DR JOHN FORRESTER (sworn)

Questions by MR MACKENZIE

THE CHAIRMAN: Good morning. Dr Forrester, if you feel
tired at all, just let me know. Yes, Mr Mackenzie?

MR MACKENZIE: Thank you, sir. Good morning, Dr Forrester.

Today we are looking at our topic C2, which is the
question of whether surrogate testing for non-A non-B
Hepatitis should have been introduced in the 1980s.

I would like to start, doctor, with looking at your CV,
please, which will come up on the screen. It's
PEN0170005.

We can see you have provided us with an outline CV.

We can see a 1942 you graduated with a MA with honours
in Classics at St Andrews and between 1942 and 1946 you
saw war service as an artillery officer. In 1952 you
obtained your medical degree at Oxford. Between 1952
and 1963 you were in general practice in England and
between 1963 to 1978 you came to the
University of Edinburgh as a lecturer and later senior
lecturer in physiology.

You also became a member of the physiological
society and a fellow of the Royal Society of medicine.

Then, between 1978 and 1985, you were a medical officer
at the Chief Scientist's office in SHHD, mainly with the
biomedical research committee.

Then, between 1985 and 1988, you were a senior
medical officer in the SHHD with liaison duties with the
SNBTS. You retired in 1988.

Have you worked at all, Dr Forrester, since retiring
or have you stayed properly retired?

A. Yes, the Scottish Office gave me a splendid retirement
job. For one day a week I edited their journals for
five years.

Q. Thank you. We also see you state here that:

"Although the Inquiry papers make some reference to
my being a principal medical officer, this was never the
case, as the CV makes plain."

You also go on to say you are now 87 years old. Are
you still 87?

A. I'm 88 now.

Q. You say you retain no current recollection of the events
with which the Inquiry is concerned, but must rely on
the available records which you have examined as well as
you can. Would you like to make any comment on that,
doctor?

A. Only possibly to add very briefly another difficulty,
that in going through these documents I find, with my
memory now, that only about three days worth remain in.
That means that I simply cannot produce from my head, even from my own memory, recollection of all these documents. When I see them on the screen, no doubt I shall be able to say something.

Q. The rest of the document relates to topic C3, viral inactivation for blood products. We don't have to look at this document any further, thank you.

I would next, doctor, like to take you to a document showing the structure of the SHHD, including the medical officers' structure, just so we can be clear about that, please. It's [PEN0172506] at page 2508, please. We have sought to set out the hierarchy among medical officers and I think at the top is the chief medical officer and I think Dr Iain MacDonald was the chief medical officer while you were a senior medical officer between 1985 and 1988. One down we see the deputy chief medical officer and, during that period, Dr Graham Scott would have been your deputy chief medical officer. Then one down again, principal medical officer and the PMO, whose remit included the SNBTS during the 1985 to 1988 period, was Dr Archibald McIntyre. Is that correct?

Thank you.

Looking under senior medical officers whose remit included the SNBTS, we can see Dr Bert Bell fulfilled that role from some time in the early 1970s until 1985
and I think Dr Forrester, you took over from Dr Bell between 1985 until 1988. Is that correct?
A. I believe so.
Q. I'm grateful. I should ask, doctor, were there any medical officers below you? Were there junior medical officers?
A. No.
Q. Thank you. We can put that document to one side, please. I wonder if we could go first, please to --
what I would now like to do, Dr Forrester, is take you through a sequence of documents which show the consideration given in 1986 and 1987 to the question of surrogate testing within the SHHD. I think a suitable starting point in that regard might be [SNF0010135].
Doctor, these are the minutes of a meeting of the directors of the National Blood Transfusion Service of 25 March 1986 and we can see under the list of those present the last name is yourself. Was that the practice, doctor, for the medical officer within SHHD who is responsible for the SNBTS attending these directors' meetings?
A. I am afraid I cannot say.
Q. I see.
A. I just don't know the answer to that.
Q. Okay. We can certainly see from these minutes that you
appear to have been at this meeting. If we can go, please to the last page, and we can see item 5 "Surrogate testing for non-A non-B". We can see a lessons to the United States FDA Advisory Panel's recommendation which, in short, was a recommendation that, in America, blood banks start surrogate testing of blood donations. I think that was the -- really the catalyst for the matter being brought to the fore in the UK, in 1986. There is a discussion on -- A. I understand the question but I found it very difficult to comment from my own memory. Q. Yes. I'm not really going to ask you any questions about this document, doctor. It simply seemed a natural starting point in looking at the question of surrogate testing and the consideration given to it within SHHD in 1986. Could we then, please go to [SGH0027496]. This, we will see when we go over the page, doctor, is a minute of 26 March 1986 from yourself to Dr McIntyre, copied to Dr Scott. So it seems quite clear that the principal medical officer above you, Dr McIntyre, and also the deputy chief medical officer, Dr Scott, were being kept appraised of events. I think we will see that as a recurrent theme when we go through the documents and
we can see the heading. This is a note or report of a meeting of the directors on 25 March. If we go over the page, please, and in paragraph 6, item 6 we see the heading, "Testing of blood donations for non-A non-B Hepatitis."

I'm not going to read this out but just take a second to read through it, doctor. (Pause).

A. That's paragraph 6?

Q. Yes.

A. Yes. (Pause).

Q. We can see in the final sentence you stated:

"I also indicated that the department was perfectly open to proposals for funding research in this field, if research is required to determine the true size of the problem and the likely effect of any proposed remedy."

Just to pause, doctor, this appears to be a note written by you to inform or advise Dr McIntyre and Dr Scott of the matters discussed at the directors' meeting. Do you remember, would that have been your practice at the time, after every directors' meeting to write such a note to those above you?

A. I would guess the answer is yes, but I cannot remember at all.

Q. Yes. Thank you. I think the next document, please, is [SGH0028187]. If we look at the author of the letter,
this is a letter, doctor, from you dated 26 March 1986
to Dr Dan Reid at the communicable diseases surveillance
unit at Ruchill hospital. I think, in short, Dr Reid
was an expert in infectious diseases do you remember
that?
A. It says so:
"Communicable diseases surveillance unit." So he
was.
Q. Do you have any recollection of Dr Reid?
A. None, but I can see what I did there and what I had in
mind, so to speak.
Q. Okay. Now, again, please feel free to take a second to
read the letter. In short, you are writing to Dr Reid,
seeking certain information on post-transfusion non-A
non-B Hepatitis?
A. Yes.
Q. I don't propose to ask you any further questions on that
letter.

The next document -- I do propose asking you some
questions. The next document is [SGH0028142]. If we
can start on page 2, please, to see the author and the
date and we can see, doctor, your name, Dr Forrester,
and the date, 12 June 1986. If we go back to page 1 to
see the heading, please, we can see the heading,
"Transmission of non-A non-B Hepatitis by blood and
blood products: is it practicable to reduce or prevent it by introducing ALT testing of donations?"

It doesn't seem to be, doctor, a note or a minute, rather, addressed to anybody. But I think it appears to be a note written by yourself, perhaps setting out the result of your, perhaps, investigations. But I take it you have no recollection of this --

A. I have no recollection. I would have to guess. But it looks to me as though I might have prepared that to circulate to whom it might concern and that it would be available to me if anyone might ask, that I would immediately be prepared to produce a reasoned account.

Q. So like a background note or briefing paper, that sort of thing?

A. I'm just guessing but that's my guess.

Q. Thank you. If we go through the note, we will see paragraph 1 tells us:

"The information in this note is mostly derived from the PhD thesis ... completed in 1985 by Dr Dow under the supervision of Dr Follett ..."

Do you have any recollection of that thesis?

A. Not now at all. This is the sole memory that I have that I see before me.

Q. Okay. Paragraph 2 states:

"Hepatitis can be transmitted by blood and blood
products and is, in Scotland, an occasional but serious consequence of blood transfusion ... To contrast with the USA with a higher incidence."

Question 3 we can read for ourselves, rather paragraph 3. Paragraph 4 states:

"Non-A non-B Hepatitis, thus defined, is not uncommon in the population; Dr Dan Reid reckons an incidence for Scotland of 154 cases per year, but has little confidence in this estimate because it can only be derived by starting from the total of all hepatitis cases reported (probably under reported) by clinicians, and deducting the cases of Hepatitis B detected in laboratories (probably fully propertied). It is common among drug users. But, in association with blood transfusion it is very uncommon in the west of Scotland.

"Over the last 8 years, 1-5 cases are found each year there, and there is no upward trend there are peculiar difficulties in identifying its presence in haemophiliacs since their blood exhibits diverse reactions because of repeated administration of blood products, but Dr Dow found no evidence of any substantial problem. Dr Dow reckons that the proportion of donations infected with non-A non-B Hepatitis may be 18 per hundred thousand."

To pause, there, the question of haemophiliacs and
the note that Dr Dow found no evidence of any substantial problem, that's perhaps slightly puzzling to us, in that, I think, during the Inquiry we have heard evidence that reports came through in the early 1980s, perhaps 1982/1983, that all previously untreated haemophilia patients developed non-A non-B Hepatitis after use of factor concentrates regardless of whether the Factor VIII concentrates were NHS origin or from US donors or US-produced, rather. Do you have any recollection of that problem in haemophilia patients, doctor?

A. I have no recollection but, looking back on it now, it looks as though this was overtaken by much better information, arriving later.

Q. It may be something I can explore with Dr Dow -- I think he is coming tomorrow -- but it does appear, I think that, these reports were certainly, I think the first report, published in 1983 and I think there were drafts available 1982, I think -- but it may simply be you have no recollection of this?

A. I have no recollection of that.

THE CHAIRMAN: I wonder if I could ask whether you would have known, yourself, a great deal about this problem from your own background at that stage, Dr Forrester?

A. No, sir.
THE CHAIRMAN: You had spent really quite a long time, ten years, in general practice --
A. Yes, long before.

THE CHAIRMAN: -- long before, and then ten years as a full-time teacher of --
A. That was about 17 years.

Q. -- of physiology. 17. So really is it fair -- and I have to understand properly your position. Would it be fair to take the view that, when you came into this position, you didn't come with a great deal of current knowledge of developing problems among haemophiliacs, or what would your position be?

A. That was quite true, sir. I was a relayer of information and the gatherer of information from the different sources it could come in.

THE CHAIRMAN: Is that what we find in this report, in effect?

A. That is what?

THE CHAIRMAN: What we find in this report, your passing on material you had collected from others?

A. Yes, indeed. I hope accurately.

THE CHAIRMAN: Yes. I think it might be --

A. On the other hand some of it certainly turned out to be obsolete later on. It was overtaken by events altogether.
THE CHAIRMAN: Yes, but perhaps that might again reflect on your own position. You would discover that event later as information developed, I don't know. I don't want you to be put in the position of appearing to be a fully competent judge of these issues at the time if you were not.

A. That is absolutely fair, sir and I don't think I attempt to fulfil the role of a free-standing authority in these matters at all.

MR MACKENZIE: Thank you, sir. I think that is helpful. On that point, Dr Forrester, one can quite understand that you came into this role in 1985. One of your responsibilities being blood and blood transfusion and that being something you hadn't had expertise in before, or really much experience in before. Presumably those above you, Dr McIntyre had obviously been a principal medical officer with responsibilities for the Blood Transfusion Service, I think for some time. Also, I think, Dr Scott had been deputy chief medical officer with responsibilities for blood and blood transfusion for some time as well.

So presumably one can see and understand your role maybe as a relayer of information, as collecting and relaying information and not perhaps being in the best position to judge the merits of various issues.
Presumably, Dr McIntyre and Dr Scott, with greater experience in blood and blood transfusion, would have been in a better position to judge the merits of the issues that arose.

A. I think that is quite true, and I rely very greatly on Dr McIntyre, for whom I had learnt to get a great esteem, but I think, in effect, he was always in a position of overlooking what I had done and I put it to him in writing and if there was anything amiss he would have told me.

Q. I understand, thank you. Returning to the note, please n paragraph 5 we see it's stated:

"The condition is not, as a rule, serious and most the cases detected have not even been jaundiced. There may however be a tendency for it to become chronic, and the long-term outlook is inevitably not yet known. The case fatality rate is estimated in a textbook consulted by Dr Dan Reid at less than 0.1 per cent, except in pregnant women, who are at much greater risk (10 per cent if they contract it during the last 3 months of pregnancy)."

Is that again, that paragraph, doctor, you setting out what has been reported to you by others?

A. Certainly, and it was the way it seemed at the time. It turned out, I think, to be wrong.
1 Q. Would you have -- is it likely you would have taken
2 any -- undertaken any research of your own, for example
3 were there medical textbooks available to SHHD medical
4 officers to consult?
5 A. Yes, they were always available in the library, and
6 medical journals.
7 Q. Is that something you would have done at the time, gone
8 to the library and consult --
9 A. I certainly did that from time to time.
10 Q. Yes, and when producing a note such as this, it would
11 have been open to you to go to the library and consult
12 yourself textbooks and journals?
13 A. Yes, indeed. My impression was this was the way it did
14 seem to able minds at the time. It doesn't mean it was
15 true in the end.
16 Q. We will come back to that shortly. Paragraph 6, we can
17 see for ourselves what is set out. Over the page,
18 paragraph 2, please -- sorry, page 2, paragraph 7, we
19 can see the second sentence:
20 "Dr Dow concludes that in Scotland cost would be
21 extremely high and benefit minimal, especially when only
22 a few cases of non-A non-B post-transfusion hepatitis
23 are reported each year."
24 Finally in paragraph 8:
25 "Dr Dan Reid and Dr Follett do not recommend the
introduction of ALT testing of Scottish blood donations for the above reasons."

Is that final paragraph, doctor, perhaps consistent with your role as we have just explored; that paragraph 8 doesn't say that: I, Dr Forrester, do not recommend the introduction of ALT testing. Rather, you say Dr Reid and Dr Follett do not recommend. Is that again consistent with your role being a reporting and relaying of information role?

A. I think I would have thought it above my position to take an independent view of that kind, but rather to find people who knew.

Q. Thank you. I understand.

A. If they happened to know wrong, well ...

Q. The next document comes back to the question of state of knowledge and what was available. Can we go, please, to [PEN0171734]. Dr Forrester, this is an extract from a textbook by Professor Mollison, "Blood transfusion and clinical medicine", the seventh edition published in January 1983. We have heard evidence that this was the main UK textbook on blood transfusion at the time and may in fact have been the only blood transfusion UK textbook at the time. Can you remember looking at this at all, during your time as a medical officer?

A. I don't remember consulting this at all. On the other
hand, I would have relied on sources of information, both from people who treated haemophiliacs and from people who produced blood products and would be familiar with this all the time.

Q. Is this an example of the type of textbook that would have been available in the medical library in the SHHD?

A. I would think so.

Q. Yes. Over the page, please. There are two passages I would like to draw to your attention. At page 773 under the subheading, "Non-A non-B Hepatitis."

I'll just give you a couple of minutes just to read that paragraph for yourself.

A. This is the second paragraph on the screen at the moment?

Q. Sorry, no, we see the subheading, "Non-A non-B Hepatitis."

A. Yes.

Q. Do we see the subheading at the top of the page on the screen, "Non-A non-B Hepatitis." It's the paragraph that follows under that.

A. Yes. (Pause).

Yes.

Q. The particular passage I would like to take you to please, it's about half way down and it's towards the right-hand side, the sentence commencing, "As a rule
"As a rule, non-A non-B Hepatitis ..."

Do you have that?

A. Yes.

Q. "As a rule, non-A non-B Hepatitis is symptomatically mild, patients seldom need to be admitted to hospital. Nevertheless, up to 60 per cent of cases have abnormal ALT levels for more than one year. If a liver biopsy is taken, most of the cases show histological evidence of a significant chronic liver disease and approximately 10 per cent show features of cirrhosis."

A reference to a paper by Harvey Alter in 1980:

"A striking feature in non-A non-B Hepatitis is the tendency for serum hepatic enzyme levels to fluctuate markedly over a relatively short time."

Doctor, I don't suggest that there was a general acceptance in the medical community in 1983 that NANBH was a potentially serious disease. I think we have heard evidence how the general acceptance, the medical community, took some time to evolve during the course of the 1980s.

But I do suggest this, that by this stage, early 1983, it was known firstly that half or more of patients with non-A non-B Hepatitis had chronically elevated, fluctuating ALT levels and secondly that liver biopsies
in a small number of selected patients showed evidence of cirrhosis. What I would suggest, I think, is that these two matters: the knowledge of chronically elevated, fluctuating ALT levels in half or more patients, and secondly, that there was some evidence of cirrhosis, at the very least called for caution when make statements about the potential seriousness of the disease. Do you have any comments on that?

A. I don't think I can comment on that, after all this lapse of time. I think I follow what you are saying, but I don't think I could make any useful comment.

Q. I understand. So really your evidence was perhaps largely restricted to what was recorded at the time in print?

A. Yes.

Q. Thank you.

Now, the next document, please, is [SGH0016295]. This, doctor, is a -- you reporting again to Dr McIntyre and Dr Scott following a meeting of the transfusion directors on 25 June 1986. If we go, please, to the bottom of the page, to paragraph 4, item 4 -- sorry, the bottom of page 1, item 4, we see again:

"Testing donations indirectly in order to reduce transmission of non-A non-B Hepatitis."

Obviously the directors have again discussed this
matters at the meeting and you, again, are reporting that
to Dr McIntyre and Dr Scott.

We see in the second sentence of this paragraph:
"An able PhD thesis of last year concluded that, in
the West of Scotland, any advantage would in no way
justify the cost and the loss of donations entailed."

One sentence on again:
"I have previously examined a copy of the thesis;
Dr Dan Reid's opinion is that non-A non-B Hepatitis is
heterogeneous and generally mild (except in pregnant
women), and that a testing programme cannot be
justified."

So again, doctor, that's consistent with you really
relaying or reporting the views of others: Dr Dow from
his thesis and Dr Reid, I think, from his letter to you.
I should by the way, say that it's quite clear, I think,
that Dr Reid did write a letter to you in response to
your letter for him we looked at earlier. But
unfortunately the Inquiry doesn't have a copy of
Dr Reid's letter to you and we have taken steps to try
and recover a copy but that hasn't been possibly
unfortunately.

That's that document, thank you. The next one,
please, is [SGH0028146]. Now, this is a minute from
Dr Scott, dated 16 October 1986, to yourself,
Dr Forrester, and Mr Murray of the administration side. It's headed, "SNBTS, non-A non-B hepatitis screening."

Dr Scott writes:

"I should like to know where this stands. CMO DHSS is worried that if we go ahead, England and Wales will have to follow suit. I think there must be consumption with DHSS before we agree to provide funds for this screening."

I take it, doctor, that you can't remember this minute?

A. No.

Q. Can I ask more generally, please: what liaison was there at this time, in the late 1980s, between SHHD and DHSS on matters of common interest? Is that something -- there would be a liaison? Do you have any recollection?

A. I have no recollection. I would have thought that any liaison would be extemporised according to need, that if we learned something likely to be useful to England, we would pass it on and vice versa. I think you may be wondering if there were formal intermittent meetings and so forth, but I don't think that was the case except between blood transfusion interests themselves.

Q. Could I again ask, again in a general way, what the relationship was between SHHD and DHSS, as in: was it considered to be a relationship between equals? Was it
considered that the views of DHSS carried greater weight or vice versa, or what?

A. I don't think I could provide any formal opinion on that. I understand what you are asking but it seems to me to be beyond my ken.

Q. You don't have any recollection of the impression you had at the time as to whether the views of DHSS carried particular weight, carried no weight, carried any weight, or would it again perhaps depend on a particular issue, or you have no recollection?

A. I find it difficult to imagine there could ever have been such an understanding about the weight they would carry. The weight would be judged in each case, not from any overall strategy.

Q. Yes. Okay. The next document, please, [SGH0028141].

This is your response, Dr Forrester, of 17 October 1986, a minute to Dr Scott in response to his minute we just looked at, and copied in to Mr Murray and Dr McIntyre on the question of surrogate testing.

In short, doctor, by this stage the SNBTS had applied for funding to introduce surrogate testing.

Again, in short, we saw from Mr Murray's written statement that, while he was responsible for compiling the various bids for funding on medical matters, he took advice from the medical officers. If the medical
officers supported a particular bid for funding, he
would include it when the bid went on to finance, but if
the medical officers did not support a particular bid,
then he wouldn't include it. Does that accord with your
general recollection?
A. So far as it goes, yes.
Q. At the bottom of this minute we see you state:
   "There seems no justification for introducing this
   screening without gathering further British evidence,
because the American experience of frequent
post-transfusion hepatitis does not seem to be
duplicated here."
In that last sentence, doctor, it does appear as
though you have moved slightly from a role of simply
relaying or reporting information to giving an opinion
of your own. Does that seem fair?
A. Yes, I think that seems fair.
Q. Yes. Presumably what is stated in the final paragraph
of this minute will have reflected your views at the
time?
A. On the other hand, my view was accompanied by the
evidence as I saw it in the account here. It's
a reasoned opinion. That doesn't mean it's a right
opinion, but it's a reasoned opinion.
Q. Yes. Thank you. Could we then, please, go to -- we are
still in 1986, but now in November 1986 please, [PEN0171554]. If we again start on the second page, please, to see the date and author and we can see, doctor, this is a note or minute by yourself, dated 1 December 1986.

If we go back to the front page again, please, we can see it's addressed to Dr McIntyre but copied to Dr Scott and Mr Murray, and, doctor, this is a report of a meeting you attended as an observer. It was the UK Working Party on Transfusion-associated Hepatitis, which had been dormant for a number of years but then met again on 24 November 1986. I think in this memo you are recording what was discussed and I think here you are perhaps back to the role of reporting or relaying what was discussed by others.

If we can then go to the second paragraph, we can see reference to: members had already seen a searching and dispassionate written presentation by Dr Gunson and Dr McClelland had taken us to an extract from that in his evidence.

You then say:

"They considered the following issues:

1. Is the American experience of frequent non-A non-B Hepatitis in recipients of blood and blood products reproduced here?"
The answer is no:

"Such evidence as exists does bear out the American experience, but to examine the question properly would be a long and expensive business."

Question 2:

"Is ALT screening the application of a straightforward yes/No test? The answer is no; it is an arbitrary decision on where the draw the line ..."

Et cetera 3:

"Will better solutions emerge?"

A bit of a non-committal answer. Question 4:

"Is research indicated? The meeting felt that a prospective study to discover the present burden of transfusion associated non-A non-B Hepatitis was impracticable on grounds of cost and huge sample size. They propose instead a study to identify ...

In short, donors. Over the page, please, paragraph 5:

"There was some discussion of the cost of screening all donations (perhaps 8 million pounds). I asked the chairman whether he would advise screening if it were free of cost. He said no."

Last paragraph:

"The position explicitly reached at the meeting is to recommend research of no great significance or
scientific interest because the prospect of research
would serve to counter pressure from, for example,
haemophiliacs and haemophilia directors, to embark on an
indirect and largely ineffective form of screening,
which would lose us a certain amount of perfectly
harmless blood."

There is discussion after that about the number of
non-A non-B Hepatitis cases encountered annually among
haemophilia patients. I take it, doctor -- do you have
any recollection at all of this meeting?

A. I have no recollection of the meeting. I'm looking at
what I wrote, of course, but I have no independent
recollection of it.

Q. Yes. Are you able to tell us anything beyond what is
recorded in this note?

A. No.

Q. The next document, please -- we now move into 1987. I'm
sorry, it is [SGH0031657].

This is a document, Dr Forrester, that's headed,
"Material for PMO report". If we go to the bottom of
the page, we see it's written by yourself, dated
26 January 1987. If we go back to the top, please, can
you remember, doctor, what was this document for,
"Material for PMO reports"?

A. It would be material sent to Dr McIntyre for him to use
in compiling his own PMO report. He would probably invite me to send in material on these topics which he could include in his PMO report.

Q. How often would the PMO prepare his reports?
A. I couldn't tell the answer to that off my head.

Q. What happened to his reports? Were they for distribution upwards, or what?
A. There again it was above my head, it was obvious he was going to report to higher spheres but exactly which he would report to, I don't know.

Q. I understand.
A. I could guess it would certainly go to the chief medical officer and probably to someone higher on the administrative side. But I think it was a routine event, twice a year. I don't really know.

Q. Thank you. In paragraph 2 we see:
"Blood transfusion and non-A non-B Hepatitis."

Then we see:
"This 'hepatitis' is a residual rag bag when Hepatitis B and Hepatitis A are excluded, and consequently no specific test can detect it. It is relatively benign."

Again, doctor, there perhaps seems to be -- that seems to be you giving an opinion rather than purely reporting what others have said to you. When you say,
"It is relatively benign".

A. I don't think that will hold water because I was in no position to give an opinion on that. I didn't see any patients myself and so forth, I'm sure this is simply relaying the opinions of other people.

Q. Certainly, to be fair to you, Dr McIntyre and Dr Scott would have been fully aware of your experience in blood transfusion at this time and your expertise in post-transfusion hepatitis. That would have been a matter known to them?

A. Of its limited nature, you mean?

Q. Yes.

A. Oh, certainly.

Q. Again, the point I ought perhaps to put to you is, we looked from Mollison at the reference firstly to half or more patients having chronically elevated, fluctuating ALT levels and, secondly, there being evidence that at least some patients with NANBH went on to develop cirrhosis. I think I had suggested that these two points at least suggested there should be some note of caution in giving an opinion on the likely seriousness of the disease. That note of caution, I think, doesn't appear in your account of the disease here. You simply say, "It's relatively benign."

A. What do you think I should have written?
Q. Perhaps a note of caution along:

"There is evidence reported --

A. It may be relatively benign. I follow what you mean.

Q. It may be a matter of degree, perhaps, doctor --

A. Yes.

Q. -- but one, I think, doesn't see the type of evidence set out in Mollison in your note here.

Now, the next document, please, is [SGF0012261].

These are the minutes of a meeting of the directors of the National Blood Transfusion Service and the haemophilia directors, held at St Andrew's House on 9 February 1987. We can see you are the chairman of the meeting, doctor and then at page 3 of the minutes, at 2263 in item 7 at the bottom, "Non-A non-B Hepatitis screening":

"Dr Forrester reported the results of the recent transfusion-associated hepatitis working party meeting. In the USA between 5 per cent and 25 per cent of transfusions lead to the recipient contracting non-A non-B Hepatitis. In the UK the figure is approximately 2.5 per cent and in Scotland, during the last decade, there have only been 1 to 5 cases per annum. Non-A non-B Hepatitis would appear to be relatively benign, despite some risk of cirrhosis of the liver in the long-term, unless the recipient is pregnant when the
effects can be very serious."

"Non-A non-B Hepatitis would appear to be relatively benign, despite some risk of cirrhosis of the liver in the long-term".

Do you think that is something you said at the meeting or do you think that's something that others at the meeting said. Because when one looks at the beginning of the paragraph:

"Dr Forrester reported the results of the recent ... working party ..."

I think it may be an inference that --

A. I have little doubt that that was the opinion of the working party meeting.

Q. So you are reporting back the opinion of the working party meeting?

A. Yes.

Q. So, certainly by this stage you appear to have been aware that the working party were mentioning the risk of cirrhosis of the liver?

A. Yes.

Q. Does that seem fair? This may be a point of detail, it may not, but I also wondered, is there an inconsistency between, on the one hand saying non-A non-B Hepatitis
would appear to be relatively benign, on the other hand saying, despite some risk of cirrhosis of the liver in the long-term. Are these really two inconsistent statements?

A. I wouldn't see it that way.

Q. Why not?

A. There doesn't seem to me to be an inconsistency between these two. If the risk of cirrhosis of the liver is small, then it is relatively benign.

Q. But there is --

A. I'm not saying that that was the case, but supposing it to be the case that cirrhosis of the liver is relatively uncommon, then it is relatively benign.

Q. This may be overly simplistic but it does seem to me that one way of looking at the statement is that what was being said was that, on the one hand this disease is generally harmless but, on the other hand, it may lead to serious liver disease and possibly death. That's where I saw a potential inconsistency. Or do you think that's overly simplistic?

A. Yes, I do.

Q. Also perhaps, doctor, it depends if one is looking at the question as a matter of epidemiology, as a public health doctor, or from the individual's perspective. Obviously, one can see that, as a matter of
epidemiology, one may say that, as a generality, the
disease appears to be relatively benign. But when one
comes down to the individual level, then for the
individual obviously a risk of cirrhosis is always an
important risk.
A. Possibly.
Q. Putting the point another way --
A. I did not really follow the line of thought.
Q. -- if you were to ask how serious is the disease, the
question you got may depend on who you ask?
A. I'm still having difficulty in seeing the inconsistency
between the two statements. They seem to me to be
reasonably consistent.
Q. Put it this way: how can something be relatively benign
if there is a risk of serious liver disease?
A. I think it's a numerical question, is it not? It can be
relatively benign in most cases -- in practically all
cases. Then again there was always a margin of error in
such cases; if somebody does die of cirrhosis it may be
from something else, if you see what I mean. So to
describe it as relatively benign doesn't seem to me to
have anything absurd or misleading about it.
Q. I can certainly understand the numerical explanation.
I can understand that.
A. Yes.
Q. Thank. The next document, please, is [SGH0016653].

These are the minutes of a meeting of the transfusion directors on 3 March 1987. We can see you are noted as having been present, doctor. If we can go to page 5 of the minutes, please, at 6657, item (f) at the bottom, we see, "Surrogate testing for non-A non-B." just take two minutes to read that, doctor. (Pause).

Then over the page, please. Again if you just take two minutes to read the top few passages. (Pause).

Thank you. You see the recommendation by the directors to the SHHD that surrogate testing for non-A non-B should be implemented, with effect from 1 April 1988 as a national development, requiring strictly new funding. The question is this, doctor: do you remember what action, if any, you considered was required by you in response to that recommendation?

A. I can only guess, but it looks to me as though this recommendation was passing to the government Health Department, through a channel other than me, which would not be surprising at all. So, from my point of view, no specific action on my part was required.

Q. What was that other channel?

A. I can't deal with that from memory.

Q. It's simply when you say it looks to you as if the recommendation was passing through a channel other than
you, I just wondered what you had in mind by that, as in
did you envisage the directors --
A. I see. You mean would I be the messenger to carry from
the meeting the request?
Q. Yes.
A. I don't think -- it would be done in writing and
separately from my direct involvement.
Q. So you envisage the directors doing something more, as
a matter of procedure --
A. Yes.
Q. -- to bring the recommendation to the attention of the
SHHD?
A. Yes, I doubt very much if this minute would be the
channel.
Q. Certainly one possible procedure was through funding.
When SNBTS made their funding bid, they could include,
obviously as we will see they did, they could include
funds for such testing. That would be one procedure?
A. Yes.
Q. It does seem to have been the case, doctor that, after
these directors meetings -- it does seem to have been
the case that a day, or a day or two later you would
report to Dr McIntyre and Dr Scott on the matters
discussed at the meeting?
A. Yes.
Q. For some reason we can't find in our database of documents a report immediately following this meeting. But presumably it's at least possible you may have followed what appears to have been your practice, in reporting to those above you the matters discussed at the meeting?

A. In any case a minute drawn up by me reporting on the meeting to Dr McIntyre would not be a channel through which a request for surrogate testing of this kind would go. It was an information channel.

Q. So you would understand there to be some formal way for the transfusion directors to make this request?

A. Yes.

Q. Either through a letter, perhaps by Professor Cash, or perhaps by -- through their funding bids?

A. Yes, indeed.

Q. I understand. The next document, please, very briefly look at [SGH0016652]. This is an administrative document by Miss Corrie, secretary at the SNBTS. If we go to the top of the page please, we see it's dated 13 April 1987 and it's simply Miss Corrie sending Mr Murray at the SHHD a copy of the minutes of the meeting we have just looked at. What I wondered was whether there was a practice for Miss Corrie to type up the minutes of the meeting, perhaps some weeks after the
meeting, and then send the draft minutes to Mr Murray for his approval or comments. Do you have any recollection of that at all?

A. I cannot tell.

Q. But it's certainly -- it does not seem to be the case that the minutes were available straight after meetings. Understandably there is some delay for the minutes to be typed up and then approved and circulated and what have you.

A. I agree.

Q. The next document, please, is [SGH0028127]. Over the page, please. We can see this is a minute by Dr McIntyre, dated 6 April 1987. If we go back to page 1, please, we can see it's addressed to Dr Scott and others, including yourself, Dr Forrester. Please just take a few minutes just to read through the first page. It's really a passage on page 2 I'm going to take you to, but just out of fairness to you, just take a few minutes to read page 1. (Pause).

Over the page, please. (Pause).

We see, in the second paragraph on page 2, Dr McIntyre states:

"The directors of SNBTS are unanimous and are now pressing fairly strongly that this screening should be instituted. Though perfectly aware that it would be
costly and could not abolish transmission completely, they could then claim to have taken all steps open to them to reduce transmission. Before embarking on such an expensive programme, it would seem logical to participate in the proposed research and to delay any further action until the results of this were known."

"If recipients of this minute are agreeable that this is the correct line to adopt, then the Edinburgh SNBTS will be asked to prepare a detailed proposal along similar lines to that of their English counterparts."

So it certainly seems clear, Dr Forrester that at this date, 6 April, 1987, Dr McIntyre understood that the SNBTS directors were unanimously in favour of surrogate testing. So, regardless of any reporting which may or may not have occurred, or formal procedures after the meeting in March, very soon afterwards Dr McIntyre and also, by implication, Dr Scott, who was a recipient of this letter, were aware of the SNBTS directors' position.

One point which arises, doctor, is that the November 1986 meeting of the UK working party on transfusion-associated hepatitis recommended not to undertake a large-scale prospective study involving the following up of patients to consider surrogate testing, but instead to restrict their study to looking at
donors. That's then really the proposed study that goes forward, this question of following up donors, not recipients. The view of Dr McIntyre as set out in the second paragraph:

"Before embarking on such an expensive programme of testing, it would seem logical to participate in the proposed research and to delay any further action until the results of this were known."

The proposed research is the proposed follow-up of donors, not recipients, and the question really is: did you have any view at the time as to whether that study, following up donors, was likely to be of any value?

A. I venture that I would keep a very open mind, because it was a very dark problem at that time.

Q. Certainly looking at things now, do you think it seems logical to restrict one's study to donors rather than also looking at recipients?

A. I don't think that I could hazard an opinion on that. It would be not within my compass really.

Q. So we are back, perhaps, to you had attended a meeting of the UK transfusionists working party and they were really best placed to decide what sort of study there should be.

A. I don't think I could comment on that either.

Q. Would you have considered they were better placed than
you to decide what sort of study there should be?

A. It would seem to me a very difficult issue.

Q. Yes. Presumably the more difficult the issue, I suppose
the more one would defer to experts on that issue?

A. Yes, and hope that they would agree.

Q. Yes. The next document, please, is a short one,
[SGH0028126]. Dr Scott, on 7 April 1987, a minute to
Dr McIntyre and copied to various individuals, including
yourself, Dr Forrester. The heading is, "Scottish
participation in UK research project on
transfusion-associated non-A non-B Hepatitis".

Dr Scott writes:
"I agree in principle with the procedure outlined in
your minute of 6 April: we must do whatever we can to
prevent the BTS going ahead with a full-scale
introduction of this testing -- or at least trying to
blackmail us into the provision of funds.
"The research proposal from Edinburgh will, of
course, have to be subject to the scrutiny of the
appropriate CSO group and the availability of finance.
I would not like to see it fail on the grounds of
finance because the stakes are high."

What do you think Dr Scott meant by use of the word
"blackmail"?

A. I really wouldn't like to speculate on what Dr Scott

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might have had in mind there. I think it would be
presumptuous.

Q. We will have to ask Dr Scott perhaps.

A. Exactly so.

Q. Just to follow up the fate of the Edinburgh proposal for
inclusion in the UK multi-centre trial into looking at
ALT and anti-HBc in donors -- I'm not going to go to the
documents but for the record there is an [SGH0028079].
It's a minute from Dr Forrester to Dr Forbes, the
secretary of the chief scientist's office on the matter.

Separately, [PEN0160152], is a letter from Dr Forbes
of the chief scientist's office to Dr Smith, his English
equivalent, of 13 November 1987, explaining that the
biomedical research committee of the chief scientist's
office in Scotland had rejected Drs Gillon and
McClelland's application for funds to take part in the
UK multi-centre trial.

In short Dr Forrester, the application appears to
have been refused on scientific grounds. There seems
little doubt of that when one looks at all of the
documents, including the letters and views of the
assessors and referees.

If we can perhaps -- again this is for the record,
without going to it: [SGH0028058] is a minute from
Dr Forrester to Mr MacDonald of 14 April 1988. For the
record, without going to it, it is all along the same line of funds not being available for the Edinburgh centre for inclusion in the research. [SGF0012059], a minute from Dr Moir, again at the chief scientist's office, to Dr McIntyre.

I think there are three final documents I would like to take you, please, to, Dr Forrester, the first of which is this: [SGH00024672]. Over the page, please.

This is a minute dated 13 August 1988 from yourself, Dr Forrester -- back to page 1, please -- addressed to the chief medical officer, who would have been Dr MacDonald, I think, at this time. It's copied to Dr McIntyre, Dr Scott and Mr Macniven.

Item 1 doesn't concern us. We have looked at this, I think, in another topic. This is the Punch and Judy minute we looked at before. Then item 2, "Commercial Factor VIII made by Alpha". Again the details don't concern us but I will give you two minutes just to read the minute, doctor.

A. This is minute 2 -- or paragraph 2?

Q. Read the whole minute, just out of fairness. Have a chance to read it all.

A. This is the one, "Commercial Factor VIII made by Alpha"?

Q. Yes. (Pause).

We will see again it's the last paragraph, (e):
"We can't prudently make much of the point, but this particular hepatitis is so benign, at least in the short-term, that evidence of transmission has to be specially sought, the patient not being ill at all in the ordinary sense."

Again, in that formulation, paragraph (e), one doesn't see a note of caution about giving an opinion on the likely seriousness of the disease. Does that seem fair?

A. At least I did say there, I say:

"At least in the short term". I was keeping an open mind.

Q. Can I ask you this, doctor: how influential would your views on the seriousness of the condition have been within SHHD, both within the medical side and within the administrative side?

A. Not very. They would only have been influential to the extent that they drew upon the opinions of other people in a much better position to judge -- as relayed by me, if you like.

Q. One can quite see that in terms of your medical superiors.

A. Yes.

Q. Presumably in terms of your administrative colleagues, they would have had to defer to you in respect of your
views on the condition.

A. I think they would be much more likely to ask me: whose views are you relaying? Or where did you get this from? Partial answers to that do seem to be in the papers and that is what they would look at.

Q. Thank you. I think there are two final letters that I ought to put to you, doctor. One is [SNB0059240]. This is a letter from Professor Cash, dated 21 August 1986, to Mr Morison at the Scottish Home and Health Department. We only came upon these letters relatively recently. I take it, doctor, you have been shown a copy of this recently?

A. Yes.

Q. I should preface my question with one remark: I understand the question of the Sandoz's collaborative research agreement. It has been suggested there may have been a misunderstanding between two different conditions: endotoxic shock syndrome and separately, toxic shock syndrome. I should say to you, do you have any recollection of the matters discussed in this letter?

A. Not now. I have read this document several days ago and I don't think I have any comment to offer upon it.

Q. In terms of --

A. I have no memory at all of the episode.
Q. Looking at the final paragraph on page 1, do you have any comment you would wish to make on that final paragraph?

A. None at all. From memory I can't comment on what underlay that at all.

Q. Yes. We should for completeness look at the response by Dr MacDonald. It's [SNB0132880]. This is Dr MacDonald responding to Professor Cash, on 8 October 1986. We can see in the third paragraph Dr MacDonald wrote:

"Dr Forrester is a knowledgeable and experienced doctor who applies himself with great diligence to his duties."

A. I find that very comforting.

Q. The final paragraph, there is a separate point raised I would like to ask you about. Dr MacDonald writes:

"Unfortunately, because of the highly unfavourable conditions of service in the medical Civil Service, we have lost some very experienced colleagues, including Dr Bell and at present we are operating four senior medical officers under strength."

Do you have any recollection of problems with staffing levels among the medical officers between 1985 and 1988?

A. Not so far as I was concerned. I have no recollection of being hampered by lack of people to deal with.
I seemed to me to have the contacts that I would wish to have, operating smartly.

Q. Certainly from your point of view you had a principal medical officer, Dr McIntyre. We have seen his involvement in the documentation we have looked at this morning.

A. Yes, I never felt under any delay due to there being nobody available to intervene or do anything.

Q. Thank you. I'm almost finished, doctor. Simply for completeness, could we go, please, to [PEN0171752]. This is the first of the two statements you provided for us. I think we have covered all of the ground. So I'm simply going it take this statement as read and not ask you anything further about it.

Finally, there was a supplementary brief statement, [PEN0172052].

A. I'm sorry, am I being --

Q. It is simply doctor so the statements formally form part of the Inquiry record that I refer to them, but we have, I think, covered all of the ground that's set out in the statement already. So I'm not going to go back over them and similarly, this is your supplementary statement. Again I think we will simply take that as read without me asking you any questions about it.

A. May I thank you for enlarging on the screen the displays
because if they had not been enlarged I would barely be able to read them.

Q. It does help me too and we have Mr Stemp to thank for that.

Sir, I have no further questions for this witness.

THE CHAIRMAN: We will have a break.

(10.56 am)

(Short break)

(11.19 am)

THE CHAIRMAN: Mr Di Rollo?

MR DI ROLLO: Mr Dawson is asking the questions.

THE CHAIRMAN: Mr Dawson?

Questions by MR DAWSON

MR DAWSON: Thank you, sir. Dr Forrester, I have a few questions for you, if that's okay. You have given some evidence already about your role within SHHD and you have told us about the extent of your experience of blood transfusion matters when you arrived --

A. Yes.

Q. -- in your job there. Could I just ask you, what was the role of the SNBTS directors group in informing decisions made within SHHD?

A. I find that a very difficult question to answer. I'm almost wondering what kind of answer I think might be expected.
Q. You referred in your earlier evidence to deferring to people with expert knowledge --

A. Oh, yes.

Q. -- and I'm wondering whether, in Scotland, the SNBTS directors group was the body with expert knowledge of blood transfusion matters to whom you might defer?

A. No. There would be no exclusive body. I would get information where I could or where it appeared, on an international basis. That would certainly be one of my major sources of information, but certainly not the only one.

Q. So your position is that the directors group was one of the sources of information --

A. Yes.

Q. -- but not the only one?

A. No, not the only source. In that sort of field I think you get information, if it's good information, wherever you can get it.

Q. Okay. Thank you. You may or may not be aware that Mr Macniven has already given some evidence in this section last week in connection with his role in relation to the non-introduction of surrogate testing. He told us, in particular in relation to SNBTS applications for funding, that he would often have occasion to go back to the SNBTS directors after an
application had been made, to seek clarification of its contents.

Did you often have occasion to go back to the SNBTS directors group to seek clarification of medical matters?

A. No that I can recall. Are you thinking of applications submitted to the chief scientist's office?

Q. I'm thinking of any applications in which you might have had some involvement.

A. Yes, I see. No I don't think so.

Q. Thank you. Could I ask, please, to have up a document which we have seen already? It's [SGH0028142]. Hopefully you recall this, Dr Forrester, it is one of the documents you were shown earlier. I think this is the one which you described as being a, "To whom it may concern", type document?

A. Yes.

Q. If we just flip over to the second page, we will see the date there and that's 12 June 1986, just to put it in the correct place in the timescale. If we could flick back to the first page, please, you are giving some information here about the position, as you understood it, as regards surrogate testing. I just wanted to ask you a question in particular about paragraph 6. Could we scroll down a little bit? You say in paragraph 6
that:

"In the absence of a specific test, for some years the suggestion has been made that an enzyme test (ALT) which detects faulty liver function, should be applied to every donation."

You talk a little bit about the advantages and drawbacks and, in the final sentence there, you say:

"Rejection of donations might reach 3 per cent, a grave loss."

What I wanted to ask about that was whether, at that time, you had sought the views of SNBTS directors as to whether they would be able to cope with the type of loss of blood that you had contemplated would result from surrogate testing in that paragraph?

A. I have no recollection of having done so.

Q. Okay, thank you. Could I ask for another document, which we have looked at as well, to be brought up? This is [PEN0171554]. Hopefully you recall this document as well, Dr Forrester. This is the note which -- this is the memo which you sent to Dr McIntyre, giving details of a meeting which you had attended of the working party on transfusion-associated hepatitis, which had been reconvened and had met on 24 November. Do you recall that document?

A. No, I don't really recall any document apart from seeing
Q. You recall being taken to it earlier this morning?
A. It's the only available memory I have. Sorry, which paragraph?
Q. You recall being taken to this document earlier this morning?
A. Yes.
Q. Could we just skip over to the second page, please? You say there in paragraph 5:

"There was some discussion of the cost of screening all donations (perhaps 8 million pounds)."
You say there:
"I asked the chairman whether he would advise screening if it were free of cost. He said no."
You will recall that the chairman of that group was Dr Gunson. As far as you can remember, your position is that that represents accurately what you discussed with Dr Gunson at the time?
A. Yes, I think so.
Q. Okay.
A. It seems to be rather a good question to ask.
Q. Could I just ask for a passage to be brought up from the transcript from 16 November, please? It's at page 118.
THE CHAIRMAN: Which day is that, Mr Dawson?
MR DAWSON: That would be day -- I think it's 64. In his
evidence -- this is the evidence, Dr Forrester of Dr Brian McClelland.

A. Yes.

Q. You recall him?

A. Yes.

Q. Do you recall him?

A. Well, yes.

Q. He was one of the SNBTS directors at the time.

A. Yes, I know -- I knew him.

Q. In his evidence, Dr McClelland told us that he had found the material which Dr Gunson had presented to that meeting on 24 November 1986 as being very persuasive in his developing attitude towards being in favour of surrogate testing.

A. Yes.

Q. At this point, Dr McClelland was asked how or whether he could reconcile his interpretation of the Gunson evidence and the passage that we just looked at from your memo and, reading from line 17 onwards, he says:

"Looking back at this while I was preparing these reports, I found this very hard to square. I would not wish to conceal that at all. I think I have said it in my statement. I find it very difficult looking back, with the wisdom of hindsight, to understand how a group, of which I was a member, could have this very well
prepared, well argued, well sourced, well informed paper
presented to us with these quite disturbing numbers and
then proceed to agree to do yet another study of
prevalence in donors."

I'm wondering if you might be able to assist us,
Dr Forrester, with the apparent inconsistency between
Dr Gunson's position as represented in your memo, that
he would not introduce surrogate testing even if it were
free, and the reliance placed by Dr McClelland on the
information Dr Gunson presented in favour of surrogate
testing?

A. I'm sorry, but with my recollection really totally
absent apart from my own note, I cannot help with this
at all. I see what you are asking --

Q. Yes.

A. -- but I cannot help at all.

Q. I appreciate that, thank you. Could we go back to the
previous document we were looking at, please, which was
[SGH0028142].

You told us earlier that you were generally, in
these types of memos, reporting information which you
had received from other people and you were taken to
a passage relating to the prevalence of non-A non-B
Hepatitis amongst the haemophiliac community.

Could you tell me, if you are reporting information
about the prevalence of non-A non-B Hepatitis in that community, what the source of that information that you are reporting would have been likely to have been?

A. Sorry, I know what you are asking but my memories -- apart from this, I have no independent recollection at all.

Q. I see, thank you.

A. I can see what you are asking, I'm not seeking to insult you, but I just have no mental contents that would help.

Q. Thank you. Could we look at document [SGF0012100] please. I don't think this is a document to which you were referred earlier but if we just scroll down to the bottom, we will see it's another memo by yourself dated 10 February 1987. So we have moved on a little bit in time. If we could just scroll up to the top, please, you will see it's a memo going to Dr Moir in the CSO department. In this memo you are again setting out the background as regards surrogate testing at this time and you refer -- you will see there -- in paragraph 3, to the fact that:

"Joint consideration by SNBTS, SHHD, DHSS and the English Transfusion Service indicates that, instead of blindly adopting American practice, research should be conducted, and a project involving 3 English and 1
do we take it from this document -- it would appear to be saying that at this stage, which is February 1987, the general position appeared to be that more local research was required into surrogate testing?

A. It certainly was the position of some people. Whether it could be called the general position, I'm really not quite sure. As you will know already, opinions varied widely.

Q. Was it the position of SHHD at this time that that was the course which should be adopted?

A. Quite honestly I couldn't tell you. Again I see what you are asking. If I haven't written it down at the time, then I don't know, I am afraid.

Q. Okay. Obviously, we have looked at another document, which we may as well just have up to the screen, which is [SGH0016653]. This is a document that you were taken to earlier. It's the minutes of the SNBTS directors meeting on 3 March 1987. This is the document in which the recommendation was made by the SNBTS directors that surrogate testing should be introduced. Do you remember that document?

A. I saw this earlier today?

Q. Yes, indeed.

A. That's right, yes.
Q. Could we just skip over, please, to page 6658? That's the passage you were referred to earlier, where the recommendation is set out and you have already been asked some questions about that. Would it be fair to say that, within this minute, there is not very much by way of detail as to what the directors thought process was in recommending that surrogate testing be introduced at this stage?

A. This is a report of a meeting.

Q. Yes, I think --

A. Well, that may simply date that they didn't discuss the matter you mention in great detail at the meeting.

Q. I assume, given your earlier evidence, that you don't have any recollection as to whether the reasoning was discussed?

A. I'm looking at this. This is my complete memory.

Q. I understand.

A. I imagine I would have covered it in detail if it had been important, but I'm just guessing.

Q. In his evidence about this, Dr McClelland, who also was at the meeting, he actually accepted that this came, "Rather out of the blue", was a phrase that he used, and there isn't much by way of reasoning.

A. I am afraid I can't unravel that for you.

Q. Can you recall whether, in the aftermath of this
meeting, you attempted to try and contact anyone within
SNBTS to understand what their reasoning was behind this
recommendation?

A. I am afraid I can't tell. I see what you mean.

Q. I'm looking for -- at your evidence on whether you did
anything after the meeting. So it wouldn't be included
within the minute.

A. I can only guess, but it seems to me that there I was
certainly not the channel through which the formal
application would pass. But I was aware of what was
going on. As I wasn't the channel for the formal
application, then I don't think I would have been
intervening in this way. I would expect the
directors -- the directors in their formal application,
to cover convincing detail of any kind.

Q. So your position is that you would have expected there
to be a formal application and for the reasons to be set
out in that formal application?

A. Yes.

Q. Therefore you didn't see any need for there to be any
further communication on your part with the directors?

THE CHAIRMAN: With respect, not "see any need", Mr Dawson.
It wasn't Dr Forrester's responsibility, so he didn't do
anything. I'm not sure that any of this is helping me
very much. Repeatedly to get the answer that
Dr Forrester can't remember what's not written down isn't terribly helpful.

MR DAWSON: I understand that, sir and I'll move on from this particular area.

Could I just ask you a question about another document? It's [SGH0028076]. This isn't a document that you have seen already but, if we just look at the top there, we will see it's a memo which went to you, Dr McIntyre and Dr Forbes. If we just scroll down to the bottom we will see it's a memo from Mr Macniven dated 2 October 1987.

I'm interested in the passage which is in paragraph 2. You will see, about roughly half way through, just beyond half way through, Mr Macniven says:

"But I think the worst of all possible worlds is that research can not get off the ground ..."

This is in relation to surrogate testing obviously:

"I fear that, in those circumstances, we would be subjected to increasingly irresistible pressure to spend the money in any case, for the sake of improving, at any price, the safety of blood and blood products."

I'm interested in exploring what he meant by the phrase, "Increasingly irresistible pressure". Would it be better for me to put that matter to Mr Macniven or is that a matter with which you might be able to give me
some assistance, Dr Forrester?

A. I'm just brooding on that for a minute.

Q. That's fine. (Pause).

A. Yes, I take it this pressure would come from the Blood
Transfusion Service and can I say any more about that?

Q. If you can, I would be very interested.

A. I don't think there is anything in my memory about it at all. I understand the words all right, but I don't think I know anything further relevant about that.

Q. To be fair to you, obviously --

A. This matter of political pressure was mentioned in a number of documents and phases and so forth.

Q. Yes, thank you very much, Dr Forrester. I have no further questions. Thank you, sir.

THE CHAIRMAN: Mr Anderson?

MR ANDERSON: I have no questions, thanks.

THE CHAIRMAN: Mr Johnston?

MR JOHNSTON: I have no questions, thank you.

THE CHAIRMAN: Anything arising? Dr Forrester thank you very much indeed.

A. Thank you very much.

THE CHAIRMAN: I think we have put you under some pressure to try and recollect events in the distant past, thank you for doing your best.

MR MACKENZIE: Sir, the next witness is Dr MacDonald and
I wonder if I could seek a short adjournment while we re-arrange the seating.

THE CHAIRMAN: I trust everyone is aware of Dr MacDonald's hearing problems and if there are other gyrations that are necessary, we can take care of them.

(11.38 am)

(Short break)

(11.44 am)

DR IAIN MACDONALD (sworn)

Questions by MR MACKENZIE

THE CHAIRMAN: If you can't hear, make sure that we know.

A. Thank you.

THE CHAIRMAN: To whom do I look first? Mr Mackenzie?

MR MACKENZIE: Thank you, sir. Good morning, Dr MacDonald.

Can you hear me okay.

A. Yes, thank you.

Q. Thank you. I would like to start, please, by looking at your CV, which will come up on the screen. It's WIT0030295.

Just going through matters chronologically, doctor, we can see in 1950 you obtained your medical degree. In 1954 you obtained a diploma of the Royal College of Obstetricians and Gynaecologists. In 1955, you obtained a diploma in public health. In 1958, you became a doctor of medicine and in 1979 you became a fellow of
the Royal College of Physicians. Then in 1978, is that
a reference to becoming a member of the Faculty of
Public Health?
A. Yes, it was public health medicine. At that time
I think they have simplified it to public health now.
Q. I see. I think that the Faculty of Public Health or
Public Health Medicine, I think is a joint faculty of
the three royal colleges of physicians in the UK.
London, Edinburgh and Glasgow?
A. That's correct.
Q. Thank you. Looking then at your appointments, please,
we start in 1950, when you were a house officer. Could
I then move forward to you joining the Scottish Home and
Health Department in 1964.
A. Yes.
Q. We can see you were a medical officer in the SHHD
between 1964 and 1966. You were then a senior medical
officer in that department, between 1966 and 1973 and
then a principal medical officer between 1973 and 1974.
You were then appointed Deputy Chief Medical Officer and
you held that post between 1974 and 1985 and you were
then Chief Medical Officer between 1985 and 1988. You
explain also that, between 1974 and your appointment as
Chief Medical Officer on 1 December 1985 there were two
deputy chief medical officers and before and after these
dates there was only one?

A. That's correct.

Q. Thank you. I think we have heard a little from another witness as to why that was the case.

A. Yes.

Q. I would now, please, doctor, like a to take you to your first statement you provided for us on this topic. It's [PEN0171702]. It will come up on the screen but if you would prefer to use your hard copy, doctor, then feel free to do that, if that's easier.

The first three paragraphs give us various matters of biographical detail, which we don't have to go back over. Then, if we could pick up, please, in paragraph 4, which is under the heading, "The medical staff in SHHD", so this is all by way of background to how the SHHD was structured and operated, and we can see that:

"Until 1974, SHHD had one deputy chief medical officer, to whom principal medical officers reported. Each principal medical officer headed a group of perhaps 3 or 4 senior medical officers and medical officers and each PMO group had a defined remit. In 1974 a second DCMO post was created and I was appointed to that post. Responsibilities at that level had therefore to be divided so that some PMOs reported to one DCMO and some
You say:

"The PMO group with responsibility for blood transfusion did not report to me, although our liaison arrangements, to which I will refer in paragraph 5 below, ensured that I had some awareness in broad terms of major developments."

Then:

"In 1985, when I was appointed CMO, SHHD reverted to the arrangement prior to 1974 and had only one DCMO. As chief medical officer from 1985 to 1988 I had a total medical staff of perhaps 20 to 25 individuals."

Over the page, please. In paragraph 5 you refer to:

"Two practices in SHHD were intended to keep the CMO and DCMO aware of the work in which medical staff were engaged and of any special or difficult situations that might be arising."

The two practices were firstly:

"A meeting was held every Monday morning, chaired by the CMO or, in his absence, by a DCMO, and attended by the PMOs heading each of our group."

You say, "These were quite informal meetings and notes were not made."

Secondly:

"SMOs and MOs wrote a monthly report indicating..."
briefly the activities in which they had been engaged during the month. These were passed to their PMOs and by them to the CMO and DCMOs."

You explain:

"Unfortunately these reports cannot now be found."

I think we have taken steps with the solicitor to the Scottish Government seeking to recover these documents but it hasn't proved possible?

A. That's right.

Q. In paragraph 5 we are again looking at things in general terms. You say that:

"A CMO or a DCMO might decide to take the lead in particular issue with support from the relevant PMO group because it had some unusual significance."

You give an example that when you were CMO:

"... I chose to take the lead in trying to introduce measures to limit the spread of HIV by the shared use of injecting equipment."

We can see what else is said:

"It was a serious matter, but also a sensitive matter requiring agreement at a senior level in SHHD, the consent of ministers and the cooperation of police and others."

We can see for ourselves what's then said at the bottom of the page. Over the page, please, page 3 we
"Medical staff were related to administrative colleagues as advisers. While the administrative staff were ultimately accountable for expenditure, the advice of medical staff would be taken into account whenever appropriate.

"The consideration given to the question of introducing a surrogate testing for NANBH ... provides an example of how this arrangement works in practice. If departmental medical itself had been persuaded, after consulting colleagues with relevant expertise, that surrogate testing for NANBH was a reliable procedure which would give few false results (positive or negative) and be free from adverse effects, they would have advised administrators accordingly and it would have been highly likely that funding would have been provided. In the event, departmental medical staff were not sufficiently persuaded and advice reflected this."

We will go on to look at the detail of surrogate testing shortly, doctor, but to what extent were you personally involved in the decisions that required to be taken regarding whether surrogate testing should be introduced in Scotland?

A. I don't think that I was really involved personally. I was, I think, kept fairly well informed of what my
colleagues were doing and I don't think that I really
had occasion to intervene. I was content to leave it on
that basis.
Q. Yes. Do you recall whether the issue ever came to you
for a final decision to be taken, or even a decision to
be taken on: should surrogate testing be introduced in
Scotland?
A. No. I'm not sure. It's quite long time ago. I'm not
quite sure that a final decision was ever taken.
I think we were still agonising over the question of
setting up research. Frankly, I just don't quite
remember the end of it, except that we didn't do it.
Q. Yes. In paragraph 7, five lines from the bottom, when
you say that:
"In the event, departmental medical staff were not
sufficiently persuaded and advice reflected this."
Which member or members of staff in particular would
that refer to?
A. That would be Dr Scott and Dr McIntyre and Dr Forrester.
Q. Yes. It wasn't a matter, I think, that -- or was it
a matter that came to you for your specific views on it?
A. Not in that sense. I think that I must have seen enough
paper to have a reasonable idea of what was going on
and, as I say, I didn't intervene.
Q. If you -- can you imagine a circumstance where you might
have intervened?

A. I think, if the advice appeared to be veering towards introducing it, I would have found it necessary to intervene.

Q. Why?

A. Certainly on two grounds. One is that I did have reservations which will emerge in another paper that we will perhaps come to. But I did have reservations, mainly on the grounds that -- well, partly -- it wouldn't be the complete answer to the problem as far as the recipients of blood and blood products were concerned, but it would also have repercussions on the donors. Testing the donors, we know -- we don't know the proportions that we would have found in this country, but testing the donors would undoubtedly have yielded a fairly appreciable number of positives, some of which would be false and, at the other end, a fair number of negatives, some of which would be false.

If you then -- what are you going to do about the positives? You won't know which are false and which are genuine. You bring them in and -- or you perhaps have done your best to explain the position beforehand but then some of them will have to be followed up and I think we would -- there was some risk that we would find that donors would be disturbed by this situation
and I think that was something which we really should not have risked doing. That's one side of it.

The other is a point which I think has already come out this morning, about DHSS. We will may, I think, come to this later but the point that I think has to be made is that DHSS and the Scottish Office, which included SHHD, and for that matter, the Welsh Office, were three different departments of the same government, each responsible to a Secretary of State in that government and the secretaries of state were sitting together round the same cabinet table.

On an issue of this kind, where there was a group, the Haemophilia Society, and perhaps others, watching all our moves carefully, if one of us -- and it might have been us -- if one of us decided to institute testing and the other didn't, that would be extremely difficult to explain. One of us must be right, one must be wrong, would be the reaction.

But it goes a little further than that because, as I recall it, we were facing a situation in which the Scottish directors were pressing for the introduction of testing and the English directors -- I think pretty unanimously at that stage, the English directors were against it. I don't think we could ignore the fact that there was a well informed body of opinion, not very far
away, with a different view.

So I think in that situation I would certainly need to have become involved.

Q. Yes. Just to pause there, doctor, my understanding is that in 1986 and 1987 you were perhaps aware, in general terms, of the consideration being given by your medical officers to the question of surrogate testing --

A. Yes.

Q. -- but you were not directly or personally involved at that time?

A. Yes.

Q. I had raised with you the possibility of when you might have become involved and --

A. Sorry did.

Q. Sorry, yes. I then asked you why might you have become involved personally or directly involved, and you have given an answer to that.

What I simply wonder is, hypothetically speaking, if you had decided to become involved, let's say in the middle of 1987, would your involvement have been to say:

"Hang on, those below me have recommended we now introduce such testing, but I think there are wider issues that need to be considered."

Or would your involvement in, say, the middle of 1987, have gone as far as saying:
"In my opinion we should not introduce such testing."

A. That would be correct, but I think I ought to say that Dr Scott and Dr McIntyre certainly had been in the department long enough to be as well aware as I was of the -- certainly of the difficulty of taking a different line from DHSS.

Q. Yes. I will come back to explore that with you, but just for the avoidance of doubt, hypothetically speaking; if, in the middle of 1987, you had become personally or directly involved in the question of surrogate testing, would your involvement have been simply to say, "Hang on, there are wider issues we need to consider." Or would you have gone even further at that time and have said, "We should not introduce such testing"?

A. I think I would have to have gone further.

Q. I see. So, in the middle of 1987, you had formed a view on whether surrogate testing should or should not be introduced?

A. Yes, I think that was the view that Dr Scott and Dr McIntyre were taking and I think Dr Forrester. I would have accepted that view and agreed with that view.

Q. I understand. Thank you. I'm sorry, I have taken you
off your statement a little bit. I would like now to
return to the statement and work my way through it,
please. We had reached, I think, paragraph 8 on page 3
under the subheading, "My first responsibility for blood
transfusion matters". And you explain that:

"As an MO/SMO I had responsibility, between 1965 and
1973, for the department's medical interest in blood
transfusion."

Et cetera:

"I believe I spent about a third of my time on blood
transfusion matters."

Paragraph 9 and then all of the next page moves into
fractionation and the manufacture of blood products and
I'm simply going to take that as read. It is of
interest and relevance but not for topic C2, I think.

So as I say, page 4, we will simply take all of that
as read, if I may. Also going to the top of page 5.
I would like then to come back to paragraph 15 and this
relates to your concern with blood transfusion as chief
medical officer and you say that:

"When I was one of two DCMOs, from 1974 until 1985,
the PMO group with responsibility for blood transfusion
did not report to me. When I became CMO from
1 December 1985, blood transfusion was, of course, part
of my overall responsibility for medical matters within
SHHD. However, the day to day concern with blood transfusion, including the impact on it of HIV and Hepatitis C infections was left in the hands of experienced colleagues whom I knew well as competent and conscientious individuals who had been undertaking this for several years."

To pause, Dr MacDonald, you became CMO in December 1985?

A. Yes.

Q. I think at that stage presumably, the experienced colleagues, who had been working in blood transfusion for many years, that must be a reference to Dr Scott and Dr McIntyre?

A. Yes.

Q. Because we know that Dr Bell, I think, left in 1985 and Dr Forrester replaced him?

A. Yes. That's right. I think Dr Bell had left shortly before I became CMO.

Q. I understand. You then refer to a minute by Dr Forrester, 1 December 1986. We will come back to that. Over the page, please.

A. Yes, can I just a make a point here? The last sentence there.

Q. Bottom of page 5, please.

A. Yes:
"That working party's advice went, of course, to DHSS as well as to SHHD."

That was quite a common feature of our arrangements, that we participated in the same working parties and advice came to the two departments. Indeed, I would think to the Welsh Office as well at that point.

Q. Thank you. Over the page, please, at page 6. We then come to the set of common questions we asked all witnesses.

A. That's right.

Q. Although I think the questions may have been slightly more focused towards the SHHD in this instance. We asked firstly.

"What consideration was given by the SHHD in the 1980s as to whether surrogate testing should be introduced?"

In paragraph 16 you explain that:

"I did not have responsible for blood transfusion matters in the early 1980s, before I became CMO ... and Dr Scott (the other DCMO at that time) had responsibility for blood issues."

We can see what else is -- and you say:

"Thereafter [so once you become chief medical officer] although blood transfusion was of course part of my overall responsibility, the day to day concern
with this matter was undertaken by experienced
colleagues."

You have explained that and I think that's also
consistent with the documents we have looked at where
I think your name doesn't appear at all, or if it does
it's very rarely. The day to day business or
consideration is a matter really for Dr Scott,
Dr McIntyre and Dr Forrester?

A. Yes.

Q. The next question, the research funded by the SHHD.

I think we can take that answer as read and equally
paragraph 18. I would like to take that as read as
well, please.

Page 7. They then asked:

"What was the response by SHHD to each of the
requests by the SNBTS for funding to introduce surrogate
testing?"

In paragraph 19 you say:

"I have now seen the relevant PES documents. I did
not see them at the times when they were submitted to
SHHD. It would, however, have been exceptional for them
to have been shown to me, or for me to have been
involved in considering them."

I think we heard evidence from Mr Sandy Murray, as
to his role in collating the various funding bids,
taking advice from medical colleagues and then, I think, the approval being required of Mr Macniven --

A. I'm sorry.

Q. I'm sorry, the approval being required of Mr Duncan Macniven --

A. Yes.

Q. -- before the funding document was then sent to the finance department. When Mr Murray sought advice from medical colleagues on the different items for which funding was sought, what level of medical officer would be involved in giving advice to the administrative colleagues?

A. I think probably Dr McIntyre, but if Dr McIntyre wasn't immediately available and it was urgent, he might well have asked Dr Forrester.

Q. Yes. Would Dr Scott or yourself have been involved in giving advice to admin colleagues on funding bids in the late 1980s?

A. Yes -- I wouldn't, simply because I wasn't handling the detail of this. Dr Scott would. I think probably after Dr McIntyre had seen it and perhaps identified a point that he thought was more difficult than usual and might have wanted to take it up with Dr Scott.

I don't think I would have expected to see these documents.
Q. Thank you. The next question we asked was:

"The response by SHHD to the recommendation of the SNBTS directors (agreed at their meeting on 3 March 1987) that this surrogate testing should be introduced with effect from April 1988."

We will come back to that minute shortly.

I should make one point. I think in your answer in paragraph 20 you say:

"This was, in fact, a meeting of the SNBTS directors and haemophilia directors ..."

I think that's wrong. I think it was in fact the SNBTS directors only.

A. Oh.

Q. But we will come to look at the minute shortly.

A. Sorry, yes.

Q. I think it also follows that the meeting, because it was simply that of the SNBTS directors, was not chaired by Dr Forrester. But we will see that in the minute shortly.

You say:

"The departmental response to the directors' representation was negative, which is not at all surprising in the light of Dr Forrester's account of the meeting of the UK Working Party on Transfusion-associated Hepatitis on 24 November 1986."
So really, I suppose the point one can make is that the SNBTS directors were, in a way, going it alone --
A. Yes.
Q. -- by recommending the introduction of surrogate testing because that wasn't the view of the UK Working Party on Transfusion-associated Hepatitis.
A. I'm sorry, yes.
Q. It appears that that working party's view was to undertake further research first. That, we have seen, was also the view of the SHHD and also at least certain transfusion directors in England as well.

The next question we asked was:
"The extent to which the cost of surrogate testing was taken into account by SHHD in considering whether to finance such testing."

You say:
"I cannot answer this question from my own knowledge. Cost is always a factor that has to be taken into account, but never without regard to any other relevant considerations. In this instance, the other relevant considerations were the doubt and uncertainties described by Dr Forrester in his account of the meeting of the UK Working Party on Transfusion-associated Hepatitis on 24 November 1986."

We then at the bottom of the page asked why
surrogate testing was not introduced in Scotland.

You say:

"I cannot add anything to what is recorded in the
minutes referred to in the Preliminary Report.
Essentially, there was too much uncertainty about
various aspects of surrogate testing to justify
introducing it."

I take it, Dr MacDonald -- was that your view at the
time, for example, 1987, that there was too much
uncertain about various aspects of surrogate testing to
justify introducing it?

A. Yes, I think it was. I had been CMO at that time for
over a year, so I think I would have been over that
ground with colleagues.

Q. Looking at things now, having had the opportunity of
looking perhaps at the preliminary report and with the
knowledge of Hepatitis C now, with the benefit of
hindsight would you be any more positive towards having
used surrogate testing for NANBH in the late 1980s?

A. I don't think so.

Q. Why not?

A. The position, I don't think, had really changed very
much, even by the time it was possible to screen for
Hepatitis C. I think the facts remain that you were
going to get quite lot of false positives, quite a lot
of false negatives, and you would not be able to make
a complete -- to eliminate the infection completely.
I don't see that the position had really changed in
any way that would have made me change my view.
Q. If, hypothetically speaking, it was reasonably
believed --
A. I'm sorry.
Q. If hypothetically speaking, it was reasonably believed
that the introduction of surrogate testing was likely to
reduce the incidence of post-transfusion hepatitis by,
say, 30 or 40 per cent -- if one accepted that, do you
think there then becomes a reasonable case for
introducing surrogate testing?
A. No, I think I would still have argued against it.
I think too much uncertainty still remained and I would
have put considerable weight on the possibility that
donors would find it disturbing. I think the one thing
that we really had to avoid, almost at any cost, was
disturbing donors because the whole enterprise depended
on them.
Q. Donors presumably are part of the equation but equally
patient safety, presumably, is an important part of the
equation too?
A. I wouldn't for a moment dismiss the question of patient
safety, but on the donor side you are dealing with
healthy individuals -- or at least they appear to be and believe that they are healthy -- who come along with the altruistic intention of giving blood.

You then find yourself having to subject some of them to a series of investigations, at the end of which you might be able to say to some of them, "Oh, don't worry, you are not actually positive". To others certainly you would have to say, "I'm sorry, we have found that you were positive". But, even to the ones where you said, "You are not positive, so go away and don't worry", some people wouldn't find it easy to go away and not worry.

Of course, at that time, as I understand the position, there was no possibility of treatment. That, I think, came rather later. So, on the whole, you were exposing these people who had come along to give blood to situation that could be quite unfortunate. On the recipient side, well, yes, of course, we wanted to do the best we could for them, but you were dealing with an established problem; it was a different situation from that of the healthier, apparently healthy donor.

Q. Can we go back to your statement, please? We then asked about the main discussions between the SHHD and the Department of Health in England on the on research into surrogate testing and whether surrogate testing should
be introduced. You say:
"There were obviously exchanges between individual medical officers in these two departments. But I don't know what might be covered in the reference to 'main discussions'."

I think there were really two questions doctor. Firstly, this relates specifically to surrogate testing: what discussions or liaison was or were there between English health officials and the Scottish health officials in relation to surrogate testing. But also the far broader question: in general to what extent did the two health departments liaise with each other.

Dealing with surrogate testing in particular, do you have any recollection of any liaison between the two health departments in respect of surrogate testing?

A. I don't have any recollection and I don't think there probably was any occasion when officers of the two departments sat down on their own and said -- if I understand your question -- said "let's sort this out". I don't recall that sort of thing happening.

I do -- I'm sure that there was information flowing between Dr Forrester and his colleagues in DHSS, again at Dr McIntyre's level and I'm sure Dr Scott was occasionally involved. So I think each department would have a pretty clear notion of where the other stood but
Q. Is the picture you are presenting, doctor, of liaison or communication at all different levels, so certainly from Dr Forrester with his counterparts in England, Dr McIntyre, his counterparts and did that continue up between deputy chief medical officer level and chief medical officer level? Not just with surrogate testing, but just as a general principle, was there such liaison between the two departments at all levels?

A. Yes, that really went on at all levels and of course, we are talking specifically of a very narrow subject. If you look at the range of activities in the two departments, there was an enormous range of activity.

Q. When you were chief medical officer, Dr MacDonald, between 1985 and 1988, what was the relationship between the two health departments, in terms of: was it a relationship of equal partners, or did the English department carry greater weight, or what?

A. Well, I think -- I'm not sure if I haven't touched on this somewhere in something I wrote. I think the position, as ministers would have seen it, was that the DHSS would have been expected to take a lead on major policy matters and Scottish, SHHD, and the Welsh Health Department, would have been expected to fit their policy around that. In other words, there can be a bit of
variation for local circumstances, but broadly the
policy would be evolved in DHSS.

Having said that, I think I should go on to say --
and we have touched on this already -- what very often
happened was that an expert group -- I mean, not just
blood transfusion, but in every respect -- an expert
group would be assembled in various ways, sometimes very
formally, by ministers, sometimes by the departments,
and there would usually be Scottish members.

I mean, if it was in some paediatric subject, they
would invite a paediatrician from Scotland who had an
interest in the subject, maybe more than one, and one of
our medical staff would attend these meetings, so that
we were getting feedback from that. In that way the
Scottish input was made. By that I mean to say, if
there were one or two Scottish members of the group,
they would be able to make an input and they would be
able to go back to colleagues in Scotland and perhaps
clarify their views and go back and this sort of
exchange would take place.

On the whole, I think it worked reasonably well.
I think the profession in Scotland was content with it.
I think they would have been less than content if DHSS
involved only their English colleagues, but they were
sensitive to it and I think it did work quite well.
Q. Yes. If, in the middle of 1987, SHHD officials, including yourself, had taken the view that surrogate testing was justified --

A. I'm sorry.

Q. I'm sorry. If, in the middle of 1987, the view was taken in SHHD that surrogate testing was justified and if you had also been of that view, if you had been unable to convince your English colleagues of that, would it have been open to Scotland to introduce such testing in any event?

A. I think in a very theoretical sense. This was never tested. I think what would have happened, I can, I believe, have advised Scottish ministers that testing should be introduced in Scotland. The CMO and DHSS could have advised his ministers that it should not be tested in England. I think we would have been bound, each of us, to tell our ministers that the other minister was being given the opposite advice. I don't know what would have happened then. I suspect that a solution would have been found before it ever got to that length --

Q. I see.

A. -- but that's the sort of reality of the existence.

Q. Thank you.
entrenched, it would become a decision --

A. I'm sorry, sir.

THE CHAIRMAN: If the two sides, Scotland and England, had each become totally entrenched in their own view, it would have become a matter for ministerial decision, possibly at cabinet level at some stage?

A. Yes.

THE CHAIRMAN: Of course, no one can forecast precisely.

A. I'm sorry, sir.

THE CHAIRMAN: No one can forecast precisely what the outcome of an issue of that kind might have been.

A. No, I think I would risk a bet on it.

THE CHAIRMAN: I wondered. Yes.

MR MACKENZIE: Dr MacDonald, if -- let me put it this way: if, in the middle of 1987, you had sat down to apply your mind directly to whether surrogate testing should be introduced or not, would the fact that officials in the Department of Health in England were against surrogate testing -- would that have been a factor in your decision-making and, if so, what weight would you have placed on it?

A. I think that it would have presented us with quite a difficult problem. I think we really -- we would be going over the ground we have just covered. Would we be prepared to advise our minister that it was worth taking
that particular view? The minister would certainly want
to know, in some detail, why the other view was being
taken in England. It's a question of how easily we
could have persuaded them. I think in this particular
issue we had a group of regional directors in Scotland
expressing one view, we had a group in England
expressing a different view. Circumstances in Scotland
and England were not different in relation to this
issue. Which one is preferable, the preferable view?

I think we would have to ask ourselves if we could
reasonably -- if we were prepared to put it to the
minister that we felt so strongly in favour of it that
we really wanted him to press it.

Q. You would have done that if you had felt so strongly
about an issue?

A. Yes, but -- I mean, in any issue of this kind, if there
had been a significant difference in circumstances
between Scotland and England, rather than just the
opinions of groups of staff -- if there had been that
sort of thing, there might have been -- and this is all,
of course, very hypothetical -- there might have been
a case to argue.

I don't think there are satisfactory answers to
these questions.

Q. Thank you, doctor. I would like now to put -- I think
we will just finish this statement. We had asked you:

"If surrogate testing for non-A non-B had been introduced in Scotland, the extent to which the incidence of post-transfusion NANBH/hepatitis C is likely to have been reduced."

You answered:

"In the light of the unresolved uncertainties this question is unanswerable."

A. Yes.

Q. We can put that statement to one side, please and turn to the second statement you provided for us. This document will come up on the screen. It's [PEN0172048]. Paragraphs 1 and 2 we can read for ourselves in the interest of time. Paragraph 3, please.

In respect of the large-scale prospective study of the type undertaken in America and proposed by Dr McClelland in the early 1980s, in the third line from the bottom we see you say:

"While such a study would have provided additional information about NANBH in the UK, it seems doubtful whether sufficient new information could have been obtained in time to influence the decisions that had to be made by blood transfusion services. The US TTV study commenced in July 1974 but, in reporting on an interim analysis in 1978, caution was advised in interpreting
the data, 'since the number of patients analysed to date is small'."

Paragraph 4 you say:

"Other considerations have also to be taken into account."

You refer to the duty of care towards donors, as well as towards recipients, and the need to maintain an acceptable balance between these two duties. We can see what else you say there. Paragraph 5, you list various quotes from the literature about the problems raised by using a surrogate test and the problems in advising donors. We can talk all of that as read, I think, because you set it out very clearly.

Over the page, please, question 6 referred to the work of Drs Dow and Follett. We have got Dr Dow coming tomorrow so I'll ask him about that.

I take it, doctor, that you have no recollection of having personally read Dr Dow's thesis at the time?

A. No.

Q. Question 7, we asked if, in the second half of the 1980s, SHHD medical officers placed sufficient weight on the likely prevalence and seriousness of post-transfusion NANBH, and if their views in that regard influenced their opinion on whether surrogate testing of blood donors should be involved.
Could I pause, there, and ask you this: if one is considering, let's say in 1987, whether surrogate testing should be introduced, presumably -- and there are a number of factors to take into account -- presumably one factor is a consideration of the seriousness of the disease?

A. Yes.

Q. Then, if a condition is entirely harmless and benign, then the case for testing to prevent the condition would be reduced, but the more concerns one has about the seriousness of the condition, then the more there becomes a case for testing to prevent the condition. As a generality does that seem reasonable?

A. Yes, but you can't -- at the same time you can't ignore what you might call the quality of the testing.

Q. Yes. Presumably, there were a number of factors to be taken into account in considering whether such testing should be introduced. One was the quality of the testing, the effect on donors, the likelihood of increasing patient safety, seriousness of the disease, prevalence of the disease and perhaps the cost of undertaking testing as well.

A. Why yes.

Q. No doubt there will be other factors, but these will be some of the main factors, I think.
A. Yes, indeed.

Q. Returning to paragraph 7, please, you refer to Dr Forrester's note of 12 June 1986, which I'll come back to shortly. We see the quote from that.

There are some other documents you refer to as well and I will come back to some of these. So I think we will simply take your answer 7 as read for now. As I say, I will come back to ask you one or two of the documents.

A. Yes.

Q. One point. On the third last line on page 3 you say -- the third last line:

"In his minute of 6 April 1987, Dr McIntyre is reporting a situation as it existed and does not appear to be endorsing views expressed elsewhere or expressing a view of his own on the characteristics of NANBH."

This question of Dr Forrester not expressing a view of his own on the characteristics of NANBH; would that be consistent with your of your understanding of Dr Forrester's role at the time?

A. I'm sorry, I'm not quite following you here.

Q. I'm sorry, we have jumped about. Could we go back to page 3, please? Third line from the bottom.

A. Yes.

Q. Yes, it's Dr McIntyre, sorry.
A. Yes, it's Dr McIntyre, isn't it?
Q. I apologise, Dr MacDonald. It's entirely my mistake but let me ask the question this way: we have heard evidence from Dr Forrester this morning that his role was really to ingather and relay information to others, rather than him personally giving a judgment or opinion on, for example, the characteristics of the disease, NANBH. Would that be consistent with your understanding of Dr Forrester's position at that time?
A. I think that's a reasonable position for Dr Forrester to take. I think that if he had formed a view, the expression of that view would have been welcomed. In other words, I think we always were open to listening to the views that might be offered.
Although it was a hierarchical set-up, it wasn't a rigid one in the sense that you are only such and such grade, so you mustn't, if you had reason to think you should say something. In fact you could quite well find that, because of some experience in the past, somebody relatively junior to you knew more about it than you did.
Q. Yes. Thank you. Then, the top of page 4, please. You go on to say that: "While the views of SHHD medical, officers may have contributed to their opinions on whether surrogate
testing of blood donors should be introduced, these views do appear to have been properly balanced."

I take it, doctor, you say that from having had the chance -- for the purposes of this Inquiry, of going back over some of the documents at the time?

A. Oh, yes, yes.

Q. Paragraph 8, question 5. We asked about:

"... the possible consequences if surrogate testing of donors had been introduced in Scotland."

We can see what you say there. In paragraph 9 -- I'm interested, doctor, in the final sentence of paragraph 9, where you say:

"The existence of these commercial producers cast a long shadow over fractionation activities within the NHS."

Really to ask what you meant by the reference to "a long shadow". What's that a reference to?

A. I think this was a very peculiar situation, in which the NHS was itself a producer and in that sense it was in competition with commercial producers, in a way that I don't think was quite replicated anywhere else in the service. I think what struck me at the time, when I wrote that, I was aware of the -- I had seen notes of it -- that commercial producers, particularly in the United States, were beginning to introduce surrogate
testing. In the way in which commercial operators work, they would be presenting this in the publicity in their advertising as an advantage. My stuff is better than your stuff. I wouldn't be sure that that was altogether fair but we, really, I don't think I felt that we could quite adopt these standards.

So there was a lack of balance. There was also the general pressure that we had -- we really had to be producing material which not only was good in a pharmacological sense, but also was easily administered and all these sort of features. I think my feeling was that, in some respects, the NHS was at a disadvantage.

Q. Yes. One matter which occurs to me there is that obviously in the 1980s, for example, the NHS in Scotland was producing blood products, Factor VIII and IX concentrates, equally available on the open market are, perhaps US-produced, commercial products.

In the 1980s -- this is a very wide question -- it may be unfair to ask you, but in the 1980s did the NHS produce any other pharmaceutical products which may have been in competition with commercial products?

A. I think there -- and I'm not sure about this. I think there might be something like that in the field of vaccines and immunisation products, but I'm not just
quite sure of that and whether that would be quite the same problem.

Q. But it does perhaps seem to have been relatively rare for the NHS to be producing a product which was in direct -- or in competition with a commercially produced product.

A. Yes.

Q. Which may have given rise to a set of unique or particular issues?

A. I'm sorry?

Q. That, in itself, may have given rise to a set of quite unique set of issues. Perhaps which wouldn't arise more generally across the NHS?

A. Yes.

Q. In general across the NHS. The NHS can get on and do what it thinks is best?

A. Yes.

Q. Without being subject to, at least in the 1980s, perhaps, commercial supply.

I think that takes us into far wider territory. So I'll stop your statement there, thank you, doctor. But I would like to now ask you some questions about one or two documents which we haven't looked at yet.

The first document, please, is [PEN0171734].

Doctor, this is an excerpt from a textbook by
Professor Mollison, "Blood Transfusion and Clinical Medicine". The seventh edition published in January 1983. If we go over the page, please -- we did go over this with Dr Forrester and I'm not sure, Dr MacDonald, if you were present at that stage, when I took Dr Forrester to this passage this morning?

A. Yes, I was but I was over there and I really didn't hear any of Dr Forrester's replies.

Q. Yes. Under, "Non-A non-B Hepatitis", about ten lines down, if we look to the right-hand side -- I'll pick up the passage commencing:

"As a rule, non-A non-B Hepatitis is symptomatically mild. Patients seldom need to be admitted to hospital. Nevertheless, up to 60 per cent of cases have abnormal ALT levels for more than one year. If a liver biopsy is taken be most of the cases show histological evidence of a significant chronic liver disease and approximately 10 per cent show features of cirrhosis."

A reference to a paper by Alter in 1980:

"A striking feature of non-A non-B Hepatitis is the tendency for serum hepatic enzyme levels to fluctuate markedly over a relatively short time."

To pause there, doctor, is this the sort of textbook that would have been available to medical officers in SHHD in the 1980s?
A. I'm not sure if this particular one would have been available immediately, but we had an arrangement that we could draw on the pretty extensive library that DHSS had, so in that sense we could have got it. They would have sent it up to us.

Q. We have heard evidence that this was the main, perhaps only, British transfusion textbook at the time. Would you have assumed that your medical officers would be aware of information contained in such a textbook?

A. Not really. I think that perhaps a medical officer who had spent as long as Dr Bell had spent liaising with the blood transfusion people -- I think he might well have been aware of this. But I think there is a point -- and I wondered if it was beginning to emerge this morning.

Generally speaking, we were not individuals who were taking up anything resembling specialist positions. There were one or two examples at variance with that, but broadly speaking we really, I think, would have regarded ourselves as generalists. This is quite an interesting point because, as medicine has become increasingly specialised -- and it has become more and more so since my time -- there is a problem how you bring it all together and decide as between one and the other and realise what the implications are.

If I can give you an example from my own experience,
I joined the department in 1964. They advertised a post for someone to advise on, I think it was, maternity services and child health. I had done a little, not technically good or particularly profound work and produced one or two very modest papers in rather modest journals and I got the job. Within about a year, the DCMO at that time called me in and said he would like me to take on the job we talked about earlier in the early days of the service, when it was an association, and also deal with the committee that advised on laboratory services.

That was the sort of thing. I was never involved in maternity and child health services again. So it is this kind of lack of -- relative lack of specialisation, maintaining a degree of generality that is what we wanted.

Q. I can quite understand that, Dr MacDonald, but it was a normal part of the job of medical officers to form a view on the matter and to give advice, in particular to their administrative colleagues --

A. Yes.

Q. -- perhaps from time to time, occasionally to ministers. When a medical officer had to give advice, it does seem to be an obvious starting point, in informing oneself on a matter, to go to the main textbook in the area.
A. Yes, I think that's reasonable.

Q. Yes. So if a medical officer in SHHD is considering the issue of post-transfusion hepatitis in the 1980s, does it seem reasonable that one would go to Professor Mollison's book?

A. Well, I'm a little hesitant to narrow this down to one particular book, but I do understand the point you are making, yes.

Q. Yes, and in particular --

THE CHAIRMAN: I wonder if I could follow a little because I do want to get a feel for what you would have expected your medical officers to do.

At one end of the range of possibilities is the possibility that the MO would be expected to do his own research, find out what the up-to-date position was and advise on that basis.

I suppose at the other end of the spectrum, one would seek out the author of the book and ask him what the up-to-date position was, given that it might have moved on since the last edition.

What would you have expected people to do?

A. In broad terms, I would have expected them to keep up-to-date. I would -- how shall I put this? I would perhaps warn him, if I was giving advice, that he has always got remember that the people he is dealing with...
in the subject know a lot more than he does and he is not going to get himself on to that level.

THE CHAIRMAN: So there is a difference between doing enough research to know what the questions are and doing enough to provide answers to them?

A. There is, and I think it's interesting you should put it that way because I have sometimes felt that one of the justifications for our existence is that we know the questions to ask.

THE CHAIRMAN: Certainly there are people lined up out here who are no doubt grateful to know that that's a justification for their existence, doctor. But looking at it from the service point of view, the health service point of view, I wouldn't want to be carried away with the notion that you need a lot of prima donnas in research terms or development terms or whatever, if that were not factually accurate.

A. I'm sorry, sir, I'm not ...

Q. I want to get a proper measure of what you think was reasonably expected of the MOs at the time. I don't want to exaggerate it by thinking of them as sort of prospective prima donnas in research and development terms, if that's not real.

A. Yes.

THE CHAIRMAN: What is the reality? What should one think
A. I think they have to go some way towards mastering the subject, but I think what we really expect of them is to be able to come in and tell us what people out there are thinking and be able to explain, to some extent, why they are thinking it, but not to go too deeply into the subject itself.

THE CHAIRMAN: In some ways you seem to me to be putting the medical officers on a par with the administrative officers, whose primary qualification seems often to have been that they were not horses for courses.

A. No, I don't think it goes as far as that. I mean, if that were the case, they could do without us. I think there is a view in some quarters that leans in that direction.

I think that -- just to go back to what I said a moment ago, I think our function was to know enough about medical matters to know what we ought to be asking. I think if you -- leaving blood transfusion apart and thinking more generally of the work, I think that you can see situations in which someone without a medical background is very easily swayed by a persuasive clinician in the field who can put a good case. There are other clinicians who can't put such good cases, that's the kind of thing that we want to be
able to get at.

MR MACKENZIE: Thank you, sir. Dr MacDonald, could I look at this in another way, please? Going back to the extract on the page and the panel I read out commencing: "As a rule non-A non-B Hepatitis et cetera..."

A. I have it, yes.

Q. So reading that, so:

"The matter of up to 60 per cent of cases have abnormal ALT levels ... for more than a year; if a liver biopsy is taken ... approximately 10 per cent show features of cirrhosis."

What I suggest, doctor, is this, that that passage sets out knowledge of NANBH at the time and that, I would suggest, one would presumably at least some of the medical officers to have that knowledge if they required to advise others, for example, admin colleagues. It doesn't really matter where they get the knowledge from, but that's the standard or level of knowledge one would expect an SHHD medical officer to have at around that time. Does that seem reasonable?

A. Yes.

Q. Thank you. Following from that passage, I do suggest that, when making statements in 1986, for example, about the potential seriousness of non-A non-B Hepatitis, the evidence, as set out in that passage would at the very
least suggest a need for caution. Does that seem reasonable?

A. Yes, caution, yes, but not absolute certainty.

Q. Yes. Then, the final matter I wish to take from this extract before lunch, if I may, is over the page, please. Under, "Frequency of post-transfusion hepatitis", the author states:

"Anicteric cases of PTH are commoner than icteric cases. For example, in a study reported from the USA, in which 2,204 patients were followed, and in which PTH was diagnosed in 241 patients, the disease was icteric in less than one fifth of the cases. It follows that repeat sampling of recipients is necessary if all cases are to be detected and that only prospective studies are likely to give a true indication of the frequency of PTH."

Would that have been your understanding at the time, doctor, in roughly 1986/1987, that if one wished to know the prevalence of post-transfusion hepatitis in Scotland and the UK, one would have to undertake a prospective study of recipients of transfusion?

A. Yes, yes. But -- yes, that's right, that's correct.

Q. There is a logic to what is said, I think, in the passage?

A. Yes.
Q. Sir, I have a few more documents. It may be convenient to adjourn.

THE CHAIRMAN: I would like to get a feel, please, for the sort of time that's required when you say you have a few more documents, because I know that Professor James has got one or two questions. Are we going to go over the range of documents that we have seen already in this context?

MR MACKENZIE: We perhaps have five or six.

THE CHAIRMAN: We will see whether we can pick up.

MR DI ROLLO: Yes, it is.

THE CHAIRMAN: I imagine, Mr Dawson that you have quite a lot of questions that you do wish to ask Dr MacDonald?

MR DAWSON: No, I don't.

THE CHAIRMAN: How disappointing. He seems to be able to answer, Mr Dawson. But you do not think you are going to take time on it? Very well. If we can start just a little bit earlier, it might help me solve some other problems.

(1.03 pm)

(The short adjournment)

(1.56 pm)

THE CHAIRMAN: Mr Mackenzie?

MR MACKENZIE: Thank you, sir. Good afternoon, Dr MacDonald. Before I go on to look at some more
documents, could I ask, please, what steps were taken by
yourself and your fellow medical officers to keep up to
date in developments in medicine?
A. Mainly, I think, we were dependent on reading journals,
sometimes attending meetings that would be organised by
Royal Colleges, universities. To be fair, it turned
out -- it did turn out to be rather difficult in
practice. The meeting you wanted to be at in Edinburgh
would crop up on a day you had to go to London, that
sort of thing. It was difficult, but we did try.
Q. Which journals did you read yourself?
A. BMJ obviously, The Lancet, several public health
journals.
Q. Did you expect your medical officers to read those
journals too?
A. Yes, and perhaps others that they were particularly
interested in and I wasn't.
Q. Thank you. Returning to the documents, please, the next
document is [SGH0028142]. If we go to page 2, you will
see the date and the author. We will see this is a note
by Dr Forrester of 12 June 1986. If we go back to
page 1, I think you have had a chance to look at this
before, Dr MacDonald, I think it's referred to in one of
your statements. I'm interested in paragraph 5,
please --
Q. -- where Dr Forrester sets out:

"The condition is not as a rule serious, and most of the cases detected have not even been jaundiced. There may however be a tendency for it to become chronic and the long-term outlook is inevitably not yet known. The case fatality rate is estimated in a textbook consulted by Dr Dan Reid at less than 0.1 per cent, except in pregnant women ..."

I did wonder, doctor, whether it would have been better if that narration of the seriousness of the disease had included the possibility of progression to cirrhosis?

A. Yes, I think it would.

Q. We saw the extract from Mollison before lunch --

A. Yes.

Q. -- and I don't for one second suggest that there was common agreement among the medical profession, certainly in the first half of the 1980s, about the risk of cirrhosis. But, certainly in Mollison in 1983, a risk of cirrhosis is reported from studies?

A. Yes.

Q. Thank you. The next document, please, is [SGH0028146]. This is a memorandum from Dr Scott, of 16 October 1986, to Dr Forrester and Mr Murray. On the question of NANBH
screening Dr Scott writes:

"I would like to know where this stands. CMO DHSS is worried that if we go ahead England and Wales will have to follow suit.

"I think there must be consultation with DHSS before we agree to provide funds for this screening."

The impression one has from the document, doctor, is that this was something between the CMO in England and Dr Scott. Do you have any recollection of being involved in this exchange?

A. No, but I think I have seen somewhere else in the documents that I have looked at recently that it was one of the medical staff, not the CMO himself, in DHSS who indicated that CMO DHSS was worried. I'm not sure where I saw that but I think that was probably -- I don't -- where are we? 1986, yes. I'm pretty sure that if the CMO DHSS had been doing it personally, he would have done it to me.

Q. Yes. In terms of the relationship between the SHHD and DHSS, what's perhaps interesting is the reference to:

"The CMO DHSS is worried that if we [Scotland] go ahead, England and Wales we have to follow suit."

So there certainly seems to have been some apprehension in England that Scotland might actually go ahead and introduce testing unilaterally?
A. I think we would need to look at other papers, but there was indeed such an impression. I think that, if my recollection from other papers is correct, this was because Professor Cash and the Scottish regional directors were pushing this so hard and I think my colleagues in SHHD really had some difficulty in persuading DHSS that their opinion wasn't necessarily ours.

Q. But in terms of the question, could Scotland have gone ahead and introduced testing unilaterally? Certainly it appears from this minute that officials in DHSS took view that, as an option that, at least in theory, was open to Scotland?

A. Yes, they may have seen this as an option but, following on from the sort of discussion we had this morning, I think it would have been a very theoretical option. I think I probably ought to say that perhaps we had a better understanding of where the Scottish Office stood in relation to Whitehall departments than the Whitehall departments sometimes had.

Q. I understand. Simply following on from that, when Dr Scott states:

"I think there must be consultation with DHSS before we agree to provide funds for this screening."

Would you go further and say that there must be the
agreement of DHSS or do you think, "Consultation", is correct?

A. I think I would -- well, I think it's quite fair on Dr Scott's part to phrase it that way. I would think he probably had in mind agreement, and that would certainly have been in my mind.

Q. I understand. The next document, please, is [SGH0031657]. This is just a short document from Dr Forrester of 26 January 1987. It's headed, "Material for PMO report."

A. Yes.

Q. Can you help us: what were PMO reports? How often did they take place and who were they to?

A. They were monthly reports. Did we touch on it? I mentioned this in the first paper you looked at this morning.

Q. Yes.

A. MOs and SMOs had to produce every month a report saying what they had been doing during the month, not a detailed exposition, but just so that DCMOs and CMO could pick up any points they wanted to. The procedure was that the MOs and SMOs handed these into the PMOs who collated them and put the thing forward. So I think this particular document would have been Dr Forrester's contribution to Dr McIntyre's PMO report at some --
whatever the date was.

Q. These PMO reports would keep the CMO and DCMO informed of the issues which medical officer staff were considering?

A. Exactly and also it kept other PMOs because they also saw them. One of the things we were always careful to try and catch is if one PMO group had picked up something that had some relevance to another group and they perhaps hadn't picked it up.

Q. Thank you. Now, we can see under paragraph 2, "Blood transfusion and non-A non-B Hepatitis (Dr Forrester)":

"This 'hepatitis' is a residual rag bag when Hepatitis B and Hepatitis A are excluded and consequently no specific test can detect it. It is relatively benign."

The point, "It is relatively benign", is perhaps a fuller narration of the seriousness of the disease in the Mollison extract we looked at. In particular firstly the tendency for half or more patients to have chronically elevated, fluctuating ALT levels and secondly, at least the possibility in some patients of cirrhosis.

A. Yes.

Q. When the CMO -- rather, when the principal medical officer, the deputy chief medical officer or yourself,
as chief medical officer, read a statement such as that, "It is relatively benign," would either yourself, your deputy or the principal medical officer have been expected to have the fuller knowledge about the disease?

A. Not necessarily but -- I mean, I can't say what this may have stimulated, if it did.

Q. I think it just -- it's a snapshot and really no more than that perhaps in capturing at least the view of a senior medical officer in relation to the potential seriousness of the disease. What I'm interested in exploring is whether -- to what extent that may influence the views of those higher up as to the potential seriousness of the disease?

A. What was the date of this, by the way?

Q. That was 26 January 1987.

A. 1987, yes, early 1987. I'm not just quite sure of where we would have stood at that point. Again I'm not -- this was -- this is obviously his contribution. I can't recall what may have happened.

Q. Yes. Put it this way, trying to look at things in a different way: it must at least be possible that Dr McIntyre, Dr Scott and yourself had your own views, perhaps from your own reading, as to the potential seriousness of NANBH. Is that true as a possibility, at least?
A. I think it is possible -- it is possible that we all might, but I think it's more likely that Dr McIntyre, because he was a PMO of the group that worked with this, would have been a little more up-to-date, if that's the right phrase, than certainly I would probably have been at that stage.

Q. We may come back to that a little but the next document, please, is [SGH0016653]. These are the minutes, Dr MacDonald, of a meeting of the transfusion directors in Scotland on 3 March 1987. Dr Forrester was in attendance. We can very briefly, I think, go to page 6657 please and under paragraph (f) at the bottom, "Surrogate testing for NANB" picks up the reconvening of the working party in transfusion-associated hepatitis. Over the page, please, we can see the top paragraph:

"It was noted that some commercial plasma collectors and non-profit blood collectors in the US had begun surrogate testing ..."

Further down:

"The directors discussed the options open to Scotland and agreed the following:

"To recommend to the SHHD that surrogate testing for NANB should be implemented with effect from 1 April 1988 as a national development requiring strictly new funding."

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I'm not sure if you can recall, doctor, but do you remember there coming a time when you knew the SNBTS directors had recommended that surrogate testing should be introduced?

A. Yes, I think I did. I can't be more precise than that. I think it's one of the things that Dr Scott probably, Dr McIntyre, if the opportunity arose, might have made a point of telling me, because it obviously was going to have major repercussions.

Q. Yes. Is such a recommendation something which you, as the chief medical officer, would have expected to be told about?

A. Yes, I think so.

Q. How would you have been told? Would there have been a particular procedure or could there have been a variety of ways for that to have happened?

A. It could have happened by Dr Scott or Dr McIntyre copying this paper to me. It could have been done by quoting that particular item. I think it's more likely that they would have come into my room and told me verbally.

Q. I suppose as well -- we made mention before lunch to the Monday meetings, chaired by the CMO. I suppose that may have been an opportunity and equally the monthly reporting by the PMOs. That may have been an
opportunity for that as well?

A. It may have been, yes.

Q. But, in any event, at some point you did become aware that this recommendation had been made?

A. Yes.

Q. Thank you. The next document, please, moving on is [SGH0028127]. Over the page, please. We can see this is Dr McIntyre's note of the memorandum of 6 April 1987 and back to page 1, please. We can see in the top left-hand corner, it's addressed to Dr Scott and others but I think your name does not appear there, Dr MacDonald?

A. No.

Q. Is this another example of the issue of surrogate testing being dealt with on a day to day level by those officers beneath you?

A. Yes.

Q. We can see the heading, "Scottish participation in UK research project on transfusion-associated non-A non-B Hepatitis".

Over the page, please -- I'm sorry, doctor, have you had a chance to read this note before?

A. I'm sure I have, yes.

Q. Please take two minutes just to go through it. (Pause).

A. Yes, I'm sure I have seen this one.
Q. We can then go over the page as well, please.
A. Yes.

Q. Then the second paragraph:

"The directors of the SNBTS are unanimous, and are now pressing fairly strongly that this screening should be instituted ... Before embarking on such an expensive programme it would seem logical to participate in the proposed research and to delay any further action until the results of this were known."

So it seems to be this is a minute in which Dr McIntyre is suggesting that there should be further research first, before the introduction of further testing, and seeks the views of various colleagues.

Really two points occurred to me, firstly that there doesn't seem to be any mention that to determine actual prevalence, one would require to follow up recipients and the study wasn't designed to do that. That was the first point that occurred. Secondly, there seems no discussion of the potential seriousness of non-A non-B Hepatitis and really the question is whether those two points should have been included in the minute to allow fully informed decisions to be taken?

A. Can we just go back? At what point did it exclude or not include recipients?

Q. Yes. When the UK working party on transfusion
associated hepatitis was reconvened in November 1986, the members of that working party -- so it was the transfusionists themselves -- proposed that the UK multi-centre study into surrogate testing should only follow up donors.

A. Hm-mm.

Q. So it was the UK working party themselves, which proposed that study restricted to donors. Dr McIntyre's note, which we looking at, really is concerned with that proposal from the UK transfusionists to study donors.

A. Yes, I'm sorry, I'm still not quite grasping the point, I'm sorry.

Q. Yes, at the end of 1986 -- put it this way -- start again. In the early 1980s, it had been proposed, by Dr McClelland, that there should be a prospective study along the lines of the American study, following up donors and recipients to give an indication of the prevalence of post-transfusion hepatitis in the UK.

Come the end of 1986, the UK transfusionists meet again, and the working party, and it's considered, I think, impractical to carry out a prospective study of recipients and therefore the working group suggests restricting a prospective follow-up study to donors only.

A. Yes.
Q. So that's all of the background. We had looked at the extract of Mollison before lunch where the author had set out that, to determine the true incidence of post-transfusion hepatitis, a prospective study is required; a prospective study of recipients.

But come late 1986, when the transfusionists meet up again and now propose to only follow up donors, I just wonder whether the SHHD medical officers at that stage should have said: what's the point of such a study, without including recipients?

A. Yes, I can see the point of the study might have been to ascertain the amount of -- the state of infection among donors. I think I saw a reference somewhere -- yes, I think I did -- to the fact that -- did somebody not try to ascertain how feasible it would have been? The thing is that recipients may disappear, there are patients in hospital who will be discharged.

Donors on the whole will tend not to disappear. Once a donor, they very often continue to be donors and even if they are not, they are the kind of people who are not flitting around the country. Patients discharged from hospital quite often -- from the point of view of tracing -- disappear. I'm sure I have seen a reference to this at one point.

Q. One can fully understand the practical difficulties of
trying to undertake detailed, regular, follow-up of recipients. I think Dr McClelland's position ultimately to us was that such a study, involving detailed follow-up of recipients, would have been possible but it would have required approval and support from the very highest level, ie of government, with funding to match it as well.

I don't think it was the case that the SHHD ever proposed or suggested a prospective, large follow-up study of recipients, I don't think.

A. No, I think that's right.

Q. In a way perhaps, looking at this memo, are we back a little to the position we discussed before lunch of the SHHD medical officer -- as to some extent a generalist, relying on the expertise of others. So when it late 1986 one has the expert transfusionist group recommending a study of donors, then it may be -- I don't know, it may be to some extent the SHHD medical officers would at least defer to some extent to those experts.

A. Yes, but I would hope not uncritically.

Q. That's the point, I think. If one looks at Mollison, saying that to determine the true incidence one must follow up recipients, one doesn't, I think, see that logic or reasoning in this memo.
A. Well, Mollison may have said that, but I would have thought it warranted some further consideration. I see the practical difficulties. I'm sure that I did see some effort to establish how feasible it would be and the answer was that so many of the people disappeared after they left. We would try and trace them through their old address and they are gone, or they live in a different part of the country.

Q. The other point I suggested, doctor, was missing from this minute was any discussion of the potential seriousness of the NANBH and in particular the risk of cirrhosis. Is that a matter which ideally should have been included?

A. Well, it wouldn't have been amiss to include it, but what you are perhaps suggesting is that, if the condition is serious, we should introduce a screening method in which we don't have any great confidence. If the condition was less serious, that would perhaps not be so objectionable but -- I don't really follow that. The screening method is either worth doing or it's not worth doing.

You may want to tease this out a bit more but I think the general view is that it -- the screening method was not really good enough.

Q. Yes. I think we discussed before lunch there may be
a number of factors one ought to take into account in
considering whether to include such screening and one
would certainly have been the reliability of the test --
A. Yes.
Q. -- in detecting true positive and true negatives. It
does seem to me that that cannot be the only factor;
there must be other factors, presumably including the
prevalence of the disease in one's population and the
likely seriousness of the disease. There must be other
relevant factors, do you not agree?
A. I think one has to be a little careful about the
seriousness of the disease. I don't think it's in the
same sort of bracket as the levels of infection in the
population.
Q. I see. So you may accept seriousness as a relevant
factor but one with less weight, perhaps even much less
weight, than the other factors?
A. I would say so. We have seen sometimes the effect of
introducing screening methods and if the screening
method itself is not good, it may create more problems.
You see, the thing we come back to -- I know you are
trying to look at it in a particular way -- but come
back to is that this particular screening method was
certainly going to throw up problems as far as the donor
population was concerned. You really have to make sure
you give enough weight to that.

Q. Yes. The next document, please, is [SCH0024672]. If we go over the page, please, we will see it's a minute from Dr Forrester, 30 August 1988. Back to page 1, please, this was addressed to yourself, Dr MacDonald, as chief medical officer --

A. Yes.

Q. -- and copied in to others. The point that concerns us is not paragraph 1 -- we have seen that in a different topic. Under paragraph 2, the details don't concern us of the commercial Factor VIII made by Alpha but, over the page, the final paragraph on page 2 in paragraph (e):

"We cannot prudently make much of the point, but this particular hepatitis is so benign, at least in the short term, that evidence of transmission has to be specially sought, the patient not being ill at all in the ordinary sense."

It's really a question of whether that paragraph accurately sums up the state of knowledge of the seriousness of the disease, as at August 1988?

A. Well, Dr Forrester did include the phrase, "At least in the short term".

Q. Would you have understood, on receipt of that minute, that firstly half, if not more, of patients with the
A disease suffered chronically elevated fluctuating ALT levels and secondly, that for some patients at least, there was a risk of cirrhosis?

A. Sorry, I don't think that particular paragraph -- it really excludes that. It's specifically about, "At least in the short term".

Q. Put it this way, doctor: it's quite hard for us, as outsiders, to get a feel for what the perception was among medical officers in the SHHD as regards the potential seriousness of hepatitis because all we have to go on, of course, are the documents, the records. One doesn't tend to see a particularly full explanation or account of the potential seriousness of the disease; rather, we have quite short comments such as this. So really what I wonder is whether these short comments such as this do accurately set out the understanding or view of medical officers at the time as to the potential seriousness of the condition or whether I'm missing something, whether there was a greater awareness that isn't necessarily set out in the documents?

A. I think there was a greater awareness but I come back to the point: I don't think Dr Forrester was touching on that, but that doesn't mean to say that he wasn't aware of it.
Q. Okay. There are three final documents, please. Firstly [LIT0010328]. If we look, this is the letter, published in The Lancet -- the top of the page, please. We can see the date is 4 July 1987. If we go over the page, please, we can see the authors are the SNBTS directors, including Dr Perry. Back to page 1, please. I take it, doctor, that is a letter that you will have seen, at least in the run-up to the Inquiry?

A. I think I have -- yes. Yes.

Q. The title of the letter:

"Testing blood donors for non-A non-B Hepatitis: irrational, perhaps, but inescapable."

In short, the SNBTS directors set out that the time has now passed for a full -- a large study into -- a prospective study into surrogate testing and that the introduction of surrogate marker testing is now virtually inescapable for three reasons. Do you remember seeing or becoming aware of this letter at the time?

A. I really can't say.

Q. One reason, the first reason why such testing is virtually inescapable is setting -- is reference to the new strict product liability legislation coming into force.

A. Yes.
Q. Do you have any recollection as to whether that was considered by the medical officers in SHHD in their wider consideration of whether surrogate testing should be introduced?

A. I wasn't involved in that. I'm sure that Dr McIntyre and probably -- yes, I think Dr Scott also would have been aware of that. But I think it was an issue on which the chief pharmacist was taking the lead. Of course, it was very much a matter on which we needed legal advice.

I have never quite -- it may be remiss on my part but I have never quite established what advice had been received before this particular statement, for example, had been made. Certainly something that had to be taken into account.

Q. Did you consider it was a matter for your department to take legal advice on this legislation or was that something you left to the chief pharmacist's office?

A. Well, the chief pharmacist was part of our department. So that wasn't really a distinction.

Q. Yes. Do you remember ever taking legal advice on the new legislation?

A. I don't, no.

Q. Do you know whether your department did -- whether your medical officers did?
A. I don't know whether the medical officers did on their own or whether that was -- may have been sparked off by the chief pharmacist.

Q. Okay. Two final letters, please, doctor. Firstly [SNB0059240]. Doctor, this letter came to light reasonably recently but I think you have seen a copy recently?

A. Yes.

Q. I should say that, in relation to the second paragraph, the Sandoz collaborative agreement, there has been a suggestion that there may have been a misunderstanding.

A. I saw that.

Q. You saw that, yes. It's really the last paragraph of the letter and simply to ask whether you have any comment on the last paragraph?

A. That's the one about --

Q. On page 1, I'm sorry.

A. I think we are on page 2 now, are we?

Q. Yes, I think we will go back in a second. Thank you. I should have said, it's the last paragraph on page 1 --

A. :

"This most recent episode ...?"

Q. It's really the second half of the paragraph, the last three lines.
A. Yes.

Q. Do you have any comment on that?

A. I think that it's rather a sweeping statement and -- well, as you will know, it didn't move me to feel that I had to take the action that Professor Cash wanted me to take.

Q. If we then finally go to your letter of response, it's [SNB0132880]. This is your letter of response to Dr Cash of 8 October 1986.

A. Yes.

Q. We can see what is set out there, including what's set out in the third paragraph.

A. Sorry, which paragraph?

Q. The third paragraph.

A. Oh, yes.

Q. Presumably that sets out your view at the time?

A. Yes. The information about the -- a delay in the AIDS validation studies, I'm sure came from Dr Scott and possibly Dr McIntyre.

Q. Thank you. There is a separate matter in the final paragraph stating:

"Unfortunately, because of the highly unfavourable conditions of service in the Medical Civil Service we have lost some very experienced colleagues, including Dr Bell and at present we are operating four senior
medical officers under strength."

If I pause there, was -- were the staffing levels among medical officers between 1985 and 1988 -- did that create a difficulty for you in any way?

A. Between 1985 and 1988?

Q. Yes.

A. 1985, things weren't too bad but we had -- I may not have expressed that as well as I should. When I say we have lost some experienced colleagues, I wasn't meaning that they had upped and away. People retired and we were looking for replacements. Yes, things were beginning to look difficult by the time I was writing this letter.

Q. Did those -- what, if anything, resulted from these difficulties, in terms of the medical officer service being able to carry out their day to day duties?

A. I think it did put -- it certainly put stress on us. I don't think that we neglected any, one might say essential duty, but I'm sure that there were things we should have looked at and would have looked at if we had been more fully staffed that we didn't do.

Q. Would surrogate testing come within that category?

A. I don't think so.

Q. I suppose we have seen a number of documents where we can see the consideration which was given to that issue.
A. Yes.

Q. Just finally on that point, doctor, were there difficulties in staffing around the time HIV testing was being considered, around the start of 1985?

A. I don't think so. Yes, that was before I was CMO. But I would have been involved in the staffing matters at that point. No, I don't think really think so.

Q. Thank you, Dr MacDonald. Sir, I have no further questions for Dr MacDonald but we were, I think, going to swap seats, if I may, before Mr Dawson were to carry on.

THE CHAIRMAN: Oh, yes, certainly. Do we need to leave or do we think that the exercise can be carried out while we are all here?

MR MACKENZIE: I think we can just carry on, I think.

Questions by MR DAWSON

THE CHAIRMAN: Do you need to get switched on or tooled up or whatever you do there? All right? Ready to go?

Yes, Mr Dawson?

MR DAWSON: Thank you, sir. Good afternoon, Mr Dawson, can you hear me okay?

A. Yes, at the moment, thanks.

Q. I would just like to ask you some questions initially about the roles and responsibilities within SHHD during the time that you were CMO.
Q. As far as blood transfusion matters were concerned, you said earlier that the medical officers working within your department were generalists and not specialists; is that correct?

A. Broadly, yes.

Q. Do I take it from that that, particularly related to blood transfusion, there were no people there with any great experience of blood transfusion?

A. That's correct.

Q. As far as blood transfusion matters were concerned, would it not be accurate to say that you had the benefit of an expert group, from whom to take advice and seek information, namely the SNBTS directors?

A. Yes.

Q. On a complicated issue such as surrogate testing, what efforts would you have expected your officers to have made to understand fully the reasons for the SNBTS directors' recommendation that such testing be implemented?

A. I would have expected them to go into this pretty thoroughly.

Q. Could we have up, please, document [SGH0016653]? You were showed a moment ago the document which contained the recommendation of the SNBTS directors from
3 March 1987. There is very little in that document by way of explanation as to the rationale behind the recommendation. Against a background of very little detail of the rationale behind the recommendation having been given, would you have expected your officers to institute a dialogue with the directors about what their reasons had been?

A. Yes.

Q. That's it there. This is the document I was referring to, just to remind you Dr MacDonald. Sorry about that. This is the document in which we have the recommendation you will see set out in bold there, that:

"Surrogate testing for non-A non-B should be implemented with effect from 1 April 1988."

It might be actually useful to go to the previous page so we can just see the entire section.

You can see that the section is introduced, "Surrogate testing" at the bottom there. There is reference to the UK Working Party on Transfusion-associated Hepatitis and there is a proposal for a study referred to. If we can go over the page again, please and you see there at the top it says -- there is a reference to some commercial plasma collectors and then we have the recommendation set out there.
Would it be fair to say that there is not an awful lot of detail there as to the reasoning behind the recommendation?

A. Well, in one sense, yes, but I think that if you look at that first paragraph that's up there just know, I think that we were conscious of the fact that what the commercial collectors and others were doing was really playing a powerful part in the decision that came later to recommend that we go on with it.

Q. So was it your understanding that that consideration was playing a powerful part in the rationale of the directors?

A. Yes.

Q. Okay. Would it be fair to say that this recommendation came as a surprise to SHHD at this time?

A. I think it probably did come as a surprise at that precise moment, but I think there was an awareness that it was coming, it was on the way. But I think at that point it was a surprise.

Q. Against the background to this recommendation that you have just been discussing there, would you have expected your officers to institute a dialogue with the directors after the recommendation, so that they understood fully what the reasons for the recommendation were?

A. I think they did really -- I think they would really
have understood at that point. I think it was clear that the regional directors shifted their position and I think that it was reasonably clear that that was for what one might call protective reasons.

Q. Can you tell me what you mean by protective reasons?
A. That, because the commercial collectors, and the others in the US, were doing surrogate testing, they would be vulnerable to litigation if they didn't.

Q. So as far as you are concerned, your understanding of the reasoning at that time was really bound up with the issue that's discussed in the top paragraph there, to do with competition between the NHS as a producer of blood products and commercial producers?
A. Yes.

Q. Can you try and explain to me what advantage you understood surrogate testing would have for -- as far as blood products produced for haemophiliacs were concerned?
A. Well, blood products are a particularly interesting one, because I think it would probably have surprisingly little benefit. I think the critical thing to remember here is that, by this time, it wasn't really a question of one infected donor giving one infected bag of blood, which was transfused into one patient; every drop of plasma that could be squeezed out of that was going into
the pool for processing and that really meant that these pools had very substantial numbers going in. That really meant that, unless the screening process could identify and eliminate all the genuine positives, you weren't going to achieve very much.

Q. Were you aware, as chief medical officer at this time, that the thinking of certain of the directors, certainly in the SNBTS, had been influenced heavily by a perception at this time that surrogate testing would have significant safety benefits as far as blood transfusion patients were concerned?

A. When you say blood transfusion patients, are you meaning patients other than the ones being given products?

Q. Yes.

A. No, I don't think I was aware of that and I'm wondering if I should have been.

Q. Okay. I'll just move on to a slightly different area. You have answered a number of questions from Mr Mackenzie on the issue of knowledge surrounding the severity of non-A non-B Hepatitis at around this time.

A. Knowledge affecting the ...?

Q. Knowledge of the severity of non-A non-B Hepatitis.

A. Yes.

Q. Could you just tell me where you would have expected your medical officers to get up-to-date information on
the current understanding of the severity of that condition?

A. I think that the regional directors would -- I would expect -- have kept themselves fairly well informed or tried to. But the more obvious source, I'm sure, would have been physicians who were specialising in the diagnosis and treatment of these patients.

Q. So you would have expected there to be a dialogue between SHHD medical officers and, both haemophilia doctors effectively, and transfusion doctors on that issue?

A. I think something of that kind, yes.

Q. Okay, thank you. Could I just look very briefly --

THE CHAIRMAN: Before you go on, could I ask a question? You have not referred to any possible role of Dr Cash as national medical director in this context. Did he have a role as a source of advice and comment?

A. Oh, certainly, yes. He would be the one who would -- he would convey the views of the other directors, but add a view of his own.

THE CHAIRMAN: That's why I'm asking because I think Mr Dawson, and indeed I think Mr Mackenzie, has taken you directly to the transfusion directors and the haemophilia directors and I would like to make sure that we take in the role of Dr Cash or someone holding his
A. Yes, be that would be essential. In fact, the position of national medical director was created around -- I think it was 1973, just before the reorganisation and the Blood Transfusion Service became part of the CSA. Part of the reason for doing that was to have a figure in that position, to whom we could turn.

THE CHAIRMAN: You might like to ask about what level the contact would be, Mr Dawson. I'm finding it difficult to shout at Dr MacDonald, but I think it's reasonably clear now why I'm interfering.

MR DAWSON: Yes, indeed, sir. What -- can you explain what role Professor Or Dr Cash would have had in that dialogue, as far as you are concerned?

A. He would -- I think I would say he would have been really our adviser, although I believe, while I was not involved, I believe he was designated as our consultant adviser and I think he gave that up.

Q. When was that? Do you recall?

A. It must have been -- I think it was getting on towards 1985, I think.

Q. Right. So by the time that we are talking about here, which is really 1986 to 1988, he had given up that official role?

A. No, he didn't have that official role, but he was
obviously the leader of the transfusion directors, as it were.

Q. Did that giving up of that official role change his relationship with you in any way?

A. Not in practice, I wouldn't think.

Q. So he remained an important source of information on these types of matters?

A. Yes.

Q. Could I just refer you to a document which you have seen already, just to remind you of it. It's [SGH0031657]. Hopefully you recall this document, which you looked at earlier?

A. Oh, yes.

Q. If we see at the top, it's entitled, "Material for PMO report". If we scroll down to the bottom we see it is a document which appears to have been prepared by Dr Forrester in January 1987. In particular I just wanted to remind of the passage under paragraph 2, where we seem to have an explanation of blood transfusion and non-A non-B Hepatitis:

"This hepatitis is a residual rag bag when Hepatitis B and Hepatitis A are excluded and consequently no specific test can detect it. It is relatively benign."

Could I just refer to you another document, please.
This is paragraph 9.1 of the preliminary report. I assume you are familiar with the inquiry's preliminary report, Dr MacDonald?

A. Sorry, are we on to something --

Q. Yes, it has not quite come up yet. I'll just wait until it does. I assume you are familiar with the Inquiry's preliminary report, Dr MacDonald?

A. Yes.

Q. Yes. This is an extract from chapter 9, in particular I want to refer you to paragraph 9.1 where there is a summary of the position which has been reached at this stage in the narrative, if you like, which says:

"From about 1985 onwards there appears to have been a growing awareness that non-A non-B Hepatitis (NANB hepatitis) was a potentially serious and progressive disease which could lead, over time, to cirrhosis of the liver, hepatocellular cancer and death."

There is a reference there, number 1, if we just scroll down to the bottom -- I obviously don't want to go into any of these in detail but you would see there, Dr MacDonald, there are a number of references supportive of that proposition and there are a number of articles, in particular, which one finds in The Lancet from 1985. Are these the types of documents to which you would have expected your medical officers to have
regard in keeping themselves up to date, in particular
as regards the perceived severity of non-A non-B
Hepatitis at that time?
A. Yes, I don't think I would have expected them to read
them all. But some of the more accessible ones. But
how much time they would have for this depends -- really
depends on what pressures they were under.
Q. But, as you said earlier, if they didn't have time to
look at these documents, then the SNBTS directors group,
in particular Professor Cash, would be a source of
information --
A. Oh, yes.
Q. -- about this?
A. Yes.
Q. Could we just scroll back up to 9.1. Do you accept that
the summary, which given in 9.1, on the basis of these
documents, appears to be inconsistent with the summary
given by Dr Forrester in the 1987 document we looked at
a moment ago, about the severity of the condition?
A. Can we go back to that, please?
Q. Of course, it's [SGH0031657]. I referred you to the
first paragraph under number 2.
A. Yes. Well, I think perhaps something should be added to
the relatively benign statement to qualify it. Yes,
I think a little more could have been said.
Q. Okay, thank you. Just moving on to a slightly different area. In relation to surrogate testing, there would, would there not, have required to have been a number of practical elements considered before testing could be introduced.

A. Yes.

Q. Do you think that's right?

A. Yes.

Q. I'm thinking, for example, about considerations of training for staff, equipment, measures to replace blood lost to the donor system and, as I think you have mentioned already, potential counselling for donors. These are all things that would have had to have been considered. Is that correct?

A. That's correct. I think counselling is perhaps -- one should elaborate a little more. It's not simply a matter of counselling and advice but there would be a number of donors identified who would have to be referred to a physician, subjected to laboratory tests, reviewed for a period of at least some months, I would have thought, before it would be possible to offer them an opinion as to whether they were infected or not. In other words, whether they were the false positives or genuine positives. Yes, there is quite lot involved in this.
Q. Given that there was quite a lot involved in it, would you have expected to have received, from the SNBTS directors, at about the time of their recommendation, advice and information about these practical areas?

A. I would -- yes, I would have expected them to have raised the issue. I think they might have done it by saying to us, "You will need to do something about this".

Q. In the absence of any information or view on these areas from the directors, would you have expected your medical officers to seek out such information and views from the SNBTS people?

A. I think that would -- I think that would depend on where we thought we were going. Yes, you are right, but I think that it was by no means clear that we were going to go down that road.

Q. Okay, thank you. Could I just take you to another document, please? It's [PEN0171554]. Could I just explain to you this document you will see the title, which is, "UK Working Party on Transfusion-associated Hepatitis". In the first line we have:

"This working party was established in 1981 and has been active for some time ... It reports to English and Scottish BTS directors ... It was convened on 24 November 1986."
I think this is one of the meetings that you refer to in your own statement. Could we just go over the page, please?

THE CHAIRMAN: Before you do, there is something intriguing in the top right-hand corner. What does that handwritten note say? Does it say something about a precedence book?

A. About, sorry, sir?

THE CHAIRMAN: A precedence book?

A. Yes, yes.

THE CHAIRMAN: I may have misread it, but that's the best guess I can make. If so, it suggests the existence of a document of some significance that I had not heard about otherwise than on this document.

A. I think -- I think it's all clear except for the first word on the second line, I think.

THE CHAIRMAN: I think the first word on the second line might be "I":

"I have note in precedence book ..."

Is my guess.

A. Yes, that doesn't make sense to me, but that's what it looks like, yes.


A. No.
THE CHAIRMAN: Perhaps I have inspired someone to tell me.

Sorry, Mr Dawson for interrupting, but if there is something of significance there, I would like to know what it is.

MR DAWSON: Indeed. You will see at the top this is a memo which is circulated to Dr McIntyre, Dr Scott and Mr Murray. If we go over the page, please, we can see the author of this document was Dr Forrester and its date, 1 December 1986. Could we just scroll further up the page, please? Obviously what we have here is Dr Forrester reporting to other members of the team, if you like, what had happened at the meeting and he says there:

"There was some discussion of the cost of screening all donations (perhaps £8 million). I asked the chairman whether he would advise screening if it were free of cost. He said no.

"The position explicitly reached at the meeting is to recommend research of no great significance or scientific interest because the prospect of research would serve to counter pressure from, for example, haemophiliacs and Haemophilia Directors to embark on an indirect and largely ineffective form of screening, which would also lose us a certain amount of perfectly harmless blood. Figures were produced at the meeting
for the total number of non-A non-B Hepatitis cases encountered either annually among haemophiliacs (A and B) and patients with von Willebrand's disease. The average UK total per year is 35 over the past 6 years but 1985 saw a sharp decline to 11 in all. A proportion of these cases among haemophiliacs and similar patients are asymptomatic."

Would it be fair to say that this is the kind of document that would be relied upon by the SHHD team looking at the issue of surrogate testing in reaching a view as to whether this is a matter which should be put to ministers or not?

A. I don't think that we would have put that kind of wording if we had been going to ministers. I think that it might have been explained in different terms. But we were not, in fact, contemplating going to ministers at that point.

Q. What I'm trying to get at, Dr MacDonald is the information which is contained in this memo, about what happened at that important meeting, would be information which would be part of the department's consideration of whether to go to ministers or not.

A. Well, can I -- sorry, can I just take up this last point about going to ministers? If our view had been that we were going ahead with screening, we would certainly have
gone to ministers and set it all out in a submission.
If our view had been -- as it was at that stage --
either we hadn't made up our minds or we weren't going
to put it forward, we may not have troubled ministers
with that statement, except if we anticipated some
pressure from the Haemophilia Society or from the media.
We might have then said to ministers, "Look, this is
something that we are still looking at, or that "we
don't think we should be pursuing." That's the
question -- that's the point about going to ministers.

I take it this is Dr Forrester reporting faithfully
what he took from that meeting. I think one must be
truthful and say that -- and I think this applied at
that stage to -- certainly to the directors in England
and perhaps a bit later for the ones in Scotland. But
we were really trying to, I think, give ourselves a bit
more time and not be rushed by the pressure coming from
the commercial producers. Then, as far as the Scottish
directors were concerned, that seems to become
overwhelming.

Q. As the former chief medical officer, does the first
sentence of the second paragraph there seem slightly
unusual to you, in particular the suggestion that the
members of this working party, who were scientists,
would recommend research of no great significance or
scientific interest because of the prospect that research would serve to counter pressure from certain groups?

A. I don't think we have actually got the minutes of that meeting, have we? I think one would need to look at what precisely was said and how far this might be a gloss put on it when Dr Forrester was writing up his note.

Q. Just taking it as it's stated there, does it seem to you unusual that that should be the position taken by scientists, effectively putting what appears to be political pressure at the forefront of their thinking?

A. Well, they were more than scientists. I think they had administrative responsibilities as well, most of them.

Perhaps it's unusual to be, shall I say so, frank.

Q. Thank you very much. Just move on to a slightly different area. You have given some evidence already about the fact that, in considering surrogate testing, you would have placed considerable weight on the position of donors. Is that correct?

A. Yes.

Q. It is, is it not, an important part of the responsibilities of the SNBTS directors to consider the position of donors. Is that right?

A. Yes.
Q. Given that, would you have expected your medical officers to seek a clear explanation from the SNBTS directors as to why they had recommended surrogate testing, despite the fact that it might have some impact on donors?

A. I think it's fair that that question should have been put. I'm not quite sure how fair it is to, as it were, to put the onus on our medical staff. We said a moment ago that there was an element of surprise in -- when the Scottish directors came forward with such a firm recommendation.

   I think that point, the one about the safety of the -- rather the interests of the donors should have been come up and -- well, I'm a little surprised. I mean, I had a pretty close association with the regional directors at an earlier stage. To a certain extent it was another generation, but I would have expected that to have emerged and to have been given more attention.

Q. What was the quality of the working relationship between SHHD and SNBTS at this point in time -- talking about late 1986 into 1987?

A. I wasn't directly involved. I think -- I think I would have to say that it was a little difficult.

Q. Could you expand upon that?
A. What I learned, I suppose mostly from casual conversations with colleagues like Dr Scott and Dr McIntyre -- I think they had some difficulty in understanding, at times, just where the regional directors stood and would be a little uncertain if the position that they seemed to be taking was the position they were going to hold. I'm not referring specifically to this surrogate testing issue, but I think there was an uneasy relationship.

Q. If there was this underlying uncertainty, I think you have put it, using that word, would it not have been all the more important that both parties try and understand, as clearly as they possibly can, when recommendations are made, what the nature or the reason for that recommendation is?

A. I think you are obviously right. I think that might not have been altogether easy.

THE CHAIRMAN: I think you have to tell me why, Dr MacDonald. This is not an area where we can be superficial. If there are fundamental problems of relationships that had an impact on decisions that were taken, I suspect, however unwillingly, I have to know about them.

But I can't be doing, in effect, with superficial comments that simply raise the fly, but don't take it
much further: so could you explain, please?

MR DAWSON: The chairman, I think, is looking for more concrete and specific examples of perhaps the difficulties in the working relationship that you have outlined, Dr MacDonald. Can you be of any assistance to him in that regard?

A. I think it's difficult because I wasn't directly -- I wasn't directly involved in this, but ...  

Q. The nature of the proposition which I'm making, which might be of assistance, is to the effect that it does seem that there may have been a degree of communication breakdown between the SNBTS directors and the SHHD at this time. Do you think that's a fair proposition?

A. It's a possibility.

Q. In your view, as the chief medical officer at the time, can you tell me yes or no whether there was such a communication breakdown?

A. I don't think I can be as definite as that.

Q. Right --

THE CHAIRMAN: Mr Dawson, perhaps you can deal with this but there is a difference, of course, between a communication breakdown, which suggests a non-communication of ideas, and a difference of opinion so fundamental that, even if it were communicated directly, it wouldn't have led to
agreement. So I think I have to know whether it's just
non-communication or communication of such differences
of view that they were irreconcilable. What is it we
are talking about? You have raised it and I think
I have to understand where it's going.

MR DAWSON: Absolutely, sir. The chairman has raised
a distinction between a situation where there might be
a lack of communication --

A. Yes.

Q. -- and a situation where there might be difficulties
based on a fundamental difference in opinion and around
the surrogate testing issue, if we deal with the first
area, first of all, was there a lack of communication, which caused problems?

A. I wouldn't -- I don't think there was a lack of --
I don't think there was a lack of communication.
I think that it appeared, certainly on the surface, that
Dr Cash and the regional directors were changing their
position and it appeared to us that they were changing
it for a reason that we would not have regarded as
a proper assessment of the merits of the screening
procedure.

I think that, to try and address the chairman's
point, there was a difficulty -- and I saw it without
being involved in it. There was a difficulty in that
Dr Cash's lines of communication seemed to be a bit erratic. He didn't quite see the distinction between medical issues on which he should have come to the medical staff, as he quite often did, and more administrative issues which he should have channeled through the CSA management to the administrators in the SHHD.

One example is -- so I suppose I was involved slightly. One example is that letter that we had up on the screen two or three minutes ago, to Mr Morison about Dr Forrester. That should have come to me. Why did he put it to Mr Morison? Did he think that by doing that, he would get a different answer from what he was going to get from me? I think that's the kind of thing that caused our medical staff a bit of difficulty.

Q. Do you think that, on the issue of surrogate testing specifically, you felt confident that the medical officers, who were working under you, had a proper and full understanding of the issues surrounding that topic and in particular the reasons for the recommendation made by the SNBTS directors to introduce such testing?

A. Yes, I think so. I'm just -- I'm pausing because I'm just wondering about the point about the influence of the commercial -- the way the commercial producers were behaving. I think they were fairly frank about that,
the regional directors, and I think it was clear that it was protection that they were -- necessary protection in their view.

Q. Sir, I'm planning on moving on to a slightly different area. Are there any remaining questions, I have very few left?

THE CHAIRMAN: It doesn't matter. I don't want anybody being rushed. So we should have a break.

MR DAWSON: Okay.

(3.20 pm)

(Short break)

(3.39 pm)

THE CHAIRMAN: Right, Mr Dawson.

MR DAWSON: Thank you, sir. Dr MacDonald, could I just take you to a document to which you referred just before the break. This is [SNB0059240].

This is the letter to which you have been taken already and to which you referred. It is the one which I think you described as relating to Dr Forrester. Could I just read out some pans of this, please. It's, of course, the letter from Dr Cash to Mr Morison, dated 21 August 1986, in which Dr Cash says:

"Dear Hugh, I must once again request that consideration be given by appropriate colleagues in SHHD to give Dr JM Forrester duties which do not include an
interface with the Scottish transfusion service.

"I cannot begin to understand the problems but the quality of Dr Forrester's remarks at the last PDT subcommittee meeting, in the context of the Sandoz Collaborative Research Agreement, were with regarded by my colleagues, particularly Dr McClelland and myself as bordering on insulting. They also revealed a depth of scientific/medical understand that was remarkably and disturbingly shallow."

Then certain further remarks about the circumstances leading up to the letter. At the bottom of that paragraph Dr Cash says:

"Dr Forrester did not take the trouble to make contact with me in the period between 6 August and the BTS subcommittee to further discuss the matter, and indeed had clearly briefed you, in my opinion, wrongly, for our meeting on 18 August.

"This most recent episode has all the hallmarks of the events which took place in late 1985, which led to a six month delay in the AIDS validation study of our plasma dried blood products. A delay which would have been much longer without the intervention of yourself and the CMO.

"Taken together along with other episodes of only minor importance, I must, with regret, conclude that the
SNBTS directors have little or no confidence in the person who currently provides the vital medical link between the operational part of the Blood Transfusion Service and SHHD."

It appears that Dr Cash is suggesting, first of all, that this is not the first occasion on which he has had to bring up this matter. Secondly, that he and the SNBTS directors had lost confidence in Dr Forrester. Thirdly, that something required to be done about it -- and he makes a suggestion as to what could be done -- and fourthly there is a reference there to an episode relating to lack of communication between Dr Forrester and Dr Cash before briefing Mr Morison.

I take it that, when this letter came to you, you treated this as an extremely serious matter?

A. Yes.

Q. Can you tell me what impact this state of affairs had on the consideration of the issue of surrogate testing?

A. I don't think that I can go into that amount of detail.

No, I really can't relate this precisely to that particular issue.

Q. Perhaps if I put it this way: what steps did you take, after this was brought to your attention, to try and ascertain what practical effect this breakdown in confidence was having on the proper discussion of
important issues, such as surrogate testing?

A. Well, first of all, as stated in my reply, just going to the last paragraph there, Dr Forrester, as we have said -- I said in my letter back, had not been involved in that issue at all. I was -- I felt that the first paragraph was really a very sweeping, extreme sort of statement and I wasn't very confident that I could accept it at face value.

I think there is some doubt now as to whether this was quite as it's set out there from Dr McClelland's evidence, although obviously I didn't know that at the time.

I think that's about all. Having discussed it, obviously, with Dr Scott and Dr McIntyre, I, as you will know from the reply, came to the conclusion that the situation should be monitored and that was done; Dr McIntyre was asked to look at it.

Q. You have focused there on the specific incident which has given rise to this letter, but does this letter not indicate that there is a more general lack of confidence and issue with communication amongst -- between Dr Forrester and the SNBTS, irrespective of this particular issue?

A. I think I would have wanted more information and that was why I thought the situation should be left and
Q. What was the outcome of the monitoring exercise which Dr McIntyre undertook?

A. I don't think any further problem arose.

Q. What was the nature of the monitoring exercise which he undertook?

A. I cannot tell you that.

Q. Why not?

A. That was left to Dr McIntyre.

Q. Thank you. Could we just look at your response for the sake of completeness, a document that we have gone to already. It's [SNB0132880]. Obviously this is your response, which you were taken to earlier --

A. That's right.

Q. -- and I think you were taken to the final paragraph and asked some questions about the highly unfavourable conditions of service in the Medical Civil Service. In the final sentence there you say:

"As you recognise ..."

This is in reference to the second page of Dr Cash's letter:

"... the BTS has never been the simplest organisation to deal with for many, many years and several of us have the scars to prove it."

Can you tell us what it was that you meant by that
A. I think that comment was stimulated by a paragraph on
the second page of Dr Cash's letter, which --

Q. If you would like to go back to that, we certainly can.
It's page 2 of [SNB0059240]. Yes, it's that paragraph
at the top, where it says:

"I would not wish to claim at that all the fault
lies with Dr Forrester. I'm sure he may experience much
difficulty in dealing with certain SNBTS medical
colleagues and, in particular, myself. This I very much
regret but, in our defence, I would wish to emphasise
that we have never had this type of difficulty with
Dr Forrester's predecessors. Faced with this apparently
intractable problem I must therefore conclude that the
only practical option for resolution is an accommodation
by colleagues in SHHD".

I assume that's the paragraph you are referring to?

A. That's the one.

Q. What was it that you meant by the comment at the end of
the reply?

A. Can we go back to that page?

Q. Yes, indeed. Thank you.

A. Yes that really was -- I was simply picking up the point
that -- trying to end on perhaps a lighter, less severe
note, that I had noticed that he had agreed that the BTS
had never been an easy organisation to deal with.
I didn't fasten particularly on the detail of what he
said and I was referring to the fact that I, among
others, had dealt with it for a very long time. It
wasn't simple and it seemed reasonable to pick up that
point.

Q. There doesn't seem to be any attempt at all in that
letter -- and please tell me if I'm getting the wrong
impression -- to try and build any bridges, if you like.
The reference to the past suggests that that wasn't your
intention. Is that a correct interpretation?
A. No, no. Are you still talking about the final sentence?
Q. I'm talking about the entire letter.
A. Yes. I don't think that Dr Cash's letter suggested that
he would have perhaps been receptive, or that it was
necessarily a good time to try to build bridges.

Q. Okay. Thank you. Moving on to a slightly different
area, could I ask you to have a look at document number
[SGH0028126], please? I think this is a document we
have seen already, Dr MacDonald. It's a memo, you can
see there, from Dr Scott to Dr McIntyre, dated
7 April 1987.
A. Yes.

Q. This one is in response to the detailed explanation of
Dr McIntyre's views on surrogate testing in the minute
of the day before, which one can see from the first paragraph.

A. Yes.

Q. In that memo, Dr Scott says in the second paragraph:

"We must do whatever we can to prevent the BTS going ahead with a full-scale introduction of this testing, or at least trying to blackmail us into the provision of funds."

Could you give me some explanation as to why it was that Dr Scott thought it was appropriate that SHHD should do whatever it could to prevent the Blood Transfusion Service going ahead with the introduction of testing?

A. Can you just remind me of the date?


A. Yes, I think that at that -- well, we have been over the ground. We in SHHD were not convinced that we should go ahead with this. We certainly knew that same view was held by DHSS. I think there was a fear, because I think there was some reference to it in something from Dr McIntyre around that time, that Professor Cash might, with the money already available to him, although it had not been -- at least surrogate testing had not been part of the explanation put forward for getting the money -- but that he might with the money available start and
then it would have put pressure on us to continue; put us in the position of having to make a statement to the effect that this couldn't continue.

Q. Can I just refer you back to --

THE CHAIRMAN: Don't leave. The first line refers to "BTS" which I think might either be the United Kingdom organisation on the whole, or the English and Welsh version as distinct from SNBTS. What do you think is referred to here?

A. I'm sure it's SNBTS.

MR DAWSON: I just want to refer you back to a similarly brief memo from about seven months before that, again by Dr Scott. It's [SCH0028146], please. Again, I think this is one that we have looked at before. It's 16 October 1986, so six or seven months before the one we have just rook looked at. It's Dr Scott writing another memo to Dr Forrester and Mr Murray, where he says:

"I should like to know where this stands".

This is obviously surrogate testing:

"CMO DHSS is worried that if we go ahead, England and Wales will have to follow suit."

I asked you a moment ago why it was that you thought that Dr Scott was saying in April 1987 that SHHD should be doing whatever it could to prevent the SNBTS going
ahead with full-scale introduction of the testing?

What I would like to suggest to you is that the reason why he said that you had to do whatever you could to prevent that happening was that the primary consideration of SHHD throughout this period was that there should not be any divergence in practice between England and Wales and Scotland.

A. I don't think that that -- it was an important consideration, certainly, but I think that the staff in SHHD did attempt to form an opinion of their own and that opinion was that we should not go ahead. I think that, if we had agreed with the Scottish directors' view, Dr Scott would have said so, even if the outcome eventually for the sort of reasons that were discussed this morning, had been different.

Q. Okay. Thank you. You were asked some questions by Mr Mackenzie earlier about the position -- which I think is a fair summary of SHHD's position in the middle of 1987 -- that it favoured the research which was being proposed at that time, rather than going ahead with testing. Is that right?

A. Yes.

Q. Do you think that, at that time -- I'm talking about the middle of 1987, after the recommendation had been made by the SNBTS directors -- SHHD medical officers had
a full and proper understanding of the research that was being proposed at that time?

A. It was certainly being put to the chief scientist's organisation, but I would expect them to have seen it -- yes, I would expect them to have that knowledge.

Q. Would I be correct in saying that, one of the reasons why SHHD was in favour of research in a general sense was that such research would give local information from which conclusions might be drawn about the usefulness of surrogate testing?

A. That would have been, certainly, advanced as a reason but I think there was some doubt as to how much research would be needed and for what length of time.

Q. I think as I understand the questioning that Mr Mackenzie was putting forward, the point was trying to propose is that the research being put forward at that time was looking at donors only and not recipients. I think you answer by giving some details of the difficulties that would be associated with recipient-based testing, but is it not the case that, at that time, the research which was being proposed would give one only a very limited understanding of the usefulness of the testing. Therefore the focus on the research in SHHD was perhaps misplaced.

A. I wouldn't have said it was it was misplaced. As you
have said, there was a difficulty about the -- pursuing
the donors. That would certainly have limited the value
of it.

Q. In what respect would it have limited the value of it?
A. We wouldn't have established what the outcome would have
been as far as the recipients were concerned.

Q. What would the impact of that have been as regards
forming conclusions about surrogate testing?
A. I think it would have limited what we would have learned
from it.

Q. I repeat the question: what could it have told you about
surrogate testing and its usefulness?
A. I think it really would have told us, if anything, the
distribution of positives in the donor population.

Q. Okay. Can I just take you to one final document,
please, Dr MacDonald? I don't think this is one we have
looked at before. It's [SGH0028076]. We can see from
the top this is another memo which is going to
Dr Forrester, Dr McIntyre and Dr Forbes in the CSO. If
we just go down to the bottom, it's one written by
Mr Macniven, dated 2 October 1987, so we are moving,
again, a bit further forward in time.

If we look at paragraph one, we can see there that
he is thanking Dr Forrester very much for his helpful
minute of 1 October and he is making reference there to
issues relating to funding.

A. Yes.

Q. In particular, in the second paragraph, he highlights what the purpose of the minute is. He says:

"I am a little anxious about the timescale implied by your minute. I'm very anxious indeed for our decision (on whether or not to put resources into NANB testing) should be properly informed by research evidence. If that evidence justifies testing, then it is very important that we should be able to find the money to start it quickly. If it does not justify testing it is equally important that we should not have allocated money to the SNBTS for the purpose, thereby sterilising it for other uses.

"But I think the worst of all upon worlds is that research cannot get off the ground: I fear that, in those circumstances, we would be subjected to increasingly irresistible pressure to spend the money in any case, for the sake of improving, at any price, the safety of blood and blood products."

I just wanted to ask you in particular about the line in which Mr Macniven says that:

"The worst of all possible worlds is that research cannot get off the ground."

Would it be fair to say, at this stage, that
Mr Macniven, at least, was under the impression that the research would give him some information or justification for surrogate testing?

A. Yes, I think that's clear in that paragraph.

Q. Did that represent the overall understanding of the team, if you like, within SHHD that was dealing with this, as regards what that testing would show?

A. I'm sorry, could you ...?

Q. Do you think that that represented the generally held view amongst the team in SHHD dealing with this, ie that the testing would be useful, as regards giving information on the usefulness of surrogate testing?

A. I'm not sure of the answer to that one.

Q. Right. Was that your understanding of the proposals being made at that stage, as regards testing?

A. I didn't see the proposals at that stage.

Q. Mr Macniven refers there to the fact that if there were no testing:

"We would be subjected to increasingly irresistible pressure to spend the money in any case for the sake of improving (at any price) the safety of blood and blood products."

I'm interested in whether you might be able to help me with the concept of the irresistible pressure that might exist if research didn't go ahead. From whom
would that irresistible pressure have come?

A. Well, I don't know quite what was in Mr Macniven's mind at that point. I don't know how far he was -- can I check the date of this --

Q. Certainly, it's 2 October 1987.

A. 1987, yes. I don't know how far he was aware of the anxiety among the regional directors and Professor Cash that, because of the way in which the commercial producers were apparently moving, we would be compelled to do likewise. I think he might well have been aware of that but I can't really give you a probable answer.

Q. Perhaps that's a matter I could address to Mr Macniven more properly. Could I just, however, put to you one final thing about this minute. One might think, from the details of the second paragraph here, in particular in light of what we have discussed about research, that there was a preoccupation within SHHD with undertaking research, whatever its purpose, at all costs, as a means of putting off making a decision about surrogate testing. I would just like to get your reaction to that suggestion.

A. I think it was reasonable to argue that we didn't have sufficient information to know exactly how it would work out in our population and therefore we should look to the possibility of research. At the same time, I think
it has to be admitted that that would postpone a final
decision inevitably.

Q. But was it the postponement of the final decision that
was really the priority at this time?
A. It certainly -- it is certainly fairly clear that
neither DHSS nor SHHD were persuaded that we should go
ahead with surrogate testing.

Q. Okay, thank you very much, Dr MacDonald. Thank you,
sir. I have no further questions.

THE CHAIRMAN: Mr Anderson?

MR ANDERSON: I have about four questions. Doctor, can you
hear me all right?
A. Yes, it sounds very good, thank you.

Questions by MR ANDERSON

MR ANDERSON: Could we look together at this letter of
Dr August 1986. It's [SNB0059240]. You have told us
that, in August 1986, you were the chief medical officer
is that correct?
A. Yes.

Q. Can you remind me, please, who Mr Morison was?
A. He was one of the two undersecretaries who dealt with
health and he was the one who administratively had
responsibility for the affairs of the
Common Services Agency. He was a member of the
management committee of that agency.
Q. I'm obliged to you. Am I right in thinking that he would be, in the hierarchy, one above you as it were. Would that be right?
A. In no, in hierarchical terms, if one can compare medical and administrative, I was one above him.
Q. I see. You see the letter started:
   "Dear Hugh, I must once again request ..."
A. Yes.
Q. Were you aware of any prior requests?
A. I wasn't. I discussed this, as I said in my reply, with colleagues and the colleagues were obviously Dr Scott and Dr McIntyre. If any previous requests had been made, they would come to them. I don't remember but obviously it's years ago -- I don't remember them telling me that there had been any previous requests. If it had been made on the administrative side, then I'm sure we would have heard about it because, as you saw in this instance Mr Morison immediately passed the letter to me.
   So I really am not aware of what that amounted to.
Q. All right. You see in the final couple of lines, doctor, that what Dr Cash says is:
   "I must, with regret, conclude that the SNBTS directors have little or no confidence in the person who currently provides the vital medical link ..."
Do you see that?

A. Yes, that's the bottom of the third paragraph, yes.

Q. Yes. Would you accept that what this letter appears to seek to address is a question of communication; the link between the SNBTS and the SHHD?

A. Yes, yes, it is clearly about communication.

Q. You see, I think previously you suggested, when it was proposed to you that there may be a communication problem -- you said, "Yes, that's a possibility". But isn't it really quite clear from this that you are dealing with a communication problem? Is that not fair?

A. Yes, I think that's clear.

Q. Leaving aside personalities or questions of fault or whatever, would you accept that this letter on the face of it, appears an attempt by Dr Cash to do something about that problem?

A. Yes.

THE CHAIRMAN: It seems to be an attempt to bury the problem by getting rid of one end of the communication link.

A. Yes.

THE CHAIRMAN: Yes.

MR ANDERSON: Thank you, doctor.

THE CHAIRMAN: Yes, Mr Johnston?

MR JOHNSTON: I don't wish to ask any questions, thank you, sir.
THE CHAIRMAN: Mr Mackenzie?

Dr MacDonald thank you very much indeed. Right.

Now, are we adjourning? Is that it?

MR MACKENZIE: Yes, sir, Dr Dow joins us tomorrow.

(4.08 pm)

(The Inquiry adjourned until 9.30 am the following day)

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