NHS
Blood and Transplant

Board Meeting in Public
Monday, 18 May 2026

Title of Paper	Board Patient Story	**Agenda No.**	2.1

Nature of Paper	☒ Official	☐ Official Sensitive
Author(s)	Clair Walton and Bill Wright. Compiled by Sophie Seymour, Head of Office for Nursing	
Lead Executive	Gail Miflin, Chief Medical Officer	
Non-Executive Director Sponsor	N/A	
Presenter(s) at Meeting	Gail Miflin, Chief Medical Officer	
Presented for	☐ Approval ☐ Assurance	☒ Information ☐ Update

Is there a plan to communicate this to the organisation?	☐ Yes	☒ No	☐ Yet to be determined

Executive Summary

It is now two years since the publication of the Infected Blood Inquiry. Tomorrow members of the Board will be attending the Service of Recognition, Remembrance and Reflection, with many of those infected and affected by the tragic events of the past. We are planning our own memorial in NHSBT and we were also keen to mark this week's milestone at our Board meeting today. We are enormously grateful to Clair and Bill for telling us their stories.

Previously Considered by

N/A

Recommendation

This paper is presented for information only

Risk(s) identified (Link to Board Assurance Framework Risks)

N/A

Strategic Objective(s) this paper relates to:

☒ Collaborate with partners	☐ Invest in people and culture	☒ Drive innovation
☒ Modernise our operations	☐ Grow and diversify our donor base	

Appendices:	

Clair Walton

Clair has been infected and affected by contaminated blood through the loss of her husband, who had severe haemophilia and was co-infected with Hepatitis C and HIV. She became infected with HIV through the course of the relationship. She has been a campaigner and co-founded Positive Women to raise awareness of the lived experience of the wives and partners who were infected with HIV via their husbands/partners. Clair was a core participant in the Infected Blood Inquiry and is one of the Infected Blood Compensation Authority's User Consultants as well as a member of the Infected Blood Memorial Committee although she will be telling her story at the Board meeting in a personal capacity.

Willam (Bill) Wright OBE

I was infected with nonA-nonB hepatitis in May 1986 from a single dose of FVIII concentrate, created at Liberton, Edinburgh from Scottish donors. 38 years on, in March 2024, I was diagnosed with what has become life ending Heptapucellular Carcinoma. This news came after years of different treatments for hepatitis C, states of illness and ongoing questions over the reasons I and others were infected. It has had severe effects upon our life and financial security.

In 1997, I started asking questions in official circles about why I had been infected and found others in Scotland who were similarly minded. The launch of the devolved Scottish Parliament in 1999 allowed the opportunity to pursue those questions in a manner not previously available. I was eventually awarded an OBE in the 2025 Honours List for services to the Infected Blood Inquiry and people in Scotland with bleeding disorders.

The circumstances under which I received the FVIII concentrate in May 1986 in Edinburgh Royal Infirmary were highly controversial and are referred to in Volume 4 Page 252 to 255 of the Inquiry Report. As concluded by the Inquiry, with such mild haemophilia, I should never have received plasma based FVIII at that time or certainly not Scottish manufactured FVIII. (I also provided 4 statements to the Inquiry). In summary, I was admitted with a rebleed to a haematoma on my left thigh and was treated by a junior doctor without my FVIII being tested. I had previously not been classified as a haemophiliac and my FVIII level was above that where FVIII would normally be employed.

I recall the morning after having received the FVIII dose, I was told that I had a 50% chance of contracting nonA-nonB hepatitis and I had had enough sedative to put a horse to sleep. It was later confirmed that the FVIII was 100% infective. I was reassured that the product was free from HIV. At that time in North Edinburgh there was an epidemic of HIV and hepatitis B due to the use of needles for intravenous drug use. There was little or no screening of donations.

It was soon confirmed from liver function tests (ALT AST) that I had contracted NonA-NonB hepatitis. I was given a vaccine for hepatitis B.

I later started to question why clinicians could be so confident about my infection from my blood tests but were not screening donors for infections. The number of donors to make up a single dose of FVIII amounted to thousands.

In 1986 my wife and I moved to the Manchester area for a new job opportunity as we had been led to believe that the hepatitis was a relatively benign condition. Instead, I was informed in Manchester RI in 1988 that I might have only ten years to live.

Over the years I faced 4 attempts at interferon treatment all ultimately without success in clearing what by now was defined by Hep C. The interferon treatment proved to be very testing. It took a course of a new drug in 2015 to clear the hepatitis but by then I had already been diagnosed with liver cirrhosis in 2011.

By the time we moved back to Scotland in 1996 we had had a family. My wife Rosy had not been tested for hepC even though we were aware that the virus could be sexually transmitted. If infected, the implications would have been too far reaching on many fronts.

It did not come as a shock in March 2024 that I had developed a tumour in my liver i.e. heptapucellular carcinoma. I was then tested for the transplant list and joined it in April. By July I was downstaged back off the list as a second tumour had appeared and then permanently off the transplant list as multiple tumours had appeared by March 2025.

This means I now face a life ending situation and have embarked on a course of different treatments aimed at achieving a balance between lengthening life and quality of life.

A large part of this 40 year story has for me involved asking questions, advocating, campaigning and most importantly listening to many others who have been so badly affected by being infected or having close family who were infected, often meaning the loss of life. These deeply profound stories were a huge motive for getting to the truth about what really happened during the disaster.

In 2012 I became the founder chair of Haemophilia Scotland and we were core participants in both the Penrose Inquiry and UK Infected Blood Inquiry which proved to be highly time consuming and demanding. I remained the chair of Haemophilia Scotland for 12 years and now act as an Adviser and Spokesman on Infected Blood.

I regard the best recognition that Governments across the UK and their agencies can deliver in response to this scandal that the Inquiry concluded was largely avoidable, is to implement all 12 recommendations that the Inquiry has made.

This includes Blood and Transplant agencies in each country ensuring they take effective action to promote and fully implement recommendation 7 including, in England, full implementation of ‘Transfusion 2024’.