Witness Name: James McMenamin
Statement No.: WITN3495001
Exhibits: WITN3495002
Dated: 19 August 2020

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR JAMES McMENAMIN

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 28th June 2019.

I, Dr James McMenamin will say as follows: -

Section 1: Introduction

1. Dr James Joseph McMenamin, DOB GRO-C 1964, GMC 3244489
   My professional qualifications are as follows; MBChB (Glasgow), MRCP, MPH (Glasgow), DTM&H (London), FFPH (UK).
   I am Consultant Epidemiologist (Respiratory Team) and Interim Clinical Director, Health Protection Scotland, NHS National Services Scotland.
   I am based in Meridian Court, 4th Floor, 5 Cadogan Street, Glasgow, G2 6QE and have worked there as a Consultant Epidemiologist since 1st October 2003. Prior to this I was a Consultant in Public Health Medicine in Greater Glasgow Health board from 01/08/2001 to 30/09/2003.

Section 2: Responses to criticism of Mr GRO-B

2. Thank you for the opportunity to respond to the written and oral statement provided by Mr GRO-B. The criticisms that I have been asked to comment upon are that Mr GRO-B states that I came to speak with him at his son's bedside the night before his son died to ask that a post mortem be performed on his son. It is stated that Mr GRO-B asked me not to ask his wife about this. It is further stated that Mr GRO-B was not informed of the results of the post mortem until a chance meeting with me some six months later.

3. In responding to these criticisms, I have not had access to the case notes of Ruchill Hospital. I have been advised that they have been destroyed in accordance with retention and destruction policy. I have however, seen extracts from some other records which still exist.

4. I would make the following comments;

Background

5. I was working as an HIV registrar in Ruchill Hospital, Glasgow during the period 1990-1993. My responsibilities included the care of all children and adults living with HIV infection for outpatient and inpatient services. Ruchill Hospital had at that time a long tradition of infectious disease management for both children and adults. It retained a single general infectious disease ward for children, a single adult HIV ward and three general infectious disease wards. The infectious disease unit then had a wealth of experience of managing children and adolescents as well as adults built up over decades of experience. Care for all patients was administered by NHS consultants to whom I reported.

6. In the specific circumstance of management of haemophilia patients with blood borne viral infections, such as HIV infection, outpatient care was shared with haemophilia services (from Dr Brenda Gibson, Yorkhill Hospital for children and from February 1988, Professor Gordon Lowe, Glasgow Royal Infirmary for adults with transitional arrangements for adolescents/young adults) and Ruchill Hospital.

7. GRO-B and his identical twin brother were under the care of Dr Dermot Kennedy for their HIV management. During the time of the clinical care of the Infectious Diseases Unit, GRO-B was known to have some evidence at the time of hepatitis C antibody (an indeterminate level on RIBA testing indicative of previous exposure to hepatitis C virus) which was difficult to interpret in someone with such a low immunity, but was presumed to be due to prior receipt of contaminated blood products. There is laboratory or clinical note evidence to suggest liver inflammation that would be consistent with a chronic hepatitis C viral infection.

8. Despite acquiring infection with HIV, presumably from contaminated blood products around the same time as his identical twin brother, GRO-B had a much faster illness progression than his twin brother. The treatment of HIV during the late 1980's/early 1990's with antiretroviral medicines was in its infancy and GRO-B had already commenced treatment in August 1988 as an out-patient with zidovudine (AZT). However, despite taking AZT his underlying immune deficiency had continued to worsen. Indeed, he developed an illness acknowledged as an acquired immune deficiency syndrome (AIDS) defining illness disease in December 1990. This resulted in him being considered on a named patient basis as a recipient of a newer antiretroviral medicine di-deoxyinosine (Didanosine – ddI – Bristol Meyer Squibb) which had recently completed its clinical trials but was not yet available in the UK as a licensed medical product. Records made available from disclosure indicate that this ddI medicine was made available in a dose of 167mg twice a day from at least May 1992 though it was poorly tolerated presumably from the side effects encountered.

Request for post-mortem

9. Though I provided care for GRO-B only for a short period of time during his in-patient admissions to Ruchill Hospital, my nursing and clinical colleagues could see the profound love and devoted care from all of the family to him (and to the rest of the family). It was my privilege to care for such a loving and loved son and, along with the

rest of the staff, I was deeply saddened by his clinical deterioration across the month of GRO-B of 1992 when he received his in-patient care in ward 8.

10. End of life care is always an incredibly difficult and straining time for all families and in particular for parents of children and young adults. The deterioration in neurological function in GRO-B and his ultimate bronchopneumonia, meant that it was with heavy hearts that we moved from active care intending to preserve life to end of life care in which the clinical and nursing imperative is to keep the patient as comfortable as possible.

11. I, my nursing, medical and other professional colleagues had built up a rapport with GRO-B and his family during this final admission. His last days are an enduring memory for me, as are the circumstances surrounding the approach to the family seeking consent for a post-mortem examination. Clinically we had been unable to identify in life the cause of his neurological deterioration nor explain the rapidity of the deterioration in his immune function. These were of importance to his family and his attendant clinicians as his identical twin was also infected with HIV around the same time as him and could face the same issues. Without access to the contemporaneous clinical notes I have only my own memory of the event and the written statements of GRO-B 's parents.

12. Post-mortem requests are made at a particularly emotive point in time when families are processing the loss of their loved ones. Often decisions may change to or from permission to undertake or refuse a request for a post-mortem. These circumstances are frequently encountered by all clinical teams.

13. I recall Dr Kennedy and I approaching Mr GRO-B on the day before his son's death to sensitively seek his view about post-mortem. He initially declined this offer, but I recall saying I would leave him and his family to consider this as it was a difficult decision to make. I do not recall being explicitly told, as outlined in Mr GRO-B testimony, not to approach Mrs GRO-B about this but I have no reason to challenge the veracity of his memory of this. I do recall that following the death of their beloved son that consent to undertake a post-mortem was formally requested from both parents by Dr Kennedy and I. This is a routine part of what would be requested following the death of any patient with HIV infection and covering the details about what the family might expect to happen next and such arrangements if they gave consent. The rationale accepted was that findings of such a post-mortem could provide information that could be important for their surviving son and more generally for others suffering from HIV infection.

14. I had, until receipt of Mr GRO-B testimony, always assumed that this matter had been handled sensitively and without complaint. The reason behind this belief is that it had never subsequently been raised as an issue following the death of GRO-B during any of the social events in which my wife and I had been the guests of both parents, either to their home (to thank me for the care GRO-B had received) or to visits to the home of a mutual friend also involved in the care of their twin sons.

Post-mortem results, delay in speaking to the family about post-mortem results and retention of clinical samples

15. My understanding of what was undertaken at the time of GRO-B 's death was that post-mortem examination had to be conducted under a very controlled setting to reduce the risk of transmission of HIV to mortuary staff. This was a particular concern in relation to the use of bone-saws or other aerosol generating procedures undertaken during the post-mortem itself or from subsequent processing of materials. This usually resulted in delays to the performance of macroscopic post-mortem and on the availability of the detailed results of examination of tissue specimens obtained at the post-mortem itself (microscopic post-mortem).

16. Post-mortem neurological tissue sampling and retention is a difficult area to answer as I am not a pathologist. It is my understanding that the specialist area of expertise for neuropathology resided in the then Southern General Hospital, Glasgow. This was a particularly important area for consideration given the neurological symptoms of GRO-B and the radiological findings in life of neuropathology of uncertain aetiology. However, delays of months would often ensue in obtaining the results from detailed neurological microscopic examination.

17. The absence of the clinical notes mean that I have only my own recollection of the events leading up to the post-mortem results being available and the testimony of Mr GRO-B In the absence of the clinical notes I cannot confirm a delay of six months between death and relaying the post-mortem results. However, delays of some months in the availability of post-mortem results likely explained an interval in time between the death of GRO-B and the first opportunity to communicate these results to the family. This communication would have been either opportunistically (as stated in the testimony of the Mr GRO-B or at a pre-planned clinic appointment for either GRO-B 's identical twin or a specific appointment to relay the findings to the family. I have no reason to challenge the veracity of the recollection of Mr GRO-B about this opportunistic meeting, but do recall speaking to him on the ward to go through these findings. My recollection of what Mr GRO-B recalls about this conversation are however, a little different. I did not state "[I] could probably have saved him" but agree that his recollection of me likely saying that GRO-B "died of measles that had got into this brain" is an approximation of what was likely said during the conversation.

18. In the 1990's Subacute sclerosing panencephalitis (SSPE) (see https://www.encephalitis.info/subacute-sclerosing-pan-encephalitis-sspe) from which GRO-B appeared to be suffering and another condition progressive multifocal leukoencephalopathy (PML) were thought to be major slow virus infections of humans. SSPE was thought to be caused by a mutant measles virus after long persistence in the brain from the evidence obtained from neuropathology from molecular properties of measles viruses identified. My recollection of what I then said was that the neuropathology examination was suggestive of a diagnosis of SSPE and that this was associated with measles virus which had slowly over time produced this unusual presentation in GRO-B There were no specific treatments which were recognised at the time as life-saving so I would not have said under any circumstances

that this would have "saved him". I rather would have said that in life this diagnosis offered up an opportunity to try treatments and that, in the event of symptoms developing in GRO-B identical twin, offered up some opportunities for treatment. Thus, this knowledge was of direct importance for the future management of GRO-B 's twin providing some justification for the performance of the post-mortem and of the trauma and pain caused to the family regarding this.

19. I do not recall any discussion about what would happen to any brain specimens taken for post-mortem or of their disposal by either myself or Dr Dermot Kennedy. I had until receipt of Mr GRO-B 's testimony, always assumed that this matter had been handled sensitively and without complaint, for the reasons given above.

Section 3: Other Issues

20. Subsequent to the preparation of my initial draft statement, the Central Legal Office provided me with a copy of GRO-B 's post mortem report on 17th February 2020. I understand that it was recovered by NHS Greater Glasgow and Clyde. The post mortem report is produced as an exhibit to my statement. The report provides confirmation of the clinical diagnosis provided in my statement. It also explains why there was such a long delay to the post mortem results being available for communication to the family - an extensive list of neuropathologists across the UK were invited to contribute to the consultation on the cause of the illness. This culminated in an eventual answer from colleagues in Belfast in December, around GRO-B months after the death of the patient, confirming the presence of measles antigen in brain material.

21. Thank you for the opportunity to respond to the witness statement. I hope this further background provides GRO-B and his family with explanation which is to their satisfaction. I cannot begin to understand the pain and suffering of the family and I am sorry that GRO-B had not raised any of these concerns with me directly at the time or in the period that followed. I would have been only too glad to discuss any of these concerns, I wish him and his family nothing but the best for the future.

Statement of Truth

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

Signed GRO-C

Dated 19th August 2020

Table of exhibits:

Date	Notes/ Description	Exhibit number
	Post Mortem Report for GRO-B GRO-B	WITN3495002
