PENROSE INQUIRY
WITNESS STATEMENT
DR J GILLON
Date of Birth 24 April 1949

Penrose Inquiry – request for statistics relating to Transfusion Transmitted HCV

Preamble

In responding to the issues to be included in this statement, I have sourced information from colleagues at Health Protection Scotland (HPS) as well as colleagues in the Regional Transfusion Centres across Scotland and the Microbiology Unit. Some of the information included in this statement was included in the SNBTS paper on Lookback, which was sent to the Inquiry in 2010. In addition I obtained information from the National Hepatitis C Register (HPA Colindale) which holds data on 103 patients identified through the "targeted" lookback procedure required by the Department of Health (DoH) in 1995.

1. **The number of patients treated by the NHS in Scotland known to SNBTS to have contracted hepatitis C as a result of a blood transfusion fall into 3 categories.**

   1.1 **Blood donors HCV positive to end 2009: 867**
   Number stating blood transfusion as only risk factor: 59 (6.8% of total)
   Blood donors found to be positive for antibodies to HCV on routine testing by the SNBTS from 1991 onwards, whose only risk factor for exposure was a history of transfusion.

   Note : Such cases were investigated in order to try to establish whether a source donor could be identified. However, in only 9 of these 59 cases was a date of transfusion given, ranging

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from pre- 1970 to 1981, with one donor transfused in 1981 and 1987.

1.2 Patients identified through the "targeted" lookback procedure required by the DOH in 1995.

Number of patients traced and tested, and shown to be positive for antibodies to HCV : 133

1.3 **Patients reported to SNBTS by clinicians as possible cases of transfusion transmitted hepatitis C.**
After full investigation the following were accepted as "known "cases of transfusion transmitted hepatitis C.

Regional Transfusion Centre to which TT HCV reported:

Glasgow and West of Scotland	6
Edinburgh and East of Scotland	15
Dundee (East of Scotland)	4
Aberdeen (North East Scotland)	3
Inverness (North of Scotland)	0
Total for SNBTS	**28**

Note: It is not always possible to establish the diagnosis of TT HCV with certainty, as frozen sample archives mostly date back only as far as 1986, and it is often not possible to trace the implicated donors for testing. Nevertheless, some such cases are included in the above totals where the circumstantial evidence indicates probable transfusion transmission on the basis that no other risk factor was declared. Some cases of transfusion transmission may not have been classified as such because of the paucity of evidence, e.g. no documentary evidence of transfusion, absence of blood bank or donor records, etc.

1.4 Total number of patients from 1.1, 1.2 and 1.3 : 220

1.5 Following the introduction of HCV donor screening in 1991, certain patients were HCV screened on a regular basis by local virology laboratories. The patient groups included haemophiliacs, bone-marrow transplant recipients, and Renal Dialysis Patients. West of Scotland BTS is aware of 18 bone marrow transplant recipients diagnosed as HCV positive. None is included in the National HCV Register as there was no confirmed or definite date of transmission. The dates of the transfusions were between 1982 and April 1991 and all 18 should be considered as known positive. Identification of the infective donations was considered impossible because of the number of transfusions involved.

A small number of Renal Dialysis Unit patients were identified as HCV positive prior to the National Lookback. These patients may have been infected through blood transfusion but identification of the infective donations was not possible for the same reasons as above, and in these cases the risk of nosocomial infection from other sources was substantial.

2. **The date of transfusion which resulted in each patient contacting hepatitis C.**

2.1 A subset of the 133 patients in 1.2 above were entered into a database of "patients with known date of exposure to HCV" at HPA, Colindale (the National Hepatitis C Register). HPA has provided me with the Scottish component of these data, which are reproduced (fully anonymised) in Appendix 1.

The numbers identified in each year are as follows:

1977	1
1978	0
1979	0
1980	0
1981	0

1982	0
1983	3
1984	4
1985	8
1986	11
1987	9
1988	14
1989	19
1990	15
1991	19
Total	**103**

2.2 As stated in the Note attached to 1.3 above, it was not always possible to establish with certainty the date of transfusion in some of the cases of clinician-reported TT HCV. The most accurate information available for each patient from 1.3 above is shown in Appendix 2.

Earliest known transmission : 1979

Latest known transmission : March 1991

However, one patient (in Aberdeen) received multiple transfusions between 1970 and 1983, with no possibility of identifying the infective donation (see number 22 in Appendix 2).

3. **The blood transfusion service region within which the blood for each transfusion was collected.**

From the data supplied by HPA (the National Hepatitis C Register) the regions in which the blood was collected are as follows:

Glasgow	42
Edinburgh	24
Dundee	21
Aberdeen	10
Inverness	6
Total	**103**

4. **The number of transfusion patients known to have contracted hepatitis C as a result of blood transfusion who are still alive.**
From the data supplied by HPA the number of patients in 3 above known to be alive as at January 2011 is 49 (48%).

5. **The number of transfusion patients known to have contracted hepatitis C as a result of a blood transfusion who have died of hepatitis C or whose death was materially contributed to by hepatitis C.**
Information on the recorded causes of death for 53 out of the 54 patients known to have died (one of which I am advised by HPA was a consular notification for which no cause of death is known) has been supplied to me by the National Hepatitis C Register. The full list of causes is shown in Appendix 3, which is a print out of the information available for the patients on the National HCV Register.
My interpretation of these data is that hepatitis C was the cause of death, or contributed materially to the cause of death, in 8 of the 53 patients for whom causes of death are known.

Estimated cases of transfusion transmitted hepatitis C infection

6. **The number of patients treated by the NHS in Scotland between 1970 and the introduction of hepatitis C screening of blood donors on 1 September 1991 who are estimated as having contracted hepatitis C as a result of a blood transfusion.**
I am unable to provide such estimates as it is outwith the area of my expertise. This may be information which can be provided by HPS. I am aware that Dr B McClelland has provided more information on estimates based upon previous published studies conducted by Soldan et al.

7. **The number of such patients who are estimated to still be alive.**
Please see 6 above.

8. **The number of patients in 6 above whose death is estimated as having been caused or materially contributed to by hepatitis C.**
   Please see 6 above.

Statement of Truth

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

Signed............John Cillo............

Dated............31 January 2011............

PENROSE REQUEST FOR DATA (HCV)

APPENDIX 1: Date of Transfusion (from National HCV Register)

Date of Transfusion	Date of Transfusion
10.08.1985	17.09.1983
18.02.1986	25.07.1987
04.12.1989	17.05.1989
07.05.1987	02.03.1989
18.07.1988	17.05.1984
02.05.1989	05.06.1990
20.01.1988	25.02.1986
20.07.1988	06.03.1985
09.08.1991	03.06.1988
19.09.1990	23.02.1983
24.09.1988	01.05.1986
01.10.1987	11.01.1986
01.08.1991	09.07.1988
31.01.1990	13.06.1989
21.04.1990	12.08.1986
31.10.1989	02.09.1986
29.05.1991	26.01.1987
19.11.1990	12.10.1988
21.05.1985	08.11.1990
18.09.1987	20.07.1991
06.03.1986	07.06.1991
20.06.1990	09.01.1989
17.07.1991	22.04.1991
04.04.1991	23.01.9185
20.09.1988	12.01.1990
19.06.1987	07.08.1990
21.01.1988	16.07.1991
29.01.1987	

Date of Transfusion	Date of Transfusion
08.10.1990	15.04.1990
09.03.1991	06.02.1986
26.01.1991	17.01.1991
13.12.1988	12.08.1990
29.01.1986	14.01.1991
12.06.1987	18.05.1985
26.06.1985	05.08.1989
01.11.1984	16.01.1989
11.06.1983	02.03.1989
29.11.1989	13.04.1989
12.03.1987	18.01.1990
24.05.1991	25.04.1989
20.01.1984	14.08.1990
14.06.1991	15.03.1989
14.06.1985	13.06.1988
11.03.1989	02.02.1988
09.03.1989	17.03.1988
15.12.1984	
26.01.1991	
23.03.1988	
06.11.1990	
28.06.1991	
29.08.1989	
16.01.1986	
01.10.1989	
29.03.1991	
16.11.1977	
30.01.1985	
04.06.1991	
18.06.1989	
16.07.1986	

PENROSE REQUEST FOR DATA (HCV)

APPENDIX 2: Transmission Transmitted Hepatitis C cases identified by clinician reports – dates of transfusion

Patient No.	Date reported to SNBTS	Date of Transfusion
1	10 December 2009	11 January 1990
2	27 May 1992	12 October 1990
3	1995	27 May 1986
4	December 1995	February 1985
5	29 October 1999	1981/1984
6	June 1999	12 January 1991
7	3 April 2004	April 1986
8	May 1999	1 June 1988
9	March 1988	23 October 1987
10	9 August 1994	September 1984
11	2002	1979
12	1998	15 October 1986
13	12 December 2000	5 August 1986
14	3 November 2006	24 July 1980
15	11 October 2007	1980
16	2008	March 1991
17	2006	October 1990
18	2004	January 1991
19	2002	1988
20	2001	1987
21	2000	1987
22	2000	Multiple 1970-1983
23	2001	1987
24	2002	1989
25	2008	January 1991
26	26 September 1991	2 March 1989
27	24 September 1991	1991
28	26 April 2001	24 October 1989