Witness Name: Dr Paul Trenchard
Statement No.: WITN3604001
Exhibits: WITN3604002, WITN3604003, WITN3604004
Dated: 23.07.2019

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR PAUL TRENCHARD

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

I, Dr Paul Trenchard will say as follows:

Section 1: Response to Questions 1-3

1. I confirm my personal details, as follows:

   Dr Paul Malcolm Trenchard
   GRO-C
   d.o.b. GRO-C 1947

   Professional Qualifications (all degrees are from the University of Bristol):
   B.Sc. (biochemistry), M.B., Ch.B. (distinction), Ph.D. (platelet biophysics), F.R.C.Path. (haematology), F.R.S.B., C.Biol., L.T.C.L. (flute)

2. In late-1979 I was appointed within the Welsh Blood Service (then known as the National Blood Transfusion Service, Wales) as Consultant (in Haematology and Transfusion Medicine) and Deputy Medical Director and, simultaneously, as a Clinical Teacher of Haematology in the University of Wales College of Medicine (as is was then known).

3. My main areas of professional responsibility and clinical oversight were:

   i. blood donor care (on-site and at external collection locations);
   ii. the on-site apheresis clinic (specific machine collection of concentrated blood products from donors e.g. plasma [plasmapheresis] & platelets [plateletpheresis]);
   iii. on-site laboratory separation of blood products from whole-blood donations (particularly platelet separation);

iv. quality control of processes associated with the preceding paragraphs 3.i, 3.ii & 3.iii;
v. research into blood product storage (particularly the non-invasive quality-monitoring of platelets during storage, and partly supported by the Leukaemia Research Appeal for Wales);
vi. open communication and close collaboration with the adult leukaemia unit at the University Hospital of Wales, Cardiff, and the Leukaemia Research Appeal for Wales;
vii. clinical support for the tissue-typing laboratory (particularly in relation to the provision of tissue-matched platelet and bone-marrow donors for the adult leukaemia unit at the University Hospital of Wales, Cardiff);
viii. development of the Welsh Bone Marrow Donor Panel (in close collaboration with the adult leukaemia unit at the University Hospital of Wales, Cardiff, and the Leukaemia Research Appeal for Wales, and others);
ix. research into the quality-associated costing of platelets (partly supported by the Leukaemia Research Appeal for Wales) and its further development through collaboration with the University of Durham;
x. as a clinical teacher I gave occasional lectures to medical undergraduates and post-graduate tutorials to visiting haematology registrars when they were seconded to the transfusion centre as part of their training.

4. I continued in these roles until late-1995 when I retired, following approximately two-years of ill-health. In retirement, the collaborative research within the University of Durham continued, and the title of Visiting Professor in the University of Durham (Business School) was conferred in late-1999. This was maintained until late-2011.

5. As directed, I have looked at the 6-page PDF of the Inquiry's Terms of Reference in order to consider whether I have contributed to any relevant group/committee.

6. I believe the answer to be 'No'. Nevertheless, for completeness, perhaps I should mention that (for approximately 2-years, as far as I recall), during the early development of my research into the quality-associated costing of blood products (see paragraph 3.ix, above), I served on a Finance Subgroup of the National Blood Authority. The research supported a novel approach: that jointly-shared production costs could be allocated to individually-separated end-products according to clinical considerations. In the case of platelets, for example, this would mean allocation in proportion to the post-transfusion clinical benefit for leukaemia patients, relative to the combined post-transfusion benefit for all patients (i.e. summation with separate data for red-cell-requiring patient groups and plasma-dependent patient groups). Although the committee was initially interested and positive, the proposal was eventually rejected: partly, perhaps, because of the degree of change it would make to the relative balance (i.e. ratio) of costs across the range of end-products.

Section 2: Response to Questions 4-5

7. In consideration of the request letter (9 July 2019), and in reviewing the accompanying witness statement of Mr Anthony Lane (WITN2365001), I noted various inconsistencies and have documented them in Exhibit WITN3604002.

8. As a consequence of these inconsistencies (Exhibit WITN3604002), I became convinced of the need to exhibit authoritative historical information in support of my responses to Questions 4 & 5. Correspondingly, I submit WITN3604003 (relevant extracts from the Final Report [2015] of The Penrose Inquiry) and WITN3604004 (an abstract from a scientific paper on the 'natural history' of Hepatitis C). The three exhibits should be read in conjunction with my responses to Questions 4 & 5 (paragraphs 9-24 & 25-28, respectively, below).

Question 4

9. With reference to Mr Lane's statement (WITN2365001) and its apparent inconsistencies (as outlined by me in Exhibit WITN3604002) and in view of the background historical information provided in my Exhibits WITN3604003 and WITN3604004 my response to Question 4 of the Request for a written statement under Rule 9 of the Inquiry Rules, dated 9 July 2019, is as follows.

10. The inference I draw from Mr Lane's comments (4.2 & 4.4; but also 4.1, 4.3 & 4.5) is that he was of the opinion that I was professionally wrong, or even intentionally dishonest, to state in 1985/6 that 'Welsh blood is/was fully tested' because, according to the argument implicit within his comments, that would only have been acceptable/true if Hepatitis-C testing had been included.

11. Such an argument (paragraph 10, above) is invalid because it would be illogical, indeed impossible and nonsensical, for the term 'fully tested' to include agents yet to be discovered.

12. Hepatitis-C was not discovered until 1989, and the routine testing of donors for this agent was not implemented in the UK until 1991/2. Mr Lane's evidence (exhibits WITN2365002 - WITN2365003) explicitly endorses these facts, and correspondingly, paragraph 4.5 of his statement is illogical because 'full testing' was carried out prior to 1991/2 but it could not, and did not, include Hepatitis C.

13. To view this (paragraphs 10, 11 & 12, above) another way: factual attribution of best practice at a given point in time does not become retrospective dishonesty when best practice gets better at a later date. To argue so could be seen as defamatory.

14. Correspondingly (paragraph 13), best practice for blood safety testing in the mid-1980s, legitimately and truthfully attributable then, as 'full testing', did NOT become a retrospective untruth when hepatitis C testing could be added in the early 1990s.

15. In thinking back beyond three decades, to 1985/6, I do not recall that there was ever an official definition of 'fully tested' when used by health care professionals in relation to the screening of voluntary blood donors in the UK for the presence of transfusion transmissible diseases. There was, however, a tacit understanding by such staff that, in keeping with paragraph 11 (above), the term would only be meaningful in relation to tests actually available, and routinely implemented, within any given historical time period.

16. As early as 1971/72, Professor Cash used the term 'total donor screening' in a manner that is broadly consistent with the tacit understanding referred to in the last sentence of paragraph 15 (see Exhibit WITN3604003 in general, and the included paragraph 25.27 in particular).

17. It is worth noting that, if Mr Lane's method of retrospective criticism (Section 4 of his statement, and culminating in the confirmation he records in paragraph 4.5) is extrapolated back to 1971/72, it would condemn the phrase 'total donor screening' (paragraph 16, above) as being approximately three times more fallacious than any 1985/86 use of the term 'fully tested', in not only failing to include a test for Hepatitis C, but also in failing to include tests for HIV and more accurate tests for Hepatitis B.

18. Personally, I cannot recall the extent to which, in professional contexts, I may or may not have used the term 'Welsh blood is/was fully tested', or the extent to which I may or may not have qualified such a phrase with further information.

19. Mr Lane "can recall a number of discussions" (paragraph 4.1 of his statement) that I had with him, in a range of professionally relevant circumstances (see entirety of Section 4 of his statement), yet he has elected to repeat only the term 'fully tested' in his complaint. It is important to know, from the 'number of discussions' he recalls, whether he is sure that I never qualified the term 'fully tested' with any further information. If I did include further information, he should outline its content? Are there any contemporary records of my use of the term in 1985/86?

20. Continuing, more specifically: Did I ever mention Non-A Non-B (NANB) Hepatitis? If so, did I outline the clinical consensus that prevailed at that time, about the risks and outcomes of transmission by transfusion? Please note the prevailing contemporary clinical 'thought' at the end of Section 25.101 of the Final Report of The Penrose Inquiry, as shown in Exhibit WITN3604003, that:
    - NANB Hepatitis was generally thought to have a benign prognosis.
    - The risks for the patient that might be associated with the transmission of NANB Hepatitis were thought to be low relative to the risks associated with the conditions for which they required blood transfusion ....

21. Furthermore, given the level of surprise indicated by Mr Lane in paragraph 2.14 of his statement, it would seem he was largely, if not totally, unaware of:
    - the extent to which Blood Transfusion Services were taking very seriously the uncertainties of the 'thoughts' that could not be 'facts' (previous bullet-points) because of the ongoing elusiveness of the NANB Hepatitis agent;

- the fact that, in the hope and expectation of the eventual discovery of causality, Blood Transfusion Services were in open communication and collaboration with each other, and with various relevant interrelated clinical disciplines (e.g. hospital blood banks, leukaemia and haemophilia units, liver units and virology units), in a manner that would facilitate look-back (the right sort of retrospection).

22. The discovery of causality (1989), plus the commencement of look-back via routine testing (1991/2), provided the prospective basis for a very different understanding of the natural history of Hepatitis C (Exhibit WITN3604004).

23. Exhibit WITN3604004 is cautionary, when compared with the optimistic bullet-points of paragraph 20 (above). The difference leads me to speculate and question, hypothetically, that if the clinical consensus in the mid-1980s had guesstimated the 'real' natural history of NANB Hepatitis, how many patients newly diagnosed with acute leukaemia would have — through the process of informed consent — refused platelet therapy in preference to embarking on a journey of aggressive, but potentially curative, chemotherapy?

24. Mr Lane assigns no dates to the 'number of discussions' he recalls and, in the absence of any directly recorded evidence and, therefore, in relation to what I perceive may be only selective hearsay on his part, I have done my best to provide a carefully argued and, hopefully informative, response to Question 4. I envisage that the combination of Exhibits WITN3604002 - WITN3604004 will prove particularly informative and helpful.

Question 5

25. With reference to Mr Lane's statement (WITN2365001) and its apparent inconsistencies (my Exhibit WITN3604002), and in view of the background historical information provided in my Exhibits WITN3604003 and WITN3604004, my response to Question 5 of the Request for a written statement under Rule 9 of the Inquiry Rules, dated 9 July 2019, is as follows.

26. Question 5 asks me to comment on paragraph 8.2 of Mr Lane's statement where "Mr Lane has raised a query as to who, if anyone, told you (i.e. me) that you (i.e. I) should advise the public that "all Welsh blood was fully tested".

27. From a professional perspective the simple short answer is 'No one': I was simply doing my job to the best of my ability, with truthful integrity in relation to what was the general clinical consensus at the time (see my Exhibits WITN3604003 & WITN3604004).

28. Alternatively, indirectly, and from a deeper historical perspective, my answer is 'Yes, there was someone', namely, my father: he was the one who told me and taught me to be truthful in all things. Sadly, he died at 11.30pm 36-hours ago (21 July 2019), seven hours after I left his bedside in South Devon to return to Cardiff to complete and submit this statement. In providing the foregoing answers and comments I seek to honour his life and example of truthful integrity.

Statement of Truth

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

Signed GRO-C

Dated 23 JULY 2019

Table of exhibits

Date	Notes/Description	Exhibit Number
July 2019	Inconsistencies in: the witness statement of Mr Anthony Lane (WITN236501) and the accompanying request letter to Dr Paul Trenchard (9 July 2019) requiring a written response under Rule 9 of the Inquiry Rules 2006.	WITN36002
March 2015 SG/2015/15	Extracts from: The Penrose Inquiry, Final Report, Volume 4: Donor Selection and Screening of Donated Blood; Section 25, Screening of Donated Blood for Hepatitis B.	WITN36003
Jan 2009	Abstract from: The history of the "natural history" of hepatitis C (1968–2009) Leonard B. Seeff National Institute of Diabetes and Digestive, and Kidney Diseases, National Institutes of Health, Bethesda, MD, USA Published in final edited form as: *Liver Int.* 2009 January; 29(0 1): 89–99. doi:10.1111/j.1478-3231.2008.01927.x	WITN36004