

Witness Name: Christine Murphy

Statement No: 1

THE PENROSE INQUIRY

Witness Statement of Christine Murphy

I, Christine Murphy, say as follows:-

1. I am [REDACTED] years of age having been born on [REDACTED]. I am now retired.

2. In 1964 I began three years paediatric nursing training at Yorkhill Hospital, Glasgow. I qualified in November 1967 and in December 1967 I moved to Irvine Central Hospital where I worked in the paediatric unit for three months. About March or April 1968 I transferred to Yorkhill Hospital, Glasgow where I worked between the Accident and Emergency Department and a medical ward. I married in August 1968. At this time, when you got married you were required to reduce your hours to part-time working which I did. I stayed at Yorkhill Hospital until the February or March 1969 when I left because I was pregnant. When my child was one year old I returned to work at Yorkhill Hospital for one month. I returned to work in May 1974 and at this time I was working within the Intensive Care Unit and Accident and Emergency Department at Yorkhill Hospital. I stopped work again in April 1975 as I was pregnant with twins and they were born in August 1975. I returned to work at Mearns Kirk Hospital, Glasgow between April 1977 and December 1978 and worked in the children's ear, nose and throat ward. In January 1979 I returned to work in Yorkhill Hospital again between the Accident and Emergency Department and the Intensive Care Unit.

3. In September 1983 I began work in the haemophilia department as a part-time staff nurse. I was the first dedicated nurse to work within the haemophilia department at Yorkhill Hospital. Dr Hann, who was the consultant in the haemophilia department had requested a dedicated nurse

for this department. At this time my only exposure to haemophilia had been if someone with haemophilia attended the Accident and Emergency Department.

4. The first training I was given in the haemophilia department was in intravenous injections. I also attended study days at other hospitals in relation to the treatment of haemophilia. This could be at Newcastle, Birmingham, etc. I also learned about haemophilia from colleagues and people working in other areas of the country together with reading about the subject.

5. I had an office in the outpatients department and I also worked in the day bed area of Yorkhill Hospital to treat haemophilia patients. These areas were not solely for haemophilia patients. I worked part-time.

6. Haemophilia clinics were held every Friday. Children with severe haemophilia attended these clinics every three months. The families knew how to contact us if they had any concerns between clinics. A child with mild haemophilia may only attend the clinic every six months. If a child attended hospital with a bleed they would be seen in the day ward.

7. In May 1987 I became a sister. I worked three days per week initially, then four days per week. The staff nurse who was called Iris McKinlay (now deceased) worked alongside me.

8. In September 1993 I left Yorkhill Hospital and went into school nursing although this was still under the auspice of Yorkhill Hospital. I left this post in November 2001. In December 2001 I began work in genetics but this wasn't a nursing post. I was a family care officer offering information and support for children and adults with muscular dystrophy and other neuromuscular conditions. I left this post in July 2008.

9. When I began work in the haemophilia department at Yorkhill Hospital, the Royal Infirmary in Glasgow already had a haemophilia centre and I went there for three days training.

10. When I started in the Haemophilia Unit at Yorkhill Hospital in 1983 the patients with severe haemophilia were being treated with Factor VIII and some of them were on home treatment. A few of the younger children were being treated with cryoprecipitate. Home treatment would normally start when a child was about seven or eight years of age. It really depended on how willing the parents were and whether they were ready to take on the role of administering their child with Factor VIII. As part of my duties I trained the parents to administer the Factor VIII to their children. Children with other bleeding disorders were also treated with cryoprecipitate. I cannot remember why some were treated with cryoprecipitate rather than Factor VIII. When children started on home treatment parents were supposed to keep log books of the dates of their child's bleeds, how much Factor VIII was administered and the batch numbers of the Factor VIII administered. They were supposed to bring the log books to the clinic so that the medical and nursing staff could check how much Factor VIII they were using. The log books were returned to the Haematology department when completed. The log books were monitored when they were brought back to the hospital.

11. If children attended hospital with a bleed I would treat them when I was on duty. If I was not on duty they would be treated by the medical staff or other appropriately trained nursing staff. If a child was treated at hospital the batch number of the product used would be written into their medical records. Once I had been trained I took blood samples from the children at the clinics. The children would generally be seen by one of the doctors in the first instance. The doctor would discuss with the parent how many bleeds the child had had since the last clinic and then decide what treatment was required. The doctor would also decide whether blood tests were required. If blood tests were required the doctor would complete a form and then I would take the blood samples. Most of the children and their parents were so used to the blood samples being taken they already knew what the tests were for, e.g. blood count.

12. When I started working with haemophiliacs at Yorkhill Hospital in 1983 there was no talk at that time about HIV although Hepatitis B was spoken

about and the children were being tested for that and I presume the parents had been warned of the risks associated with Hepatitis B. I think it was 1984 or into 1985 before HIV was discussed when it appeared in the press. I do recall there was a meeting called at Yorkhill Hospital. I do not recall if it was a formal or informal meeting. I cannot recall where the meeting was held, who called it or who was there. At this time Dr Hann and Dr Pettigrew were the doctors in the haemophilia unit. Dr Willoughy had left before I started in 1983. As things progressed there were a lot more meetings.

13. I can't be sure how the parents and children were contacted regarding HIV. I think some were spoken to when they attended their normal clinic appointments or attended hospital with a bleed. I also think some were telephoned and asked to come into the hospital for a test. I don't know if any were actually written to and asked to come to the hospital for a test. Certainly some parents knew when they attended the hospital they were coming to get the result of an HIV test. I don't know how long they had to wait for the result of the test but they would have been told as soon as possible after the results were received. It was always the parents who were informed of the test result. The children were never told by the medical or nursing staff of test results. It would have been up to the doctors to tell the parents of the test result, not me or any nursing staff. I remember that one parent was told the results of their child's HIV test in the doctor's office in the haematology department. I think it was either Dr Hann or Dr Gibson who gave the result. The parent was told that the test was positive for antibodies and that their child would be carefully monitored and they would be kept informed. They were also told that if they had any further questions to come back to the hospital and speak with the doctor. I remember another parent was told the test result in ward 7A as we had moved from the day bed area to the bottom end of that ward. I cannot remember which doctor it was. I don't specifically recall asking parents for permission to take blood from their child for an HIV test. I cannot recall anyone complaining about how or when they were given the test results.

14. About 1984/1985 I do remember conversations, although I cannot recall who was involved in these conversations, about stored blood being sent for HIV testing. I cannot recall where the blood tests were sent for testing although I seem to remember London being mentioned. When I was told about HIV testing, my understanding was that blood was to be taken specifically for this test. I would send the blood samples to the laboratory at Yorkhill Hospital and the laboratory would forward them on to wherever they were to go for testing.

15. I was never involved in ordering the products. It was always Scottish Factor VIII that was used when I worked at Yorkhill.

16. There was a bit of panic to start with about the blood products. However, it was explained to the parents what would happen to their child if they didn't use the blood products. I don't recall the exact words that were used but the parents were advised of the consequences of leaving bleeds untreated. They would be informed that joints could suffer irreparable damage and any internal bleeds or head injuries could be life threatening depending on severity. They would also be told that untreated bleeds would most likely cause problems in later life. We were just reiterating what most of the parents involved already knew. We carried on using the same blood products. I do recall at one point that one of the parents got their child put back on to cryoprecipitate rather than Factor VIII as at that point in time the parent felt cryoprecipitate was safer. The child had severe haemophilia so had to have some treatment for bleeds. Eventually the child was returned to Factor VIII on the commencement of heat treating.

17. The parents were told of the risks of infection to themselves and other siblings. They were given gloves and aprons but I suspected that they never used them. The parents were provided with support, advice and information very quickly after they had been informed of the diagnosis. This was written information mainly produced by the haemophilia society. There was generally a yearly meeting held at Glasgow Royal Infirmary by the Haemophilia Society.

18. Hospital staff also wore gowns, masks and gloves when dealing with patients who had been diagnosed with HIV. Fortunately this did all calm down. As part of my duties I went out to schools and I always told them that the same precautions should apply to everyone not just someone with haemophilia. Schools were not told if a child was HIV positive by hospital staff. I know of at least one incidence of a parent telling the school that their child had been infected with HIV.

19. As the children started to show symptoms of HIV or their blood results were affected they would be referred to a consultant at Ruchill Hospital, Glasgow for treatment. As far as I can remember it was the late 1980's/early 1990s before any of the children required treatment and then they would attend clinics at Ruchill Hospital. I would liaise with community nurses but it was not my responsibility to supervise the HIV treatment. I know that some treatments had side effects on their blood counts.

20. The children's haemophilia care generally transferred from Yorkhill Hospital to Glasgow Royal Infirmary when they were 14/15 years of age although this was quite flexible.

21. In relation to staff meetings at the hospital they were possibly monthly. However, after HIV the meetings were more regular. Which ever staff members were available would attend the meetings. At one point there was a psychologist who sometimes attended the meetings and who also met with the parents. I am not sure if the psychologist met with the children. I cannot remember the name of the psychologist. Patients and their treatment would be discussed at these meetings. We would also discuss how the patients and their parents were dealing with the diagnosis. When I started at the Haemophilia Unit of Yorkhill hospital the social worker involved with the haemophilia patients was Jim Black. Christina Leitch started as the social worker after Jim Black. The social workers ran a haemophilia patients group in Yorkhill hospital. However, when HIV came along the parents no longer wanted to meet at the hospital. Christina Leitch arranged for the group to meet outside the hospital and hospital staff were not involved with this.

Feedback I received from some parents was that they found the meetings helpful. Prior to the event of HIV these meetings would be perhaps every three months and there was generally a good turn out.

22. In respect of haemophilia the children involved and their families lives revolved round the haemophilia. Their whole family and their working lives were disrupted. Some families didn't have their own transport and therefore had to rely on, and wait for an ambulance when their child required hospital attention. Some families said that it was not worth planning a holiday because they knew it would be disrupted. The children's schooling was also disrupted. Only one or two schools allowed treatment to be stored on school premises but this stopped after HIV. Therefore a parent would need to take the child home to administer treatment. Advice was given to parents about the dangers of contact sports. A fair number of boys played football but were discouraged from heading the ball.

23. I have to say that I don't recall much about Hepatitis C.

Statement of Truth

I believe that the facts in this witness statement are true.

Signed *L. E. Murphy*

Date *29.12.11*