The Infected Blood Inquiry weekly summary

The Haemophilia Society

Week beginning 6 December, 2021

A summary of inquiry hearings

Key figures from blood services gave evidence to the inquiry this week.
Dr Colin Entwistle, director of Oxford Blood Transfusion Centre from 1980 to 1995 said his was the only centre to try surrogate testing for hepatitis on plasma, using 'unreliable' ALT tests.
Dr George Galea worked for the Scottish National Blood Transfusion Service from 1984 to 2013 and helped set up the National Medical Register in 1990 which identified high risk donors across Scotland.
Dr Lorna Williamson worked at East Anglia Transfusion Centre 1991 to 1994. Analysis in 1990 showed it was issuing 80 times the whole blood it needed to. Outdated facilities meant it couldn't process and store plasma.
Dr Patricia Hewitt worked in blood services from 1984 to 2018.
Both she and Dr Williamson said the national hepatitis C look-back exercise in 1995 should have happened in 1991. By 1995 vital time had been lost and some records disposed of, meaning some blood recipients were not traced.

Inquiry focus: vCJD at-risk notification

New variant CJD was identified in 1996, which Dr Williamson described as 'chilling'. She said the assumption was that vCJD was transmissible through blood until proved otherwise, and measures were taken to reduce risk. But although the blood service acted quickly to trace implicated donations, decisions were slow on whether to tell at-risk donors and recipients. As there was no way to diagnose the prion until post mortem and no treatment, initial ethical advice was not to tell those at risk. This was overturned in 1999 when ethicist Prof Len Doyal wrote: 'If anything should now be clear in the practice of health care in Britain, it is that deception is not an option for good clinical practice or public policy.' However, it took until late December 2003 to notify at-risk recipients. Dr Hewitt told the inquiry: 'It was an example of how not to do a notification exercise.'

Quotes of the week

'The safest blood is the blood not given.'
Dr George Galea's advice to medical students.

'I guess we had learned from the mistakes of the past...there was much more use of the precautionary principle, which is designed to cover the situation where you may have a risk, it is not very clear what the magnitude of the risk is, but if there is a risk and its outcome is dreadful, as this would have been, you have to act. You can't wait for the data to become available.'
Dr Lorna Williamson on the actions of the blood service after vCJD was identified.

'I have listened to your stories, each and every person who has been affected by these awful events. I have been heartsore, upset and anxious and so I wanted to start simply by saying sorry; a huge and heartfelt sorry.'
Dr Williamson begins her evidence to the inquiry

'Thank you to everyone who has supported the inquiry's work this year in whatever way they have felt able. You are each and all of you an essential part of this inquiry'.
Sir Brian Langstaff concludes inquiry hearings for 2021