A. Because we were using Abbott technology for the Hepatitis B virus.

Q. Right. I think Abbott had a base in England, didn't they?

A. They probably did, yes. I'm not sure where their base was.

Q. Right. So they had come and asked if you might be

interested in a --

A. I think I had asked them.

Q. Oh, you had asked them?

A. I had asked them if they had access to any suitable materials that we might test.

Q. Do you actually remember this? As you sit here today, do you have a mental picture of any of these contacts with Abbott or any discussion about evaluating their kit?

A. Well, all I can tell you is that Abbott did come, not infrequently, but fairly frequently to the laboratory to see how things were going with the other testing, and if they were developing another test, then clearly they might have come and said, "Would you be interested in this test?" I would have said, "Yes, of course."

I think that's probably how it arose. It was probably them coming and saying they have a test. I knew very well that they had a test in America but whether it was available in the UK or not, I don't know.

Q. Right. You seem in this letter to be raising some practical issues in connection with this proposed evaluation.

A. Hm-mm.

Q. You are actually trying to speak to Dr Cash on the phone and you were hoping to speak to him at a meeting,

I think, last week, but hadn't managed. You go on to refer him to a copy of the MMWR. In particular you are referring to the content of that publication on the topic of screening?

A. Hm-mm.

Q. Abbott have asked you to write a letter to satisfy the FDA requirement. I am afraid we haven't been able to find the enclosed draft, and you are making some enquiries of Dr Cash in connection with ethical matters. If we just look at the second page of the letter, we can see that.

A. Yes. Do you want me to comment on that?

Q. By all means.

A. I would imagine that the reason that Abbott would be interested in a method of making sure that no information was released to competitors, for example, would be a prerequisite of their coming into the market, as far as we were concerned.

I think that was -- and I think the other problem, if I could recall at that time, would be the whole question of blinding the samples. Quite clearly it would be a bit unusual to test samples without looking at the consequences of the result.

Q. Right.

A. You might find yourself holding a very delicate and

important piece of information from a person who could be named and identified.

Q. Yes.

A. With a test which was really, as far as we were concerned, in its infancy. So that's the reason that one would look at blinding samples.

Q. Yes.

A. It was a question of trying to find out what was the frequency of positivity, how well did it perform in the field, as against what would you do with the answers if you got them.

Q. Yes. Just to be 100 per cent clear, by "blinding" you mean anonymising samples?

A. Anonymising them, yes.

We had a system in the service in Glasgow that Bob Crawford, whom you mentioned -- we had an arrangement that Bob was the only man in the department that knew anything about any particular positive individual, and these were all very confidentially marked and kept by Bob. No one got access to it. I didn't have access to it. No one else had access to it. It was a 100 per cent lock-up of information. That's how it came about initially; but so far as Abbott were concerned, I think their interest would really be in blinding and secondly in the

commercial secrecy.

Q. Right. The other letter, which goes with this one, is [SNB0059713].

A. Can I go back to the ethics committee, because that was --

Q. I'm sorry?

A. I'm just noticing there, it was Ronnie Girdwood, who of course was in fact the chairman of the Scottish National Blood Transfusion Association, which was set up to look after the interests of donors. That's what it really was all about. And he did a very good job in that sense and he had this ethics committee, rightly so, which said, if you are going to be doing work with donor samples, you have got to clear it with us, and that was the reason that I was referring it to the ethics committee. What did they think about how we should handle the specimens.

Q. I understand.

THE CHAIRMAN: This is an association ethics committee, not a hospital ethics committee?

A. No, no. When the SNBTS was set up -- that is the service was set up at the time of the founding of the National Health Service, the old SNBTA, which was an association, a kind of voluntary organisation, which ran blood transfusion, it was disbanded or stood down. But

in Edinburgh the SNBTA continued because it had this link with donors, and Professor Girdwood, when he was a member of the working parties and coordinating group of the National Blood Transfusion Service, he still kept his chairmanship of the SNBTA, which of course, was a very valuable thing because it was the way in which the Blood Transfusion Service could still get into what the donors thought about this, what did they feel about having the samples tested, anonymously or otherwise.

Q. Yes. So the role of the SNBTA was to stand up for donors, as it were?

A. That's right.

Q. And to promote the interests of donors.

A. Yes, that's exactly what they did. They had a considerable interest in donor care and management.

THE CHAIRMAN: I think the general interest, I do understand, is the particular indication you have given that included in that was an ethics committee because that might imply a structure for application, consideration, assessment, adjudication and so on. Is that what one should understand?

A. Yes, yes. I can't remember all the people who were on the ethics committee but I think it's true to say that they were not active blood transfusion directors or active individuals in blood transfusion.

I remember one was an eminent haematologist in Glasgow, Dr Robert Cumming, who was a haematologist at Stobhill Hospital in Glasgow. I remember he was a member of it but there were others and Girdwood was the chairman. But I think it was interesting that they did not disband it. It was originally ran from an Edinburgh legal office, in Edinburgh, it was Neil Milne who was Writer to the Signet in Edinburgh, who was the first, if you like, secretary general of the SNBTA, being legally -- he being a lawyer, had an great interest in making sure that the service ran very smoothly, so far as donors were concerned.

MS DUNLOP: I think lawyers are good at that.

A. I would imagine so. That's their job.

Q. I think we are happy to accept the compliment, Dr Mitchell.

THE CHAIRMAN: Only if we accept the responsibility that goes with it, Dr Mitchell.

A. Sometimes I become the director, you see, that's not uncommon.

MS DUNLOP: But when you say it was run from an Edinburgh legal office, that's the whole SNBTA, not the ethics --

A. Yes, the early SNBTA, the association, was an association of the five regional transfusion centres, right, and they met as an association of directors.

Q. Do you want just to go back to the previous letter so that we can see in its context the reference to Professor Girdwood, if we could, please. That's [SNB00059715].

A. I saw it at the bottom of the letter. It is approved by the ethics review board.

Q. He is on the next page.

A. Yes, just when I saw that, I remembered Ronnie Girdwood being the committee chairman.

Q. Yes.

A. But it was an ethics committee of the SNBTA, but SNBTS clearly recognised that as a very important standing group.

Q. Right.

A. That would give us advice.

Q. So when somebody within SNBTS was contemplating some form of research, involving work on donor samples, would they have felt it proper to consult Professor Girdwood's committee?

A. Yes, I think it would be very valuable to do that.

Q. Right. Can we go back to the other letter, please.

We can see that there have been discussions involving, obviously, yourself, Dr Brookes from Dundee. Now, Bill, is he --

A. Bill Wagstaff?

Q. You think it might have been Bill Wagstaff?
A. Bill from Inverness.
Q. Bill Whitrow?
A. Yes.
Q. And then Brian would be Brian McClelland at Trinity Park House.
A. That's right.
Q. Dr Cash is going on to say that the blood transfusion in the West should undertake initially evaluation studies of commercial kits.

Dr Cash doesn't restrict this to Abbott. So were there kits from other manufacturers in mind?
A. Well, there were people -- other manufacturers, yes.
Q. Right.
A. I think John had more contact with individuals than I did.
Q. I see. Then in paragraph 2 he sets out a proposal to use retrospective studies to donor samples currently in store, and then we can see the point you make about anonymising the samples.
A. Hm-mm. I think that's fairly clear, what John says in his letter.
Q. Yes. If we look on to the next page, we can see the third paragraph: sufficient volume to enable certain particular steps.

A. I think that's no problem. That's exactly how it would be done. I think it's important to look at point number 4. It's very important to keep residual aliquots of what I would call all the interesting samples. That's where the ideas of these Tricky Dicky stuff comes in. You are always looking for the unusual. You are looking for the needle in the haystack, because that's the one that will come back and jab you.

So we have to keep samples of these things and they were often exchanged between individual labs. You will know that many of the Glasgow samples from donations eventually found their way into national quality control standards.

Q. Right. And then the question of ethics is dealt with in paragraph 4 and actually Dr Cash is anticipating that Professor Girdwood may give ethical approval himself, without calling a meeting of his committee.

A. Yes. I think that's true, and it's true to say that John's penultimate paragraph, or ultimate penultimate one, saying that we certainly didn't want to be pressurised by any particular company. They obviously had a very considerable financial interest in having a test which would be rapidly introduced.

Q. Yes.

A. At considerable cost.

Q. Yes.
A. But that was never the name of the game. Never.
Q. Because?
A. Because we wouldn't want to put ourselves into all the difficulties of sorting out all the problems that we knew would arise, that had arisen in other testing systems that we had investigated in the past. We wouldn't go ahead with a test which was not fit for its purpose.
Q. I see. So if great speed had been used, quality might have suffered. Is that the point you make?
A. I'm sorry.
Q. If great speed was used, quality would suffer. Is that the point you are making?
A. Oh, yes.
Q. Right.
A. I think hasten slowly would be the answer.
Q. Right. Dr Mitchell, I'm wondering, have you had a look at the transcripts of some of the evidence this week?
A. Very briefly. I think they are still coming in. I think yesterday I saw a fax or an email, yesterday and I think the day before. Things have been coming in at that speed. Tedder's I hadn't seen until yesterday afternoon.
Q. I see. I just wanted to ask you what happened to this

initiative? I think before you answer, we would be primarily interested in your own personal recollection. So anything you can remember, unprompted by whatever you may have read recently.

A. I think the difficulty would have been to pursue this idea would be -- firstly, the availability of samples, availability of commercial tests. I think there would be a difficulty in any manufacturer at that level, at this time, supplying sufficient tests for us to have a look at and -- I think they were busy as it were, in their own backyard, trying to develop the tests. I think what Abbott might have been saying was, "In the event that we were willing to do this, we would ask you to do the following things", or insist on the following things.

I always said to all companies that ever approached us about any test, "We will look at your test, we will analyse it, quite unknown to you, we will look at the results, we will publish the results, fear or favour." We believe in telling what exactly we find. We will not be stampeded into making allowances for this, making allowances for that. We had to be sure that the test was fit for purpose. That was for mass screening, day in, day out. Same test today, same test tomorrow, the same expected results, the same expected performance.

Q. What sort of --
A. I think the reason that we couldn't pursue this was just because the materials were not available, weren't readily available.
Q. Is that how you remember it?
A. Yes. I think John has made that point very clear. Even with Bob going down to London, Tedder wouldn't be prepared to let Glasgow or anywhere else, outside the little group in London, have access to his material.
Q. What sort of number of kits would you have needed for it to be a meaningful exercise?
A. That's a difficult question because clearly you don't know. If you are getting false positives of 90 per cent and they give you 1,000 kits, then it's not much use. A lot depends on what you expect. You do a preliminary study first and then you start scaling it up. There would come a time when you were scaling it up to maybe being able to do a week or a day's complete turn with no problems. Then you might say the time has now come to think of a bigger introduction.
Q. Right. When you say "90 per cent false positives", I think we can understand that what that must mean is that nine of every ten samples which have reached a certain point turn out, on confirmatory testing, not to be positive, is that right?

A. No, no -- well, yes, when you do the confirmatory test, yes.
Q. What I'm wondering is, what is, as it were, the denominator? Nine out of every ten samples that ...
Is it initial screening or is it repeat reactive?
A. That would be the initial screening.
Q. Right.
A. But many of them would just repeat again and again and again.
Q. So if you repeat the initial screening, you must get rid of some of them?
A. You might get rid of some of them.
Remember, these samples that were giving false positives, they were folk walking about who were perfectly normal healthy people. You had no reason to believe that they were suffering from some related condition like HIV. They weren't suffering from slim disease or any other lymphoma or any other problem that you were aware of. These were healthy people. That's what the donor's information says: the donor shall be healthy.
Q. You didn't actually give me a figure and I don't want to press you if you don't want to give me one, but I think just a ballpark would be interesting for us. When this exercise is being discussed, would you have wanted to

get your hands on 100 kits or 500 kits or a thousand or 5,000? What sort of number of kits would you have wanted?

A. It's difficult to answer that. Certainly five kits would be useless, ten would be useless. 1,000 might be doable.

Q. Right.

A. I don't think you would get a manufacturer to give you a large number of kits. Because you might find something that he didn't like.

Q. Okay. But if you had been able to get something of the order of 1,000 kits, the exercise would have been worth doing. Is that what you are saying?

A. I think we would have been prepared to have a go at it, to look at it, but whether it would have revealed anything in particular that would promise to go on and accept large numbers, that would be a different thing. Much would depend on the results of the first run, the first analysis.

Q. You have covered in your answer to my question the whole topic of availability of kits. We understand that. You can't do any sort of experiment with kits if you haven't got the kit, but was there any other reason why this initiative didn't bear fruit? Did something else bring it to a halt?

A. I think -- as far as I understood it at the time, around about that time anyway, there was that group in London that were doing evaluations or starting to do evaluations of the Tedder kit or the development of that kit, and I think that -- what's his name? -- the virology department had looked at the various kits that were available.

Q. Philip Mortimer?

A. Philip Mortimer. He had been able to get information from -- small numbers of kits from various -- I don't know how he did it but he got some. Clearly Gallo wasn't prepared to do that but he got them from the various manufacturers and they did an analysis, but their testing didn't do much except -- I think the number was 360 samples they examined.

Q. Right.

A. Was it five or six individual kits?

Q. Yes.

A. And on the basis of that they had advised the Department of Health, or others, that two kits came out as being the most likely kits that might be useful to examine.

Q. Yes, Dr Mitchell --

A. One of those was not Abbott.

Q. I don't want to interrupt you and you are absolutely right about that but you are taking us a bit further

forward, because that exercise was completed by the end of July.

I am just interested in whether in January in 1985, something choked off this plan to do an assessment in the West of Scotland?

A. I think it stood on that basis that, "If you have a kit, please come, offer it to us and we will have a look at it for you". You see, the one thing that -- why Glasgow is chosen to do many of these tests or evaluations was because of two things: we had a very excellent technical staff. Secondly, we had an almost inexhaustible supply of test samples, being the largest region.

Q. I see.

A. And that's one of the reasons -- there would be no point putting this into Dundee or Aberdeen or perhaps Inverness. They just didn't have the throughput. So it was natural that Glasgow should be asked to do that.

Q. I'm going to prompt you a little bit. Can you have a look at the transcript for Tuesday, please? It's going to come up on the screen at page 83. Can you see that question that starts about line 7, where it says:

"We have established, I hope, the position in January, what the concerns were, and that you were initiating some evaluations in Scotland, principally or perhaps exclusively in the West. But then you ..."

And the "you" is Professor Cash because this is me questioning Professor Cash:

"... you say that you were invited to discuss the situation with Dr McIntyre and that he made it clear that SHHD was strongly opposed to the prospect of SNBTS undertaking its own kit evaluation."

There is then a quote from Professor Cash's current statement, so a statement he has recently written.

A. "SHHD have given assurance to the department that they were content ..."

Yes, that's true, I think that's right, yes.

Q. The next bit. Professor Cash has said in his 2011 statement:

"As I recall, I thereafter consulted with Dr Mitchell and Dr McClelland and we agreed that in view of the hostile reaction of SHHD, this SNBTS initiative should be stood down."

A. Yes.

Q. Do you have a recollection of that?

A. Yes.

Q. You do?

A. Oh, yes.

Q. All right. Can you tell us about it then, please?

A. As I say, this was the whole argument that went on about -- the Gallo stuff was not available in the UK.

Someone in London had developed a similar system.

Q. Yes.

A. I think there was a general feeling that it might be a good idea to promote the British system, the British test, and it might be available more readily than something which was considered to be confidential and patented and so on elsewhere. And I think that was the reason that the department set up -- that is the Department of Health -- did set up an evaluation group, to look at the Tedder isolates and Tedder materials.

Clearly, if such an evaluation was going on and the SHHD had agreed that they would go along with it, then we were dependent on them for funding and all sorts of things, and if they said, "No, we don't want you to do that," there is nothing else we could do.

Q. Right. Everything you say makes sense, Dr Mitchell, but I just want to press you on whether you have an actual memory of an occasion when Dr Cash is confiding to you that he has had a difficult meeting with Dr McIntyre. Do you remember that or do you not?

A. I often think about why did we not start the testing and clearly we would not have abandoned it except if John Cash, being national director, had agreed it with us. I think that's all I can tell you. When you say to me do I remember a meeting on 5 December, or whatever it

was, I don't remember --

Q. I know, that's really hopeless actually. We can all think back to the 1980s, it's very difficult.

A. I can remember it being said, "Look, we are not going to do this test, we are not going to do the evaluations because we understand there may well be a British test on the horizon, albeit a little bit behind the field".

Q. I see. Thank you.

A. It may take a little longer to get a British test up and running but if and when it came, we would be delighted to look at it.

Q. Right. Thank you, Dr Mitchell.

Can we go back to Dr Mitchell's statement then, please, [PEN0171002].

Over the page. Some of this we have covered already. If we just look at the questions, we can see what's being asked.

A. Yes. I think in my answer there -- I think that's again just what I have said.

Q. Yes.

A. That clearly the confirmatory testing was being set up by Dr Follett and Dr Peutherer in Edinburgh, and to us that was a very important development.

Q. Yes.

A. Because, if we had a test that we were using, we would

have no way of doing any confirmatory work in my laboratory.

Q. You are referring in your answer, Dr Mitchell, to some difficulty in obtaining test materials from England.

A. Yes.

Q. You remember this, do you?

A. Yes, hm-mm. Yes, that's right.

Q. And this was -- are you remembering the --

A. This is because technical staff do talk to one another on a regular basis. We had many other things to be going on with. So they do tend to keep in touch, and when you hear someone else is doing something, you say "That's interesting, could we do that, please?" And we tried to get materials from the evaluation team in the south but unsuccessfully, again, because, as I think I have said there, DOH had funded the thing and why would they give us free materials when they had funded it, albeit that we were not part of the evaluation team.

Q. Yes.

A. We would only be given limited access to samples and test systems. It was really a question of, "Could we have a flying start on this? Could we have a quick look at it, please?" The answer was, "No, wait until the evaluation is complete and then we will tell you what the results are".

Q. As the director of a regional transfusion service and a big one, the biggest one in Scotland, what was your mood when you knew there were going to be HTLV-III tests on the market, that they were coming? What was your personal feeling about that? Were you relieved or were you apprehensive because of the problems, or was it a mixture? What were your sentiments?
A. You mean the test on the horizon was the English test?
Q. Just any test. When you realised in 1984 that there was going to be testing.
A. Just general disappointment that we weren't looking at things that other people were looking at. I think that was the general feeling, a feeling of disappointment, not so much relief. We certainly would be relieved in the sense that we didn't have to do all that extra work. Remember, we weren't in any way funded to do this.
Q. Yes.
A. We were doing it because we were interested.
Q. Yes.
A. You may think interest is not all that relevant but it is. If you are actually working in a field, it's very important to keep up-to-date with what's going on.
Q. I appreciate that, Dr Mitchell.
A. So that's why we were talking to the English all the time.

Q. I think I'm just trying to capture the mood of the transfusion service when you learned that the AIDS risk would, one hoped, be alleviated by the arrival of testing.

A. Yes, I think you have got to consider that the American set-up was quite different from what it is in the UK: different population of donors, different availability of kits, different manufacturers, some manufacturers who couldn't meet the deadlines. If you read the American literature, you will see that some couldn't even -- even Abbott, for example, couldn't supply all of America, although they were -- I think, I believe they were licensed -- not licensed but given an undertaking to take this on as a contract. But even they were unable to supply the whole of the market. And even then, the number of positives expected in the UK would be much less than you would expect in America.

Q. Right.

A. So we were disappointed not to be involved in the evaluation in the United Kingdom.

THE CHAIRMAN: You are still concentrating at this stage on the initial evaluation exercise?

A. Yes; yes.

THE CHAIRMAN: And that's what you have been talking about?

A. Yes. I think --

MS DUNLOP: Did you regard it as a given that screening would be introduced?
A. Yes, I'm pretty sure it would be, yes, when a suitable test was available, yes.
Q. How did you feel about that?
A. Excellent, great idea, no problem. We would be very pleased at such an event.
Q. Right.
A. Yes.
Q. So what we are, I think, appreciating from your account, Dr Mitchell, is a sense of frustration that you weren't more directly involved.
A. Yes.
Q. That you weren't evaluating kits yourselves and --
A. Yes.
Q. And you couldn't get your hands on any sort of supply?
A. There were many other things going on at the time, but we would like to have been a bit busier.
THE CHAIRMAN: Quite apart from that, this surely must have been one of the big challenges facing your profession at that stage.
A. I think that's right. I think Robin Weiss wrote a paper in 1996, I think it was, I read it, saying that it was the major thing in blood transfusion; the most important event was that one, because here we were looking at

a lethal disease in those days.
MS DUNLOP: Yes.
A. "Lethal" meaning pretty quick.
THE CHAIRMAN: And you weren't getting in on the act.
A. We weren't seeking to give people bad news.
THE CHAIRMAN: No, no.
A. But at the same time we would have liked to have introduced the test as soon as possible in the Blood Transfusion Service in Scotland.
THE CHAIRMAN: There is a pride. When I refer to the "Glasgow mafia", it's not a pejorative expression. I reckon to be part of it. But --
A. We have a certain pride --
THE CHAIRMAN: You had a pride.
A. -- in our job, and anything in blood transfusion that was going on, even if on the purely physical side, I wanted to be involved. I wasn't a bystander. It would be very easy for us to just have said, "Oh, just leave it alone, don't bother with it. You know, it will unfold in its normal way and one day we will all waken up and there will be a test system and we will have a turnkey system, all we do is turn the key and it will work." That wasn't the way we looked at it.
MS DUNLOP: Yes. And this sense of positive anticipation that the testing was going to be introduced, that must

have been something that you realised when the virus was isolated or when the news broke that the virus, the cause of AIDS, had been found. That must have been your response, that a test would come and that donated blood would be capable of being tested.

A. The feeling then was, "Thank God --

Q. Yes.

A. -- we have a handle on this thing."

Q. Just looking again at your statement and trying to get as much information as we can about the availability of kits, you have been asking Dr Dow -- we have been asking Dr Dow as well -- as somebody who might have information about that, but I think really the only picture we are able to build up is that around July 1985 SNBTS was able to do mini evaluations of the two selected kits. That must have been July/August, so the Organon kit and the Wellcome kit, which had made it through the phase 1 of the evaluation. There were supplies of those kits to permit the different areas in Scotland to do their own mini evaluation.

Of course, then, based on the results of their mini evaluations, they would make the choice between the two. So obviously in the summer there were kits available. Do you remember that mini evaluation process?

A. I have a good idea I remember it, yes.

Q. Right.
A. I think a number of labs were asked to do a mini evaluation, a look at it, when it became clear from the PHLS group what tests were going to be recommended. I think was at Organon, and the Wellcome one.
Q. Yes.
A. And at that time I think a number of people were saying, "Look, hallelujah, let's get on, we have got something, let's look at it." But remember what I said to you earlier, that the Mortimer study looked at 360-odd samples, which were selected. Some of them were pretty obviously going to be positive, they were known cases of the disease, whereas when you had to scale that up to the point of technical know-how -- Mortimer's group was a group of very eminent virologists, who didn't run a blood transfusion centre, didn't run anything to do with blood transfusion.

What they said was good, their evaluation was very thorough, and I don't think we could have done it at that level of virology, molecular virology. But at the same time 300-odd samples did not really add up to mass screening.
Q. Yes.
A. And we had to evaluate -- they were telling us what to do but we knew how to do it, if you know what I mean.

Q. Yes.
A. But, in the knowing how to do it, there was a considerable amount of work still needed to be done. We had to do all sorts of things about sample identification, computerisation, all sorts of things. My centre was the first one in the world to have a computer on line to the test the system.
Q. Right. We do know, Dr Mitchell, that, as originally envisaged, the evaluation exercise was supposed to have two phases: the Mortimer phase, if we can call it that, and then the second phase, where, according to our paper, to which Dr McClelland contributed, there would have been 10,000 samples looked at.
A. That's right, yes.
Q. As far as we can tell, however, because of pressure of time, the whole of that exercise was not carried out before October 1985, when screening was introduced.
A. Yes.
Q. But that sort of phase 2 exercise is what you are describing, I think --
A. No, the mini evaluation started -- (inaudible) start with the phase 2.
Q. But it's on a very much smaller scale?
A. A much smaller scale because they weren't available, the test materials were not available.

Q. And so what we can take, I think, from what you are telling us and what's in your statement is that kits were available in the summer of 1985 for the West of Scotland to do its mini evaluation and choose between the two, but before that you think that you had also made an unsuccessful attempt to get some test kits from Wellcome earlier in the year?

A. No, I don't think --

Q. Well --

A. -- that's right.

Q. -- it's this sentence:

"Professor Cash had asked Harold Gunson to release some of the English test materials from Wellcome."

A. But that wasn't successful.

Q. That wasn't successful?

A. No, no.

Q. Right.

A. But I think -- did Brian McClelland not write to Wellcome?

Q. He did, yes.

A. Asking for a small amount of material and was not really terribly successful with that?

Q. Yes.

A. When you said the middle of July, I'm sorry, I can't remember the exact date when it was we received a number

of kits from Wellcome. Whether Wellcome are in a position to scale up and go 100 per cent overnight, I doubt that very much. I think, if I remember rightly, the early samples that we got were good, they were fine, and we could detect known positives and known negatives and so on with the small amount we got, but when that was scaled up, then we ran into all sorts of difficulties.

Q. Yes, Dr Dow has indeed given us some further detail on that.

A. Yes, that's an example of where what looks good suddenly goes bad in your hand when you scale it up. You see, a virology department has all the time in the world -- I don't mean that literally, but lots of time to look at a thing: Two hours, two days, four days, next week ... That's fine.

Q. Right.

A. Blood transfusion has to get this stuff on the shelves this afternoon.

Q. Yes. I think you are telling us exactly that at the bottom of page 2, talking about the difficulties --

A. When you start scaling it up and you discover that you have got to repeat your tests over and over and over again on the same day to get any sense out of it -- that is that the manufacturer's own controls are working okay

as against the samples, to be sure the results are genuine -- then you begin to see, "My goodness gracious, this isn't really fit for purpose at the moment."

Q. Can we move on to the next page of the statement, please, and look at your passage under the heading "Introduction of HTLV-III screening in Scotland?" Now, we know from a number of sources -- and you are obviously particularly well placed to tell us -- that the West also went for the Wellcome test.

A. That's right.

Q. And we asked some questions about short-term contracts.

A. Yes.

Q. And you have answered that. You think it would have been unwise to introduce an interim, unvalidated test whilst validation was being carried out?

A. I think I have just explained that to you.

Q. Yes. And you say no decision had been made to override any evaluation, and you also say:

"Funding for such a venture would not have been agreed for any one region, so as to avoid premature regional variation within donor and patient anxiety."

Were you in favour of a uniform date for the introduction of screening for the whole of the UK?

A. Yes.

Q. Right.

A. I think if you consider Scotland as part of the UK.
Q. I think it was -- and is.
A. You could have people coming from Carlisle up to Dumfries.
Q. Yes.
A. That was known. Donors in Carlisle give in Dumfries.
Q. I take your point. But one area did go it alone. I don't know if you remember that. There was an area in England that started testing.
A. That was Hepatitis C.
Q. Oh, well, let's look at [DHF0019468]. Do you see this?
A. Newcastle.
Q. This is 19 March 1985, and this is the DHSS writing to the PHLS and talking about the need to put resources aside in 1985 to 1986 to fund the introduction of screening tests, but the regional general manager of the northern region had replied to say that:

"Antibody screening is already being undertaken by the PHLS in Newcastle."

And that money had been allocated by the region to a consultant at PHLS to develop tests for the Blood Transfusion Service.

A. That's PHLS. That's not the blood transfusion department.
Q. Right.

A. That's not the regional centre. Dr Sherlock was not doing screening of donors.
Q. He wasn't screening donors?
A. No, no.
Q. Right.
A. This might well have been somebody trying to do what Eddie Follett was doing. They are trying to set up a regional reference lab. I think that's what -- sorry, I haven't seen that letter.
Q. No, indeed.
A. But that's what it would reveal to me. The general manager was trying -- as John Cash and David McIntosh and others have done -- to get reference centres in various regions. This was to stop -- if the tests came in, why should Newcastle send all its material, its doubtful specimens, down to London. They might get the answer back next week, whereas when we had somebody like Eddie Follett on the doorstep. And no doubt Peutherer, you were able to get an answer pretty quickly. Each region would have its own reference centre.
Q. It was just this reference to antibody screening already being undertaken by the PHLS in Newcastle.
A. Sorry, again, I'm only reading the letter as you give it to me. The PHLS in Newcastle may well have been offering an service to --

Q. To clinicians?
A. -- the clinicians for the urinary medical clinics or the haemophilia centres down there, I really don't know, but I think that would be what they were doing. They might well have been offering a clinical service, which was -- remember what Scotland had said: in order to avoid donors, or bogus donors, as I call them, attending to get a free test, it was very important that the area health boards should set up a reference laboratory which could handle the clinical samples.
Q. Yes. We can see the sort of reasoning that the DHSS are employing.
A. Yes.
Q. If we look down in the letter, they say:
"In the first place the introduction by one region of a test to screen blood donations could severely embarrass other blood transfusion centres."
A. That's right.
Q. And then:
"Secondly, we are concerned at the possible emergence of different standards of positive results ..."
A. Yes.
Q. And then:
"Lastly and most importantly, as was made apparent

at the recent meeting at PHLS, the Gallo isolate was being used to provide the antigen for the test in Newcastle. You should know that the department, some nine months ago, wrote to the United States government asking for their permission to use the isolate sent by ..."

I suppose that will be Gallo to Professor Weiss:

"... in order to provide antigen for development of tests in the NHS. Permission was not given and in the knowledge of this the department cannot but look askance at the entrepreneurial exercises that are being carried out by ..."

A. I'm sorry, I have no knowledge of that. I didn't see that letter at all.

Q. It was just an opportunity, Dr Mitchell, to refer to the fact --

A. I'm very, very surprised at that actually.

Q. There seems to have been, at least to some extent, a slight breaking of ranks?

A. I hope it wasn't within the blood transfusion ranks.

Q. I take your point.

A. It was quite clear that we were all to sing from the same hymn sheet.

Q. And you agreed with that?

A. Absolutely.

Q. Can we just scroll right down to the bottom? Thank you. Yes, there we are.

A. Sorry, I hadn't seen that before at all until now.

Q. Can we go back to the statement, please, and just move over on to the next page, so we are talking about [PEN0171002], now at 1005. In this section we were focusing on the letter which was sent to the Lancet. It actually appeared in the Lancet in March 1985 and it registered the concern of transfusion directors at the likely incidence of false positives with the commercial kits then coming on stream.

But, of course, we know too that by the end of May Professor Bloom was becoming very anxious about the lack of screening and we know about his letter to the BMJ, to which Dr Rizza and Dr Forbes were also signatories.

A. Yes.

Q. And we asked about your sources of information underpinning the belief that there was a high rate of false positive results with the commercial kits. We asked what SNBTS had done to try to obtain information from other blood transfusion services abroad and we asked about various measures that might have been taken to lessen the effect on donors or transfusion recipients and you drew our attention to the letter from Dr McClelland to Mr Madden. We have already looked at

that this week.

I think you actually went on to say that you wouldn't have been in favour of introducing tests by the back door. I suppose there would be two different possibilities. I think maybe what the question was getting at -- and I didn't put this well yesterday, but the question was really getting at introducing donor testing perhaps with information to donors when they were in the centre but without public announcements, so you wouldn't have this problem of people turning up to get a test. The information would have been, I suppose, discreet and within the transfusion centre but wouldn't have been in the newspapers or in the public arena, no?

A. Maybe that's what wishful thinking would reveal but in the real world I think you would find that that sort of information would get out pretty quickly.

Q. Yes, I take your point.

A. Remember the number of people who were actually handling all this material. The same thing happened with hepatitis, if you remember. All the information -- stuff was being leaked to the press like mad and one couldn't determine how it was leaked but at the same time that kind of information, as I think I did say, that getting out into the public domain would have been devastating on the public. They would have lost all

credibility, blood transfusion would have lost it, and people would have lost all interest in becoming blood donors. They would say to themselves, "Well, if that's what you think of me, don't bother calling me. Don't bother telling me anything more. I don't want to know if you are going to do that." You test one lot and not another lot and the guy in Carlisle says, "Maybe if I had been working in Dumfries, I would have had a test," and the chap -- you can't have people crossing boundaries and going around to find out if they are positive or negative. There was an element of that --

Q. Yes.

A. -- early on.

Q. We know that from a very early stage the need for alternative testing facilities was identified, so people whose only purpose was to get an AIDS test were not wanted as potential donors. We have some information about the alternative testing facilities in Edinburgh and I just wondered what the alternative testing facilities were in the West.

A. As far as I know, the area health board in Glasgow did set up access testing through the regional virus lab. That was through Eddie Follett and that group. I think they were well up and running about the time that we were talking about Eddie Follett setting up the

screening test and the confirmatory testing. I think they were a little bit running in parallel with blood transfusion.

Q. Do you remember as at autumn 1985 what avenues would have been open to a member of the public in Glasgow who just wanted an AIDS test. Where would they have gone? Where could they have gone?

A. I think some people did approach us.

Q. Right.

A. And we would have had to say to them, "I'm sorry, we are not offering it to general public; what we are doing is trying to get a test for donors. Please go and see your own doctor." Their own GP might well have said, "I don't know if I can have a test done but I'll find out if the regional virus lab are doing it." I think that's --

Q. So was there anything in the West of Scotland where people could just walk in off the street and say to somebody, "I would like to be tested for AIDS," and that would happen?

A. No, not that I am aware of that. No, I don't think so.

Q. So a self-referral facility? You don't think so?

A. No, I think they would either have to go through their GP or go through one of the clinics.

Q. Right.

A. You know, the drug abuse clinics or the other clinics or genitourinary infection.
Q. Right. And then I think the other point that you are making, Dr Mitchell, in your response, if we look at the final page, 1006, relates to information from other countries.
A. Hm-mm.
Q. Is it your position that it wouldn't have been safe to introduce tests straight away in the UK on the strength of evaluations that might have been carried out in other countries. Is that what you are saying?
A. Yes.
Q. Right. So you couldn't just say, "This test has been tried out in America, we can introduce it immediately in the West of Scotland"?
A. No.
Q. Why would you not say that?
A. You know from the American literature the number of false positives that they were finding.
Q. Right.
A. A tremendous number of false positives. As I say, even as I read, I think it was in that Crewdson or that paper that was sent to us. I think, if I remember rightly, there was one saying in 1986 they were still trying to improve the test so as to detect false negatives.

Q. Yes.
A. And I think in the States it was perhaps easy to say to someone, "Well, you are a donor, we pay you for this but just don't bother coming back. We don't quite know what's wrong with you." You know? But I think the position in the UK would be, "We have got to get something done about this." Your donor has now become a patient and you then have a duty to say, "Well, I'm going to get you the best information I can get for you."
Q. Well --
A. And that's where our beloved Dr Crawford took over.
Q. I understand that, Dr Mitchell, but I suppose I'm really just wondering whether, if there had been a very good commercial test from another country -- let's say the United States -- a test that had very positive research underpinning it and the field evaluations had all been carried out in some part of the United States, that would have been good enough to justify its introduction without evaluation in the UK, or would some sort of evaluation still have been needed?
A. We would certainly want to have a look at it first, to see if it was compatible with our testing systems. I mean, there may have been bits like, gearing up your lab, having to buy extra equipment, extra staff, as

I said, computing, all the -- all the paraphernalia of doing it on a large-scale.

Q. But is information about how a test performs on American donors a reliable guide to how it will perform on British donors?

A. No, they had a different population, you see.

Q. Right.

A. Many of their donors, as I understand it, were recruited from penitentiaries and places like that, where clearly there was a large degree of drug addiction and other hazardous occupations or things. So I don't think we would necessarily have just immediately willy nilly have accepted the American tests.

I think even the American, if you read, they had difficulty deciding among themselves what would be the most superior test. As far as I read, there were perhaps five or six individual tests all being used throughout the States. None of which were compared with one another. Nobody was exchanging samples to say, "Look at this tricky one. Can you detect that? Or can you detect it?" There was no correspondence between individual centres.

Q. Yes.

A. You know, what's positive with me has to be positive in Edinburgh --

Q. Yes, I think we can --
A. -- and London.
Q. We can understand that a proper comparison is really dependent on different test kits looking at the same samples. I think we can understand that, Dr Mitchell.
A. I think one of the difficulties was that many of these people in their confirmatory testing were testing the confirmatory test against the original virus, the isolate, whereas in actual fact they should have been using two separate tests, at least two separate ones. It's like comparing cheese and chalk.
Q. Yes.
A. That was the difference.
Q. Right. Excuse me a moment, Dr Mitchell.
Thank you very much.
THE CHAIRMAN: Should we have a break or ...? I'll just find out whether there are questions.
Do you have any questions?
MR DI ROLLO: Not for me.
MR ANDERSON: Nor I, sir.
MR JOHNSTON: Nor me. Thank you, sir.
THE CHAIRMAN: I don't think we need a break for Dr Mitchell's purpose.
What's your general position?
MS DUNLOP: I have no further witnesses for today, sir, but

I do have a number of other statements, as perhaps is common towards the conclusion of any one topic. There are a number of other statements and I would like to tender them.

THE CHAIRMAN: Then we should have a break and come back.

MS DUNLOP: I think a break would be sensible, yes.

THE CHAIRMAN: Thank you very much, Dr Mitchell.

(11.03 am)

(Short break)

(11.30 am)

THE CHAIRMAN: Yes?

Tendering of other witness statements by MS DUNLOP

MS DUNLOP: Yes, sir. I simply wanted to mention some of the statements from witnesses who have not attended to give evidence in person, and the first such statement is from Dr McIntyre, [PEN0170552].

If we look at that ourselves, Dr McIntyre is entirely naturally not able to remember very much and has difficulty in answering most of the questions, and we also have to bear in mind this is an omnibus schedule of questions and much of it relates to happenings within the DHSS, which one would perhaps not ever have expected him to know a great deal about.

If we just perhaps look at the second page, one point which does come across is his strong support for

the idea of an evaluation of test kits before they are introduced. We can see that particularly in paragraph 8.

THE CHAIRMAN: Is this generally or with reference to the particular examples?

MS DUNLOP: He does say "generally". He says:

"It is normal practice to evaluate a new test."

THE CHAIRMAN: That can't be a surprise really, can it?

MS DUNLOP: No, it's common sense but I think it's as well for us to educate ourselves on these points.

THE CHAIRMAN: It is better to have evidence to rely on than common sense, which is a variable element in any assessment of a position.

MS DUNLOP: In paragraph 9 he makes reference to a briefing minute to the Scottish health minister. That's the Mr Macpherson minute, that one. [SGH0027226] Mr Macpherson's minute of 21 March 1985.

Then on to the next page. He also goes back to the topic of evaluation, this time more specifically in relation to the HIV test kits and that's looking at 11.

Then on to the next page. He perhaps encapsulates the difficulty for people being asked these sort of questions when he says:

"This all feels logical but is no more than my attempt to elucidate the thinking of DHSS colleagues

after a lapse of 25 years, and my comments should be read in light of this caveat."

Perhaps a caveat that should apply to most people asked and would, I suspect, apply to us as well if asked about events in the 1980s.

THE CHAIRMAN: Yes.

MS DUNLOP: Then going on to the next page as well, he talks about personnel. He talks about Dr Bell in particular in paragraph 23, and Dr Bell's various minutes. Dr Alison Smithies and then Dr Ed Harris and Dr Mike Abrams, and then Dr Diana Walford initially before handing over to Dr Smithies.

Then his initial response to the idea of the SNBTS evaluations is set out in paragraph 26. He did actually say:

"I cannot recall being involved in any discussions between SHHD and SNBTS regarding this matter. It was also agreed at this meeting ..."

That's the coordinating group:

"... that no transfusion centre in Scotland would commence routine HTLV-III antibody testing unilaterally."

To try to be a little bit more specific, we did put Professor Cash's version of events to Dr McIntyre. We asked the Scottish Government to do so and we have an

email response, which is [PEN0171836]. I think perhaps I should just let everyone read it. (Pause)

THE CHAIRMAN: Yes. The last paragraph, which of course we have seen before, actually misses the point. I don't think Dr Cash's complaint is as to the tone of the intervention but as to its effect. When I read this first, I didn't really think that worrying about the hostile character of it and so on mattered, nor is it necessary to say that they treated colleagues in a professional manner. You can treat people in a professional manner and still fail to give them the comfort they are looking for, I suppose.

MS DUNLOP: I suppose the question is perhaps whether it was an offering of advice or opinion or an instruction.

THE CHAIRMAN: Yes.

MS DUNLOP: I'm not sure we are going to get to the bottom of that.

THE CHAIRMAN: No. Well, the one thing that seems to be reasonably clear -- and I will be interested in other people's comments -- is that however it came about, there was an acceptance as between the two major centres in Scotland, who might have been involved, that the process that was taking place in England was the right way to go about it, properly funded, and that it shouldn't be replicated here.

MS DUNLOP: Yes. I think there does come across an anxiety immediately after the New Year in 1985 about whether anything very much was happening.

THE CHAIRMAN: Yes. That's bound to be if people aren't as involved, as clearly Dr Mitchell would have liked them to be, even on an informal basis.

MS DUNLOP: Yes. When you look at material from the DHSS, it is plain that steps were being taken to put together a panel of experts to oversee the evaluation, to draft protocols and so on.

THE CHAIRMAN: Yes.

MS DUNLOP: The next individual who has provided a statement is Dr Macdonald, Dr Iain Macdonald. And his statement is [PEN0170559].

He was the other deputy chief medical officer but he points out that Dr Graham Scott, as deputy chief medical officer, had responsibility for blood transfusion matters.

I have to say, without intending any criticism, a number of his answers do begin with "I do not know", and given those circumstances and the lapse of time, that would seem to be understandable.

THE CHAIRMAN: Certainly when the alternative is "I imagine ..."

MS DUNLOP: Well ...

If we look at the second page, we can see, however, a reference to DHSS as a Whitehall department taking the lead. This is an expression that does crop up from time to time. He makes a general point about DHSS:

"... having significantly larger numbers of both administrative and medical staff who could give their attention to health matters than SHHD. Individual members of staff in DHSS could handle in greater depth a smaller number of issues than their opposite numbers in SHHD".

THE CHAIRMAN: I can see that in fact. I'm not sure it answers what might be a question in the long-term, which is whether DHSS had a role that subordinated thinking in SHHD, or whether SHHD had a continuing responsibility to assess issues for itself; no doubt with the assistance that was derived from SHHD work.

I'm not sure that I know where this should end up.

MS DUNLOP: Well, we certainly have another big topic to look at, which is analogous in relation to the introduction of Hepatitis C screening.

On the topic of evaluation, he goes on to say in 8 that:

"The government would have been criticised had there not been an assessment of the available tests."

THE CHAIRMAN: That's clearly correct, isn't it?

MS DUNLOP: Well, it would certainly seem to be supported by the evidence, and I don't think actually anyone suggests the contrary.

THE CHAIRMAN: There has been no suggestion otherwise?

MS DUNLOP: No.

THE CHAIRMAN: I don't think that is really challenged in any way by Dr Mitchell, whose department was the one that would have been doing something different.

MS DUNLOP: Then if we go on through the next pages, perhaps particularly 24 is worth noticing, he says --

THE CHAIRMAN: Paragraph 24?

MS DUNLOP: Yes.

THE CHAIRMAN: That's skipping a lot that I have not read.

MS DUNLOP: There is a lot of "I don't knows".

THE CHAIRMAN: Okay.

MS DUNLOP: It's actually only one page. If we go to the next page, 562.

THE CHAIRMAN: Right, it's quite compressed through that.

MS DUNLOP: Yes. 24, he does say he has some sympathy for SNBTS in wishing to do things on their own account without waiting for NBTS.

THE CHAIRMAN: But he really doesn't remember or know anything about the background.

MS DUNLOP: No, I think that's really right, sir.

He does make general comment in 27 about this idea

of one service introducing testing in advance of the other. Then he also remembers the need for alternative testing facilities. That's covered in 29. He makes the practical point, that perhaps no one else has said in terms, that the sheer numbers of people who might have turned up would have caused a logistical problem.

THE CHAIRMAN: I think I might have been more concerned with the possibility that with an inefficient test system, there would be false negatives that would expose patients to greater risk.

MS DUNLOP: Well, indeed, and that would certainly dwarf any point about running out of kits.

Then there is really nothing on the last page.

We then have a statement from Alexander Murray -- Sandy Murray, I think he was -- which is [PEN0121899]. He was a branch head. He says in (iii):

"My job title in SHHD was head of branch 3 of division IVD."

I'm not sure if that's 4D or IVD? Four, thank you.

It's 4D. He explains a bit about the set-up.

THE CHAIRMAN: I will just read that paragraph more carefully, if I may? (Pause)

How should one understand the relationship, if any, between A and B?:

"... to carry out the administrative and executive

functions in relation to the CSA as such."

And:

"... a number of divisions of the CSA, including the SNBTS."

Should one understand a hierarchical structure with the SNBTS functions being subsumed under the CSA, or is the care of the SNBTS separate from care of the Common Services Agency so that there is a direct relationship between branch 3 and the SNBTS, or what?

MS DUNLOP: Well, I understand it to have been pyramidal, sir. I'm not sure about the hierarchy but certainly the Common Services Agency appears to have had resourcing and staffing of its own and then underneath it would be the divisions of the Common Services Agency, and he instances the SNBTS, the Scottish Ambulance Service and the Scottish Antibody Production Unit, and as I think we have said before, the Central Legal Office too.

And branch 3 has had duties in relation to both levels. So the level higher up the pyramid, which oversaw all of these divisions, and --

THE CHAIRMAN: Would the exercise of a function relating to SNBTS have been channeled through the CSA or would it have impact directly on the SNBTS? I don't think he tells us that.

MS DUNLOP: No, but I think we can see from the documents

that sometimes Mr Murray is considering directly such matters as funding of the introduction of screening, without there having been some kind of intermediary from the Common Services Agency getting the message from SNBTS and transmitting it to SHHD. So there seems to have been some issues where there was direct liaison.

THE CHAIRMAN: But the question is what the inferences might be that one could draw from that, as to whether there was a properly structured hierarchy or something much more casual, which I think I may have to look at in due course.

MS DUNLOP: Well, I suppose, sir, it really depends on the issue, doesn't it? It's impossible to prescribe in advance how any structure will respond to any issue which might arise, and there seems to have been a degree of flexibility, which no doubt was advantageous in some circumstances.

THE CHAIRMAN: Well, may have been advantageous in some circumstances.

PROFESSOR JAMES: You could perhaps put that the other way round and say there was a degree of vagueness which could have been disadvantageous in certain circumstances.

MS DUNLOP: If it's necessary for the Inquiry to express value judgments on these management structures in the

early 1980s, I'm sure we can ask some further questions about them, but it's no doubt difficult for people to give an overall impression at this juncture.

Mr Murray points out on the second page that he has no medical or scientific qualifications and he says he is unable to answer many of the questions put to him. And there are again a number of questions to which his response has to be that he doesn't know.

Then on to the next page, please. He mentions the ministerial involvement in decision-making, which we have seen in the minutes and indeed telexes from February and March 1985.

On to the next page. He sets out circumstances in which an issue would be brought to ministers' attention. Then he talks about submissions going first to a junior minister and then to the Secretary of State.

Then not really much else on the final page, 1903.

Immediately above Mr Murray was Mr Davies and we have a statement from him, [PEN0171007].

THE CHAIRMAN: You say, all right, he moved across from science then to become a principal administrator?

MS DUNLOP: Yes.

THE CHAIRMAN: A principal of the general division, right.

MS DUNLOP: So he is head of IVD, and then IVD had a number of branches and Mr Murray was head of one of the

branches.

THE CHAIRMAN: It is interesting that Mr Davies came into the service as a scientist.

MS DUNLOP: Yes. With a background in computing, in fact.

THE CHAIRMAN: Computing, oh, all right. I see that. Well, it doesn't necessarily mean that was his background. He became involved in computerisation, but I think --

MS DUNLOP: It's just that sentence:

"I had a background in computing ..."

That makes me think that must have been his background.

THE CHAIRMAN: Yes.

MS DUNLOP: But I suppose quite early in the process, so the division which he headed between 1983 and 1985 had overall responsibility for SNBTS-related matters, and then Mr Macpherson headed another division, which had responsibility for inter alia, misuse of drugs and communicable disease. So I suppose we have had some examples of the crossover.

THE CHAIRMAN: In Civil Service terms, Mr Davies had a very interesting career path, didn't he?

MS DUNLOP: Yes. I think some members of our team -- certainly one member of our team is able to remember Mr Davies.

We can see in paragraph 5 he is mentioning

discussion of donor screening, but again I think really reconstructing events rather than speaking of any direct recollection. And predictably perhaps quite a lot of "don't knows" or "I am unable to answer this question."

Go on to 3, please.

THE CHAIRMAN: Paragraph 22 indicates that even though he wasn't directly involved in the scientific side of this, the message has got through to him that everywhere was extremely reluctant to use tests that ran the risk of giving high numbers of false positives.

MS DUNLOP: Indeed, yes.

THE CHAIRMAN: And an equal concern about false negatives -- well, not equal. It's different. He doesn't remember that as much.

MS DUNLOP: Hm-mm.

THE CHAIRMAN: We should remember that the tabloid press at the time were hysterical. Does this period stand out particularly for that?

MS DUNLOP: Then on the next page, he doesn't really again remember anything of substance, although from the paragraph at the bottom of the page he, and indeed his wife, remember this as an anxious period.

THE CHAIRMAN: Yes.

MS DUNLOP: Then on to the final page, if we could, please. It's just a small section.

So that's Mr Davies.

The next document is [PEN0170504]. That relates to Dr Alison Smithies. We did see if we could get a statement from Dr Smithies and this is the response.

THE CHAIRMAN: It rather misses the point, does it -- or two points? It's not really for Dr Smithies to decide whether she should be helpful or not and the comment that a person can make on a contemporary document may be of great assistance even though that person doesn't fully appreciate the total context in which the answer is to be considered. There you are.

MS DUNLOP: We also, sir, mindful of the suggestion made by Professor Cash and indeed Dr Mitchell too, that Dr Dow might have useful information, contacted Dr Dow and he provided at the same time a statement very swiftly. [PEN0171680].

This is the one that we looked at earlier, and we at least can see the different colours, but I don't know that anybody who is reading it later will be able to or not? They will? Yes, if they look at the PDF version, they will be able to see the black, blue and red.

At the bottom of the page Dr Dow is setting out his recollection of events in January 1985 and beyond. I'm not completely sure about the meaning of that sentence, that he knows that there was an Abbott system being used

in Ruchill. I'm not entirely sure why this is.

THE CHAIRMAN: That was the question I raised, prompted by Professor James, about what was happening in Ruchill.

MS DUNLOP: Maybe it's worth looking. Leave Dr Dow's statement open. It's worth looking at the mention of Ruchill to which I alluded when I replied, sir, which is in [DHF0019169].

So on February 11th, 1985, Abbott -- and can we just look at their letterhead, please. They are actually writing from Delkenheim. That's the factory we saw mentioned as supposedly coming on-stream in 1985 to supply Europe. They are writing to talk about the Abbott HTLV-III EIA diagnostic test kit.

They say that they have already contacted three British evaluators. If we look over the page, there we have it.

THE CHAIRMAN: There is Ruchill.

MS DUNLOP: Yes.

THE CHAIRMAN: Yes, the question is: what was the population that Ruchill was dealing with at that stage? I think the suggestion is that it may have been people who had problems of HIV/AIDS infection, not related to haemophilia.

MS DUNLOP: I suppose one can speculate that in practice there are likely to have been problems with any kind of

planned evaluation at Ruchill of a similar sort, particularly if it was in March and April 1985, that the availability of the kits seems to have been so limited that in spite of what may have been intended by Abbott, any evaluation exercise on anything approaching a large-scale may have had to have been postponed or may not have proceeded. But I take your point, sir, that there is another aspect to this, which is simply that the kits could have been being used for diagnostic purposes in Ruchill at this time.

PROFESSOR JAMES: I would think that would be extremely likely.

MS DUNLOP: Yes.

So can we go back to Dr Dow's statement then, please? He refers to the West of Scotland mini evaluation and that's at the bottom of the page. Can we just go up a little bit. He says:

"Around July 1985, SNBTS were in the position to perform a mini evaluation of these two proposed commercial anti HTLV-III tests."

Then he says on the next page:

"... there were insufficient supplies of any (other than the Abbott test) commercial HTLV-III test kit in early 1985 for a significant evaluation for blood donor screening purposes."

THE CHAIRMAN: Interesting expression:

"I realised that a national evaluation had been performed."

There is nothing to indicate that he knew in advance of the arrangements being proposed or put into effect.

MS DUNLOP: No.

THE CHAIRMAN: Of course, he has already said that he wasn't involved in procurement, which I imagine was general and not just specific to the example he gave.

MS DUNLOP: But he was at Ruchill because he said at the start that he was on a part-time secondment to Ruchill in 1985. I don't think he actually says what month he began at Ruchill.

Then at the point when we framed our questions, we were more interested in the deference between RIA and ELISA than in the difference between a competitive format and another type of format, and I think that we have been on a bit of a learning curve on that topic. So we did ask quite lot of questions about RIA versus ELISA and he gives some interesting information about the supply issue. He says that:

"Today, kits sometimes have expiry dates over a year in advance but that wasn't the position in the 1980s."

Then the point made by almost everybody that the use of isotopes for radioimmunoassay tests were also under

strict control, with laboratory staff having to wear monitoring badges:

"So it was necessary for transfusion services to accept the use of ELISA techniques that resulted in completely new equipment being used."

Another practical consideration which one should bear in mind in assessing the timing of all of this process. He has given us a photograph of the equipment necessary for performing the anti HTLV-III ELISA test made by Wellcome.

Further down then, please, we asked about the working party -- that is the regional transfusion directors' working party -- amending its report, and about various practical arrangements that had to be made. He says on the next page that he is unaware of a second stage to the evaluation but, of course, we have seen the draft report of the second stage. Then he goes back to the mini evaluation.

Again, a now familiar point about the initial problems with plate validation failures and the test kit being less sensitive than the developmental batch tested in July. Of course, Wellcome, in one sense, had been almost too successful because, despite there being two tests approved, Wellcome seemed to have attracted custom from almost the entire United Kingdom blood transfusion

services.
THE CHAIRMAN: Possibly the three factors identified by Dr Dow were generally appreciated.
MS DUNLOP: Yes.
PROFESSOR JAMES: They were probably also supplying the routine public health labs throughout the UK, when it became clear that that was a better test at the same time.
MS DUNLOP: Yes.
THE CHAIRMAN: It certainly must have put them under tremendous stress to have to gear up to cover everything.
MS DUNLOP: Yes. Then there is another --
THE CHAIRMAN: The plates would come from somewhere else, I take it, or would they be Wellcome too?
MS DUNLOP: I don't know about the plates, I am afraid, sir. Perhaps one could speculate that in that he says that equipment was delivered; it may have been that Wellcome subcontracted some aspects of that and delivered a package, but we don't actually know.
THE CHAIRMAN: It would be Wellcome who would treat the plates in the first instance, so that they would come --
MS DUNLOP: I expect so, yes.
THE CHAIRMAN: -- with their antigen and so on --
PROFESSOR JAMES: I think that's where the failures will

have lain. It's the displacement. We know what sort of assay it is. So it will be the fact that these plates, with multiple little sort of dips in them, as it were, you know, just weren't properly coated to a really high standard when they began to really, really mass produce them. That would be my guess as to why some plates as a whole, worked and others, you know, just didn't.

THE CHAIRMAN: So plate validation is much more likely to deal with the plate ready for a test.

PROFESSOR JAMES: Exactly, yes, yes.

THE CHAIRMAN: Yes.

MS DUNLOP: Then he actually gives us some more interesting information slightly further down about the practicalities of storage. He says:

"Three months' supply would have filled several shelves of our laboratory refrigerators."

THE CHAIRMAN: Yes.

MS DUNLOP: Perhaps on to the next page as well, please.

This is talking about confirmatory testing. Then this table, which we have seen before. Statistics for the first 176,149 donations tested. Actually it looks, looks, as though the positive predictive value is only about 20 per cent. But then he goes on to say that Abbott was tried and proved even less specific.

THE CHAIRMAN: Yes. All the information about Abbott that

has been adduced tends to suggest that there were great difficulties with their test.

MS DUNLOP: Yes. And of course, Dr McClelland made the point that the Abbott explanation for the less successful performance of their kit in the evaluation doesn't work once you get into the field and you are --

THE CHAIRMAN: That's right. It certainly doesn't work for the American experience.

MS DUNLOP: No.

THE CHAIRMAN: But it does suggest that, had the Abbott rep succeeded, when the fly was cast, over Dr Mitchell in January 1985, in attracting sufficient attention, things could have been bad in Glasgow if a supply had become available in April/May.

MS DUNLOP: It's perhaps fair to point out, though, sir, that there is almost no information available about the Electronucleonics test, which was approved very close to the time when the Abbott test was approved in the United States.

THE CHAIRMAN: No. They are the people who complained very bitterly about discrimination, in effect, in America?

MS DUNLOP: Electronucleonics?

THE CHAIRMAN: Yes.

MS DUNLOP: I'm not sure that I can remember that.

PROFESSOR JAMES: Are they the ones that were seen by the

chief executive of Abbott coming out of the door --

MS DUNLOP: Yes, and assumed them to have won, yes. But then I think sent away with the explanation that the approvals were granted in alphabetical order.

THE CHAIRMAN: Which I have to say is not a terribly persuasive explanation.

MS DUNLOP: Then on to the further page. It gets rather more technical. I suppose Sheffield, having chosen the Organon test, was useful.

If we go a little bit further down in Dr Dow's response, we can see that there was what seems to have been some kind of standardisation exercise required of regional centres.

THE CHAIRMAN: Can we go up just a little, please, to see the sentence introducing that?

MS DUNLOP: Yes.

THE CHAIRMAN: All right. Do you understand what the panel 2, panel 3, panel 4 and panel 5 differentiation is? We have got a low positive one, a high positive one and then panels 2, 3, 4 and 5.

MS DUNLOP: No, I don't know what the difference between these panels would be, sir.

THE CHAIRMAN: And the other thing we don't know, as far as this is concerned, is what the result of retesting of the Ruchill weak positive was. But does it come? Yes.

MS DUNLOP: I should say, sir, that the view I have taken is that both this information and the information which Dr Dow has given on the following page, about practical problems in the conduct of testing, has not been further investigated because this topic is really meant to relate to the introduction of testing and not to go further into what happened once testing had been introduced.

THE CHAIRMAN: Yes, indeed. And in any event, if it gives us a general conclusion, it is probably much more valuable than the analysis of the technical detail.

MS DUNLOP: Yes.

THE CHAIRMAN: And he does say here that the testing staff of all UK RTCs got confidence that their testing procedures would identify known positives day-to-day.

Yes, but I appreciate what you say, that you aren't really focused at this stage on the effectiveness of it.

MS DUNLOP: No. Then if we go on to the last page, we can see that Dr Dow has provided a number of references. He says [these papers show the]:

"Problems associated with the introductory use of the Wellcome HTLV-III kit with regard to sensitivity and address the problems of false positive tests (specificity)."

So these references are there.

THE CHAIRMAN: But that again --
MS DUNLOP: Yes, we are going perhaps rather further than we need to. So that is Dr Dow's contribution.

Could we go next, please, to [PEN0171000]? This is Dr Mortimer's response. Well, it's the letter to Dr Mortimer and then we have his response. So perhaps if we just take a moment to look at the letter to Dr Mortimer. (Pause)

THE CHAIRMAN: Can we go on down the page, please? I think you can go on to the second page.
MS DUNLOP: Yes, we are still on the topic of ELISA versus RIA.
THE CHAIRMAN: Yes.
MS DUNLOP: Then he replied, [PEN0171761], giving very similar information about the change to ELISA from RIA.
THE CHAIRMAN: Another new expression "sandwich ELISA".
MS DUNLOP: Yes, I am afraid I can't explain that.

Then he talks about the other precautions which were taken, if we go a little bit further down. Then perhaps we could turn over. He suggests another enquiry we could make, but we obviously have tried to look at the whole question of statistics and we do have information which we looked at in March.

Then next, if we could look at [PEN0131396], please. This is from Professor Leikola and the only purpose in

looking at this in this particular topic is just to note -- I think it's paragraph 7 -- that he gives information about when screening began in Finland. Yes, there we are:

"Testing of blood donors ..."

Well, in the Helsinki area, he says, was September 1985. I'm not sure whether that would cover the whole of Finland but obviously very similar to the timing in Scotland and England. And that's the only thing in the statement I wanted to look at in this context.

Just finally, sir, in relation to our enquiries, we do have an email -- well, a short statement, in fact, which has been sent to us from Dr Perry, about the letter -- I think it's [SNB0074920] -- that mentions an evaluation of French testing kits at the end, which seemed interesting and we did follow it up. It's not in court book yet but perhaps I can just distribute hard copies of it. Thank you.

We have a very short response from Dr Perry and yet again, I think we have caused some meticulous research of old files and no one has been able to find anything.

(Handed.) [PEN0190860]

THE CHAIRMAN: Yes.

MS DUNLOP: So if I can just simply tender that as an answer

to what was an interesting question earlier in the week.

Those are really all the documents which, together with the oral evidence we have had this week, represent our investigation of this topic.

THE CHAIRMAN: Thank you very much.

Mr Di Rollo, do you have any comment or question or other contribution at this stage on the topic?

MR DI ROLLO: I don't think so. Thank you, sir.

THE CHAIRMAN: Mr Anderson?

MR ANDERSON: I have no question, comment or contribution.

THE CHAIRMAN: Yes. Mr Johnston?

MR JOHNSTON: Neither have I, sir.

THE CHAIRMAN: Yes, thank you all very much. So ...

MS DUNLOP: We are not sitting next week and then we return a week on Tuesday to hear from Professor Howard Thomas.

THE CHAIRMAN: Right.

(12.28 pm)

(The Inquiry adjourned until Tuesday 11 October 2011 at 9.30 am)

I N D E X