The Infected Blood Inquiry weekly summary

The Haemophilia Society

A summary of inquiry hearings: week of 7 February 2022

Dr Stanley Dempsey was in charge of haemophilia patients at Royal Belfast Hospital for Sick Children from 1980-2008. In the 80s, there were about 12 patients aged up to 14 with haemophilia and von Willebrand disorder, none severe. In 1981 Dr Dempsey's confidence in cryoprecipitate was shaken after it 'failed' when he used it to treat a near-fatal incident. From that point until June 1983, he switched to using commercial concentrate. All commercial products were selected by Dr Mayne, director of the adult haemophilia centre. Dr Dempsey accepted fairly early that AIDS might be transmitted by blood products but noted there was a 'resistance' among haemophilia treaters to accept the significance of this link. He admitted that attempts to limit a patient's exposure to different factor batches 'didn't really happen' in practice.
There were also presentations this week on Wessex and Yorkshire Regional Blood Transfusion Services.

Inquiry focus: Early hepatitis C blood screening in 1991

Dr Huw Lloyd, director of Northern Region Blood Transfusion Service 1988 to 1995, caused uproar amongst his colleagues when he unilaterally started screening for hepatitis C in April 1991, ahead of the national roll-out on 1 September 1991. He said by early 1991 his service, based in Newcastle, was 'sitting on the start line' but was prevented from acting because of national delays. He told the inquiry: 'If you decide to delay testing, you're deciding to use infectious units [of blood]'. Colleagues criticised his 'maverick' decision and accused him of undermining the blood transfusion service. Dr Lloyd said when he re-read the letters he received he was struck that 'nobody mentioned the patients', which he felt was wrong. He said it was 'outrageous' that a media briefing produced when national screening was introduced described hepatitis C as 'normally a mild infection, (not like AIDS)'.

Quotes of the week

'We should make every effort to maximise this disaster to our corporate advantage'.
Dr Cash, head of Scottish Blood Transfusion Service, to his counterpart in England, Dr Harold Gunson on the 'Newcastle saga' in 1991.

'It was going to be difficult, but it was certainly in no way impossible.'
Dr Lloyd on calculations he made to introduce the first-generation hepatitis C screening test in 1989.

'The committee agreed that it was important to start screening as soon as practicable as a measure which would further enhance the safety of blood supply.'
Confidential conclusion of the Advisory Committee on the Virological Safety of Blood on hepatitis C screening in November 1990.

'I have an embarrassingly large supply of BPL factor VIII in stock. How about it?'
Letter in 1983 to Dr Jones, director of Newcastle Haemophilia Centre from the head of Northern Region BTS, Dr Collins. The inquiry heard Dr Jones had a 'preference' for commercial factor concentrate.