Witness Name: Dr Graham Peter
Arthur Winyard CBE
Statement No.: WITN7606001
Exhibits: None
Dated: 14 /12 /2022

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT
OF
DR GRAHAM PETER ARTHUR WINYARD CBE

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 3 November 2022.

I, Dr Graham Peter Arthur Winyard CBE, will say as follows:

Caveat

While writing this statement, I have become increasingly conscious that because the events that I am being asked about occurred 24-32 years ago, I have very few direct memories of them, even of documents that I myself authored. I have carefully considered all the questions and read the documents supplied and my answers are largely my best attempts to reconstruct what I think I would have intended then, given the times and circumstances, rather than direct memories that add to the material supplied.

Section 1: Introduction

1. Please set out your name, address, date of birth and professional qualifications.

1.1 My name is Dr Graham Peter Arthur Winyard and my address is GRO-C GRO-C. My date of birth is GRO-C 1947.

1.2 I studied medicine at Oxford and the Middlesex Hospital London, graduating in 1971 BM BCh Oxford. I undertook various junior medical posts obtaining the Membership of the Royal College of Physicians in 1975 when I also began specialist training in public health, obtaining Membership of the Faculty of Community Medicine[1] in 1981. I was made a Fellow of the Faculty of Public Health Medicine[2] in 1986 and of the Royal College of Physicians in 1989.

1.3 I was awarded the CBE in 1999 for services to the NHS and was an honorary Professor of Public Health Management at Southampton University from 1999 to my retirement in May 2007.

1.4 After retirement I completed a Masters degree in Buddhist Studies at the School of Oriental and African Studies in London. MA (Religions) 2013.

2. Please set out your employment history with dates if possible, including the various roles and responsibilities that you have held throughout your career.

2.1. 1972-75 - As I mention at paragraph 1.2 above, I held various junior training posts in London, Ipswich and Oxford during this period which led to my obtaining the Membership of the Royal College of Physicians in 1975.

[1] The Faculty of Public Health was originally established in 1972 as the Faculty of Community Medicine.
[2] The Faculty of Community Medicine changed its name to The Faculty of Public Health Medicine and then to the Faculty of Public Health.

2.2. 1975-77 Registrar in Public Health, Buckinghamshire Area Health Authority

2.3. 1977-79 Papua New Guinea Government, Provincial Health Officer Madang Province

2.4. 1979-81 Senior Registrar in Public Health Oxford Regional Health Authority and Lecturer in Public Health, London School of Hygiene and Tropical Medicine (combined post).

2.5. 1982-87 District Medical Officer, Lewisham and North Southwark Health Authority. This post combined the roles of Director of Public Health with Director of Planning and Information.

2.6. 1987-89 Head of the first public health Division at the Department of Health, focused on the NHS and the outcomes of care (on secondment from Lewisham and North Southwark Health Authority. The initial focus of the post was on the implementation of the "Acheson Report" on Public Health in England but this was rapidly overtaken by work on the development and implementation of the white paper "Working for Patients", including leading on the Medical Audit programme.

2.7. 1990-92 Regional Director of Public Health and Regional Medical Director (single post), Wessex Regional Health Authority. My responsibilities are set out in answer to Q6 at paragraphs 6.1-6.4 below.

2.8. 1993-98 Medical Director NHS Executive and Deputy Chief Medical Officer, Department of Health. My responsibilities are set out in answer to Q27 and Q30 at paragraphs 27.1-27.6 and 30.1 below.

2.9. 1999-2007 NHS Postgraduate Dean. During this period I was employed continuously by the Department of Health as part of their NHS regional office structure, although my geographical remit altered as a result of sequential NHS restructurings. Initially I covered the former Wessex region, then Wessex

and the SouthWest, and finally in my last year of employment I set up NHS Education South Central (NESC) covering Wessex and Oxford, as part of the newly formed South Central region.

3. **Please set out your membership, past or present, of any committees, associations, parties, societies or groups relevant to the Inquiry's Terms of Reference, including the dates of your membership and the nature of your involvement.**

3.1. I cannot recall being a member of any groups that were directly and specifically relevant to the Inquiry's Terms of Reference. By virtue of my roles as Regional Director of Public Health and NHS Medical Director, I was involved in many professional meetings from 1990-98 but I have no recollection of any specific discussions on topics relevant to the Inquiry's Terms of Reference.

4. **Please explain how you kept abreast of medical and scientific developments and research in your field when you were at Wessex Regional Health Authority.**

4.1. During 1990 to 1992 I would regularly read professional journals such as the British Medical Journal (BMJ) and The Lancet and attend conferences focused on topics of then current relevance. This was before the advent of formal programmes of continuing professional development or re-accreditation.

5. **Please confirm whether you have provided evidence or have been involved in any other inquiries, investigations, criminal or civil litigation in relation to the human immunodeficiency virus ("HIV") and/or hepatitis B virus ("HBV") and/or hepatitis C virus ("HCV") infections and/or variant Creutzfeldt-Jakob disease ("vCJD") in blood and/or blood products. Please provide details of your involvement and copies of any statements of reports which you provided.**

5.1. To the best of my recollection I have had no such involvement.

Section 2: The Wessex Regional Health Authority and your role there

6. Please describe the roles, functions and responsibilities you had at the Wessex Regional Health Authority ("WRHA") during your period as:

a. Regional Director of Public Health; and

b. Regional Health Administrator

and explain how these changed over time.

6.1. I held the combined post of Regional Director of Public Health ("RDPH") and Regional Medical Director (not Regional Health Administrator) for the Wessex Regional Health Authority from 1990-92. As regards (a) as RDPH I was responsible for both the public health function within Wessex Regional Health Authority and for providing professional leadership to the public health staff working for local District Health Authorities across the region.

6.2. An immediate challenge on my appointment in 1990 was to reconstitute an effective department within the WRHA itself, and to orientate our work to support the developing 'internal market' introduced by the National Health Service and Community Care Act 1990. I achieved this in part by establishing the Wessex Institute of Public Health, in partnership with the University of Southampton, and setting up the regional Development and Evaluation Committee which provided evidence-based advice on the cost effectiveness of health technologies, to the District Health Authorities who were grappling with their new roles as 'purchasers' of healthcare. (This formed the model for the National Institute of Clinical Excellence.)

6.3. I would meet regularly with the local District Directors of Public Health individually and collectively to support and develop ourselves as a professional group.

6.4. As to (b) my role as Regional Medical Director included direct responsibility for:

- Ensuring effective relations with the medical profession across the region, through the regional medical advisory committee system, so that the decisions of the Wessex Regional Health Authority would be informed by appropriate professional advice and that consultant staff would feel that they were being heard by the WRHA. (This had not been felt to have been the position with regard to the Regional Information Strategy, whose perceived failure/ineffectiveness had been central to the departure of the previous Regional Chair and General Manager.)
- The medical staffing department, led by a retired neurosurgeon, which discharged the WRHA's role as employer of all medical consultants working in the region, (apart from those in the Southampton University Hospital). This could occasionally generate high profile, and correspondingly time-consuming issues, where medical professional performance was questioned, which in my time included the prosecution of a local consultant rheumatologist for attempted murder.
- Overseeing the work of the Regional Postgraduate Dean and his department and the work of the newly created Regional Director of Research and Development.

7. **Please describe the organisation of the WRHA during the time you worked there, including:**
    a. **its structure and (in broad terms) its staffing and in particular to whom you were accountable;**
    b. **how the WRHA was funded and how this changed over time;**
    c. **its remit, including the geographical area it covered and the hospitals and haemophilia centres within its area;**
    d. **whether the WRHA was subject to any form of regulation and if so, what;**
    e. **the WRHA's relationship (if any) with the Blood Products Laboratory ("BPL") and any other laboratory involved in the production of blood products or processing of blood.**

7.1. With regard to (a), to the best of my recollection, the Wessex Regional Health Authority would have been reconstituted in line with the provisions of the 1990 NHS and Community Care Act with a Chair (Sir Robin Buchanan) and 5 or 6

non-executive directors, appointed by the Secretary of State, together with the Regional General Manager (Mr Ken Jarrold) and five executive directors of whom I was one. The WRHA met in public and was responsible for all major decisions. The other executive directors were the directors of Finance, Planning, Primary Care and Nursing. There were other senior managers within the WRHA responsible for functions such as Information and IT, Works and Estates and we would meet, to the best of my recollection, perhaps bi-monthly. I was formally accountable to Mr Ken Jarrold, the then Regional General Manager. I do not recall the precise figure but estimate that the WRHA's staffing might have been around 200-300 when I was there.

7.2. As to (b), to the best of my recollection, it was my understanding at the time that each Regional Health Authority was funded by an allocation from the Department of Health (DH) broadly calculated to reflect the relative health needs of the populations of each of the 14 regions within England. At WRHA we would divide out our DH allocation between the District Health Authorities in our region, again on the basis of relative population need. There would also have been numerous specific allocations for various projects and initiatives.

7.3. With regard to (c) the WRHA was one of 14 RHAs covering England. It had overall responsibility for all the health services within its geographical area which consisted of Hampshire, the Isle of Wight, Dorset, Wiltshire and Bath. The WRHA had overall responsibility for all NHS services within our geographical area. I do not recall nor do I have a list of the names or locations of the 20+ hospitals open during the period 1990-1992. The haemophilia centres were at Southampton General Hospital and the Lord Mayer Treloar school.

7.4. The early 1990s were turbulent years for all RHAs as the introduction of the "internal market" transformed their relationships with the local health authorities and hospitals for which they remained responsible. On top of this in Wessex, the end of the 1980s had seen the departure from the WRHA of the previous Regional Chair and General Manager in the wake of a major scandal over the funding and support of an over-ambitious information and

computer strategy. Thus, in the period 1990 to 1992, we were rebuilding the credibility and reputation of the WRHA.

7.5. With regard to (d) I cannot recall any significant regulation affecting our main activities. There may have been some relating to some specialised functions.

7.6. With regard to (e) to the best of my recollection the WRHA had no direct relationships with the BPL nor with any other blood product laboratory. I refer to my answers to Q10 and Q11 below as any relationship is best answered by Dr Boulton.

8. Please describe, as far as you are able, the extent to which the WHRA had regular dealings with the Department of Health and Social Security (later the Department of Health) ("DHSS/DH"), and the nature of such dealings.

8.1. During the period 1990-1992 the WRHA was accountable for its work to the Department of Health through the NHS Executive. There was a formal annual review process in which an NHS Executive team led by a Health Minister met the Regional Chair and his team. To the best of my recollection there were monthly meetings of the NHS Chief Executive and his team with Regional General Managers, while other Regional Chief Officers would meet their NHS Executive counterparts regularly. Within the NHS Executive was a 'regional liaison function' with individual grade 7 civil servants shadowing individual regions.

9. What degree of oversight or influence did the DHSS/DH have over the WRHA?

9.1. It was my understanding at the time that, while WRHA had a degree of statutory independence, there was never any doubt that WRHA was accountable to the Department of Health and obliged to operate within its national policies. Given the plethora of interactions with the DHSS/DH as set out in paragraph 8.1 above, it was relatively easy to know what was expected of us. Ultimately if the performance of the WRHA on a major issue was

deemed unsatisfactory, the Chair and Chief Executive could be removed, as had recently happened over the Regional Information Strategy (see paragraph 7.4 above). The challenge for the WRHA was around how many of those policy aspirations could be delivered within finite financial and management time constraints. This was the main focus of the annual reviews mentioned above at paragraph 8.1.

Section 3: Relationship between WRHA and Wessex Regional Blood Transfusion Centre

10. Please describe the relationship between the WRHA and the Wessex Regional Blood Transfusion Centre. Please set out, as far as you are able, the extent to which you, or others within the WRHA had regular dealings with the Wessex Regional Blood Transfusion Centre and the Regional Transfusion Directors there and explain, in broad terms, the nature of those dealings.

10.1. Although the WRHA had overall responsibility for the Wessex Regional Blood Transfusion Centre, the Centre was seen as largely autonomous from the WRHA on a day to day basis with the WRHA playing a facilitatory role when needed. During 1990-1992 I was probably the principal point of contact in the WRHA for Dr Boulton, the then Director of the Wessex Regional Blood Transfusion Centre, providing general support and guidance, but to the best of my recollection was in no sense Dr Boulton's line manager. The only issue I directly remember being actively involved in was the need to remove a particular senior manager at the Regional Blood Transfusion Centre who was seen to be causing problems. Dr Boulton would also have had interactions with the Regional General Manager, and with the Regional Treasurer when financial issues such as the impact of cross-charging policies arose.

11. Please explain, as far as you are able, the extent to which you, or the WRHA had oversight and/or influence over the policies, practices and decisions of

the Wessex Regional Blood Transfusion Centre, and the extent to which the Wessex Regional Blood Transfusion Centre was autonomous.

11.1. I refer to my answer at 10 above. It was my understanding at the time that the WRHA would not, in general, have attempted to influence the working policies and practices of the WRTC which was seen as part of the National Blood Service even before that was formalised with the creation of the National Blood Authority in 1993. Much of the WRTC's work would have been regarded by the WRHA as analogous to that of other clinical specialities in which the WRHA did not attempt to interfere.

12. Please explain how funding decisions were taken by the WRHA in relation to the Wessex Regional Blood Transfusion Centre.

12.1. I have no recollection of the WRHA taking funding decisions related to the WRTC. However, I see from Dr Boulton's evidence (**WITN3456002**, page 90, paragraph 266) that we did provide £2m capital funding for redevelopment which would have formed part of the regional capital programme and required formal WRHA approval. Other financial issues, such as the introduction of cross-charging for blood products would have been dealt with by the Regional Treasurer, Mr Len Wright and his staff.

13. As far as you can recall, did the Wessex Regional Blood Transfusion Centre/its director(s) Dr Donald Smith and Dr Frank Boulton, make requests to the WRHA for further funding at any stage during your time at the WRHA?

13.1. I had no dealings with Dr Smith who had retired before my arrival and cannot recall any specific requests from Dr Boulton for funding. I refer also to my answer to Q12 above.

Section 4: Role played by the WRHA plasma procurement at Wessex Regional Blood Transfusion Centre

14. As far as you are aware, how was plasma procurement at Wessex Regional Blood Transfusion Centre funded throughout the 1980s? Please describe the role played by you or the WRHA in this.

14.1. I was only appointed to the WRHA in 1990 so cannot comment.

15. As far as you are aware, did the Wessex Regional Blood Transfusion Centre have targets for the amount of plasma that had to be collected by the centre? If so,

a) Did the WRHA have any involvement in setting these targets?
b) What was the purpose of the targets?
c) Was extra support and funding provided to the Wessex Regional Blood Transfusion Centre by the WRHA to assist them in meeting these targets?
d) What were the consequences if the targets were not met?
e) Were there any benefits to the Wessex Regional Blood Transfusion Centre if the targets were exceeded?

15.1. I have no memory of this being an issue at the time; indeed, it is only through reading Dr Boulton's evidence (**WITN3456002** pages 58-59, paragraphs 168-170) in response to similar questions that I have become aware of this target setting. This is something that I would expect to have been handled through the national blood service networks without any involvement by the WRHA. I refer also to my answers to Q10, Q11 and Q12 above.

16. In 1989, cross-charging was introduced in England and Wales to act as an incentive for RTCs to increase the amount of plasma being sent to BPL (see NHBT0057426_002).

a. As far as you are aware, what effect (if any) did cross-charging have on the plasma supply in the Wessex region?

b. What role, if any, did the WRHA play in the introduction of cross-charging?

16.1. I have no memory of, or access to information on, the impact of cross-charging on plasma supply in Wessex. The WRHA finance function must have been involved in the introduction of cross-charging which I note from NHBT0057426_002 was developed in partnership with the Regional Treasurer group. This would have all been happening as a small part of the complete upheaval of NHS financial mechanisms as a consequence of the introduction of the internal market established by National Health Service and Community Care Act 1990.

Section 5: Arrangements for obtaining and allocating factor concentrates at WRHA

17. **Please set out your understanding of the arrangements in place in the Wessex region for the purchase and holding, and the allocation to haemophilia centres within the region, of (a) NHS factor concentrates and (b) imported commercial factor concentrates.** In particular:
    - **(a) Please identify which haemophilia centres were supplied with such products by the Wessex Regional Blood Transfusion Centre/the WRHA and over what period of time.**
    - **(b) Please explain how the haemophilia centres within the region were funded and the role played by the WRHA in funding.**
    - **(c) Please describe the role played by the WRHA in relation to the purchase, holding and distribution of factor concentrates.**

17.1. My only knowledge of these matters has been derived from reading Dr Frank Boulton's witness statement (**WITN3456002** page 66, paragraph 188, page 68 paragraph 195 and page 70, paragraph 206) and testimony (INQY 4 February 2022). Wessex RHA did not, to my knowledge, play any role in supplying haemophilia centres, nor in purchasing, holding or distributing NHS factor concentrates or imported commercial factor concentrates. I refer also to my answers to Q10 -Q16 above.

18. **As far as you are aware, were arrangements for the purchase, holding, and distribution of (a) NHS factor concentrates and (b) imported commercial factor concentrates similar in other regions, or was there a degree of regional differentiation (and if so what)?**

18.1. I have no relevant direct knowledge on these questions. This is a question best asked of Dr Boulton, the former Director of the Wessex Regional Blood Transfusion Centre.

19. **Did the WRHA contract directly with any pharmaceutical company for the purchase of factor concentrates? If so, please describe:**

    a. **how and by whom the decision was made to contract with the particular pharmaceutical company;**
    b. **the factors taken into account when determining whether to contract with one pharmaceutical company over another.**

19.1. To the best of my recollection the Wessex RHA did not undertake such contracting.

20. **Did the WRHA seek to exercise any influence over, or provide any advice or guidance in relation to, the decisions about the choice of product used to treat patients in haemophilia centres and/or hospitals, for example the choice between one imported factor concentrate over another?**

20.1. We would not have considered doing this as we did not have the necessary scientific or professional knowledge or expertise.

Section 6: Meetings of various committees

21. **The Inquiry understands that the Secretary of State for Health held regular meetings with the Chairs of the Regional Health Authorities. Please explain your understanding of the purpose of these meetings and the frequency with which they were held and describe any involvement you had in them.**

21.1. I had no involvement in these meetings but understood from comments made by the Wessex Regional Authority Chair that they were largely to keep the participants mutually informed. I cannot recall their frequency.

21.2. It is my recollection that the most important channel of communication and control of Regional Health Authorities was the approximately monthly meetings between the NHS Chief Executive and Regional General Managers.

Section 7: Reduction of risk of infections while at WRHA

Introduction of HIV testing

22. What funding and operational support was provided by the WRHA to the Wessex Regional Blood Transfusion Centre to aid in the implementation of testing in 1985? Did this have an effect on Wessex Regional Blood Transfusion Centre's ability or willingness to commence testing earlier?

22.1. I was not in post until 1990 so cannot comment.

Introduction of anti-HCV screening

23. What funding and operational support was provided to Wessex Regional Blood Transfusion Centre to aid in the implementation of anti-HCV testing in 1991? Did this have an effect on Wessex Regional Blood Transfusion Centre's ability or willingness to commence testing earlier? You may be assisted by NHBT0000193_081, NHBT0000026_009 (p36-39), NHBT0144306_001.

23.1. I am afraid that I remember nothing of the WRHA's involvement in this issue though I note the following comment in Dr Boulton's witness statement (**WITN3456002** page 169, paragraph 462))

"On the other hand, while it had responsibility for managing the WRTC, the WRHA was supportive — bailing out, for example, the costs of introducing

the screening tests for HCV when introduced in 1991 and funding the essential refurbishment of the WRTC facilities."

Such issues would have formed part of routine WRHA business, given the scale of changes requiring active WRHA involvement in the implementation of the 1990 NHS and Community Care Act.

General

24. Please outline any other steps or actions taken by the WRHA during the time you worked there to reduce the risk to recipients of blood or blood products of being infected with a transfusion transmitted infection.

24.1. I can recall no such activities and would be surprised if the WRHA had undertaken any as this would have been seen in that era (1990-1992) as very much a matter of clinical practice and not, therefore, a matter for the WRHA, which had no claim to any relevant professional expertise.

Section 8: "Lookback" programmes at Wessex Regional Blood Transfusion Centre

HIV

25. Were you involved in setting up any national or local HIV "Lookback" programmes during your time at the WRHA? If so, please describe this process and your role in it and how it was funded.

25.1. I do not believe I had any such involvement and can certainly not recall any.

HCV

26. Were you involved in setting up any HCV "Lookback" programmes during your time at the WRHA? If so, please describe this process and your role in it and how it was funded.

26.1. I do not believe I had any such involvement and can certainly not recall any.

Section 9: Your role as Medical Director, NHS Executive and as Deputy Chief Medical Officer

27. Please describe your role and responsibilities as Medical Director of the NHS Executive.

27.1. My role of Medical Director of the NHS Executive was inextricably linked with being a Deputy Chief Medical Officer ("DCMO") so to avoid confusion this is also an answer to Question 30.

27.2. As Medical Director I was accountable to the Chief Executive of the NHS Executive. My range of responsibilities evolved over the six years I was in post and initially consisted of:

- Medical education and workforce
- Acute health service policy
- Public health in and through the NHS

27.3. The initial priorities for the role were:

- to develop effective systems for health needs assessment and measuring effectiveness and health outcomes including clinical audit. This later included the establishment of the National Institute of Clinical Excellence.
- Engagement with the medical profession to attempt to secure their involvement and support in the developing internal market.
- Enabling public health professionals to take full advantage of the opportunities offered by the developing role of Health Authorities as 'purchasers' of healthcare.
- Continuing effective medical workforce planning in partnership with the medical profession to secure an adequate supply of trained specialists and GPs in the face of the need to reduce the working hours of junior doctors in training.

27.4. As one of two DCMOs I was professionally accountable to the Chief Medical Officer for the quality of the professional medical advice in all parts of the Management Executive and the doctors providing this, including their professional development and the quality of their professional input.

27.5. The other DCMO at the time, Dr Jeremy Metters, had similar responsibilities for the professional work in the rest of the Department of Health, the "wider Department" as it was known.

27.6. In practice many health policy topics do not relate solely to the NHS, and the NHS Executive frequently relied on work carried out in other parts of the Department and vice-versa. Policy on blood safety was a good example of such cross-Departmental working, with Dr Metters having a long-established lead role on this topic, including his chairmanship of the Advisory Committee on the Microbiological Safety of Blood and Tissue (ACMSBT) and its predecessor committee.

28. What was the main impetus behind the publication of the Health Circular "Better Blood Transfusion" in 1998 (NHBT0083701_002)?

28.1. I have no recollection of the processes leading to the publication of this Health Services Circular but the factors set out in paragraph 2 of the circular seem a more than adequate explanation.

29. With reference to document DHSC6693326:

a. It would appear from this document that the Secretary of State (Frank Dobson) was supportive of financial support being extended to those infected with Hepatitis C and was minded to "write to No 10" on this issue. Is it correct to understand that following discussions with the Minister of State in the House of Lords (as the Inquiry understands it, Margaret Jay), Dr Metters and you, the Secretary of State decided not to pursue the possibility of financial support for those infected with hepatitis C? Please set out your

recollection of those discussions and why (apparently) you, Dr Metters and MSL were opposed to this.

29.1. I have no direct memories of the actual discussions but the sequence of events and the issues were clear. Frank Dobson was sympathetic to the case being made by the Haemophilia Society for a special payments scheme for those infected with hepatitis C through NHS treatment. This had major implications across the NHS and beyond which are set out in MS(L)'s note to the Secretary of State of 1st June. I was particularly concerned at the many potential problems that could arise from a drift into no-fault compensation (which I have always thought has many advantages) without detailed planning and costing, including securing agreement across Government

b. In your minute of 12 May 1998 at p.10, what did you mean by there being "very real dangers in moving from specifics to general policy issues as is happening at present"?

29.2. This note was to the Permanent Secretary to alert him to the possibility that the approach by the Secretary of State to No 10 could create multiple precedents within the NHS and across Government before this had been thought through and the necessary work undertaken.

c. Your minute refers to the "potentially even more elastic concept" of a moral liability. Did you consider that there was no moral liability to provide financial support and if so, why?

29.3. I saw my role at the time as pointing out that for the Government to accept such a moral liability to provide financial support had huge ramifications which had not been considered.

d. Your minute also uses the phrase "individuals and groups who have been damaged however inadvertently". What was the factual basis for your understanding that damage had been "inadvertent"?

What did you know and understand about the circumstances in which people had been infected with Hepatitis C?

29.4. I was using the word "inadvertent' in the sense of "unintentional" and was not intending any judgement of the detailed circumstances in which people had been infected with Hepatitis C. Whatever knowledge and understanding that I had then would have come from internal DH papers on the subject but I cannot now disentangle what I knew then from knowledge acquired later, not least from the proceedings of this Inquiry.

30. Please describe your role and responsibilities as Deputy CMO.

30.1. I refer to my answer to Q27 above.

31. Please describe your understanding of the role of the CMO and Deputy CMOs in providing information, advice and/or guidance to (a) clinicians, (b) NHS bodies, (c) patient cohorts and (d) the public.

31.1. As has been set out in the evidence of Professor Sir Kenneth Calman (**WITN3430001_0056** and **WITN3430099_0066**), the CMO was very much the centre of communication with the public and with the medical profession through a range of approaches which encompassed his annual reports, CMO and "Dear Doctor" letters on specific topics of concern and, sometimes intensive, media appearances on "hot" topics. He, and therefore we, had access to a wide range of specialist advisors and committees. Dr Metters was very much in the lead on the policy issues related to this Inquiry.

31.2. I do not believe that we ever tried to communicate directly with patient cohorts as we would not have had any way of knowing who the individuals comprising such cohorts were, and because that would have risked intruding into the relationship between each patient and the doctor(s) managing their condition.

31.3. My role was principally to manage the flow of information to the NHS bodies and clinicians working within them, through NHS Executive Letters ("EIs") and Health Service Circulars ("HSCs"), a good example of the latter being NHBT0083701_002. These were introduced to attempt to control the flow of "instructions" to the NHS which, prior to the establishment of the NHS Management Executive (later NHS Executive), could receive multiple communications from different parts of the Department of Health with no consideration of their collective achievability. EIs and HSCs could only be issued by Directors on the NHS Executive though they would often be on policy subjects that were the responsibility of the wider Department.

32. Please describe in broad terms the nature and frequency of interactions between the CMO, Deputy CMO(s) and Ministers.

32.1. My memories on this subject are very general. The nature and frequency of interactions with Ministers was driven entirely by the pattern of business to discuss. The CMO probably saw a minister more days than not. Dr Metters and I would be involved whenever an issue that we were handling was being discussed; perhaps a couple of times a week for me. An extra dimension for me was whether the meeting needed to be in person or whether it could be conducted by video-conference linking the Department of Health in Whitehall with the HQ of the NHS Executive in Leeds. The CMO and Dr Metters, being based in London, did not have this complication. I always felt able to be open and frank about whatever was being discussed.

32.2. The CMO, Dr Metters and I had regular informal meetings convened by the CMO's office, perhaps monthly though my memory is unclear about this.

33. In your (and Dr Metters') advice to the Secretary of State and to Baroness Jay, in February 1998, regarding the impact of vCJD on blood and blood products (see CABO0000014_017 and the background paper mentioned DHNI0000042_081, along with its annexes CABO0000014_019) you refer (at paragraph 7) to the adoption of "a more precautionary, public health-

based approach". Did this represent, as far as you can recall, a conscious shift to a precautionary, public health-based approach? Was it your understanding that this was a new or different approach for the Department?

33.1. I have only very general memories of this submission and associated discussions but it seems clear from re-reading the submission that it is explicitly advocating such a precautionary approach in this case. Thus paragraphs 14-16 of CABO0000014 _017 contrast the standard policy approach of waiting until clear evidence is available, with taking proactive action when a potential problem has been identified, the precautionary approach. I agree that this represented a conscious shift in policy thinking, driven particularly by the lessons learned from the tragedies that are the subject of this Inquiry and also those from bovine spongiform encephalopathy.

33.2. I do not believe that this represented "a new or different approach" so much as a greater awareness of the, often difficult, trade-offs between basing decisions on hard evidence of cost-effectiveness and doing everything you can to prevent possible (but not definite) problems. A major thrust of the Labour Government's 1997 White Paper The New NHS: Modern and Dependable referred to in NHBT0083701_002 was that services should be much more evidence based with national guidelines and standards and clinical guidelines and audits developed by the National Institute of Clinical Excellence. Paragraph 4 of DHSC0006348_083 (see below) starkly presents this dilemma.

34. With reference to DHSC0006348_083

a. **Please explain what steps were taken by the Department to raise HCV awareness during your time as Deputy CMO.**
b. **Your understanding of the reasons for not rolling out a formal screening programme.**
c. **At page 3, para 3, it is stated that the main reason why the "Lookback" exercise was initiated was due to the licensing of**

Interferon. What is your understanding as to why recipients of HCV-infected blood were not traced in 1991 or thereafter and advised on the lifestyle choices they could make to reduce the progression of Hepatitis C and/or advised as to the importance of regular monitoring of their liver?

d. **At page 5, para 6, reference is made to the decision by ministers not to "speed up detection" of HCV in the general population and to the Department having avoided going down the road of reminding health professionals and people who might have been infected about HCV and the desirability of counselling and testing. Looking back now, do you consider the Department should have acted differently in these respects?**

e. **Having regard to page 6, para 9:**

   i. **Please explain what is meant by "PES tactics" .**

   ii. **Please explain what is meant by the risk of "falling over the PES convention".**

f. **Page 8 mentions 3 options for government response to HCV within the blood supply. Please set out your understanding as to which option was chosen by the Department and why.**

34.1. As to (a), with the passage of time, I am afraid I can add nothing to the comprehensive information on the steps taken by the Department to raise HCV awareness set out in Professor Sir Kenneth Calman's witness statement and annex **WITN3430001_0056** and **WITN3430099_0066**.

34.2. As to (b), my understanding of the reasons for not rolling out a formal screening programme are as in the paper (DHSC0006348_083). A formal screening programme would not have met some of the established criteria for a valid screening programme, in particular:

- Treatment at an early stage should offer clear benefits;
- Adequate health service provision should be made for the extra clinical workload resulting from screening
- The risks, both physical and psychological, should be less than the benefits

- The costs should be balanced against the benefits

It was also unclear (paragraph 8) which population would have been screened.

34.3. As to (c) my understanding, although I cannot recall being personally involved in the formative discussions, is that it was felt to be unethical to track down people, most of whom would be perfectly healthy, in order to tell them that they might have a serious disease for which no effective treatment was available. The advent of Interferon changed that potential balance of advantage although the drug only had limited effectiveness. This still feels reasonable to me.

34.4. As to (d) DHSC0006348_083 sets out (paragraphs 6-10) the inherent difficulties and uncertainties in adopting a more proactive approach, and these still seem valid. Ministers at the highest level, like decision takers further down the NHS, are always trying to achieve the best use of limited resources spread across many patient groups. An important new NHS policy thrust at the time was to focus resources on those interventions whose effectiveness had a solid evidence base. This was by definition not the case for much of what might be suggested by adopting a precautionary approach, in which you are acting in advance of definitive evidence being available. This can result in diverting resources from other patients with established needs, for example, in this specific case, those requiring specialist hepatology services.

34.5. As to (e), the annual cycle of negotiations leading to the Public Expenditure Settlement had well established rules. The references in DHSC0006348_083 paragraph 9 to "PES tactics" and the risk of "falling over the PES convention" both refer to the problem that if a Government Department announced a new ongoing spending commitment in advance of securing agreement with the Treasury for funds to cover it, it would be assumed that that Department could afford to meet that commitment from within existing resources, and thus could not bid in future years. Thus, a premature announcement of a testing programme with potential treatment

costs of £50m could block such costs being considered in future PES cycles.

34.6. As to (f), of the 3 options for government response to HCV within the blood supply set out on page 8 of DHSC0006348_083 my understanding is that, in effect, an enhanced version of option three was adopted with the look back exercise set out in detail in sections 41 of Professor Sir Kenneth Calman's witness statement and annex **WITN3430001_0056** and WITN3430099_0066. I cannot add anything of value to this from my own memory.

35. What if any steps were taken by the Department during your time there to ensure that GPs were educated about: the risks of blood transfusion; the need for HCV testing in the event of a patient having had a blood transfusion; and how patients could manage their infection when treatment was unavailable?

35.1. I do not recall any such measures being taken, though this seems unlikely. Approaching this issue via GPs does not seem an intrinsically efficient approach as GPs would not necessarily know which of their patients had received a blood transfusion. A more effective way of reaching such patients would be via the specialist services which had transfused them or the specialists managing their infection.

Section 10: Other matters

36. Please provide any further comment that you wish to on matters falling within the Inquiry's Terms of Reference.

36.1. I have no additional comments to make.

Statement of Truth

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

Signed GRO-C

Dated 14/12/2022