Witness Name: Dr Jonathan Wilde
Statement No.: WITN3086006
Exhibits: None
Dated: 9 July 2020

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF JONATHAN WILDE

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006, dated 20 May 2020 in response to criticisms made by W1014 in witness statement WITN1014001

I, Dr Jonathan Wilde, will say as follows: -

Section 1: Introduction

1. My name is Dr Jonathan Thornton Wilde MA, MB, BChir, MRCP, FRCPath, MD of GRO-C Somerset, GRO-C I was born on GRO-C GRO-C 1954. I retired from all clinical practice in August 2016.

2. Previous positions.
   -Registrar in Haematology, Northern General Hospital, Sheffield Nov 1984 to Oct 1986.
   -Lecturer in Haematology, Royal Hallamshire Hospital, Sheffield Oct 1986 to Oct 1988.
   -Senior Registrar in Haematology, Royal Liverpool Hospital, Nov 1988 to Nov 1992.

-Consultant in Haematology with specialism in Haemostasis and Thrombosis and director of the Haemophilia Service, Queen Elizabeth Hospital Birmingham, Nov 1992 to Aug 2016.

3. I was a member of the UK Haemophilia Doctors Organisation from 1992 to 2016 and a member of the UKHCDO transfusion transmitted infection working party throughout the life of this group from about 1996 to 2010.

4. Unfortunately, as these alleged incidents/events occurred many years ago (some nearly 30 years ago) I have no specific recollection of them. I have not been provided with any of the relevant medical records by the Inquiry. For that reason, I should like to reserve the right to make a supplemental statement, should the medical records be made available, and should that be necessary.

Section 2: Responses to criticisms made by Witness W1014 in statement number: WITN1014001

I shall deal with each in turn.

Paragraph 24- 26 inclusive:

5. As I mentioned above, I have not had access to the medical records when making this statement, and I do not have any recollection at all of this consultation in 1996. For that reason, it is very difficult to respond to this criticism in a meaningful way. I appreciate that receiving bad news requires compassion and that the message may be responded to in a variety of ways. My patients and their wellbeing was always my foremost priority. While I may not have always presented the bad news in the manner an individual patient would, on reflection, have preferred, I always did my best to ensure the information was conveyed sensitively and in a way that it was understood. That said, I was deeply saddened to read that this patient had the experience he described in his witness statement. Naturally, I would like to apologise if the way I did deliver the news regarding his diagnosis of HCV did cause upset. The very last thing I would want is for the way in which this diagnosis

was delivered to have had a lasting effect on top of the impact of the diagnosis itself.

Paragraph 25:

6. As I said, it is very difficult to respond in meaningful way as I do not have any recollection of this consultation, nor have I had access to the medical records. All I can say is I think it very unlikely I did not provide him with any information regarding his hepatitis C, prognosis or transmission, as that does not accord with my usual practice. I may have said that fuller and more comprehensive information and answers would be provided by the hepatologist, to whom I referred him.

Paragraph 26:

7. I can't comment without referring to the medical records. I can see from the exhibit WITN1014003, the HCV test was reported in 1992. It is likely to have been requested by one of my predecessors prior to my taking up post, which was in November 1992. It seems as though the requestor did not inform him of the result, but I am unable to comment any further. I have no recollection of any specific outpatient consultations I had with this patient between 1992 and 1996, and whether I had access to or had seen his HCV result and/or why I had not previously informed him of the result. While I cannot be certain about the dates without the records, I can say that in early 1994, I established a joint haemophilia / hepatology clinic the purpose of which was to undertake a review of all our patients who had received coagulation factor concentrate with a view to checking their HCV status. We identified from our unit factor administration records all patients who had received factor concentrate and invited them to attend this clinic. I remember the clinic was held on a Friday afternoon. This clinic may have been the first opportunity I would have had to see patients with milder forms of haemophilia as they would not have been on regular follow up in the weekly bleeding disorders clinic. I think it very likely that this patient would have been invited to attend this joint haemophilia / hepatology HCV clinic (which may have presented the first opportunity to discuss his HCV infection). What I

cannot say is whether or not he took up the invitation to attend this clinic and if he did when this was. I do remember that this patient was very hard working and because of work commitments he was not able to attend his scheduled appointments on a number of occasions. Therefore it is possible that he was not able to attend until 1996 to be informed of his HCV result but again I cannot be sure of this without access to the notes.

Paragraph 74:

8. The witness is mistaken in his recollection.
   I would like to Clarify:
   The advice the patient describes with regard to the disposal or quarantining of surgical and dental instruments did not apply per se to patients infected with HCV. This counselling advice applied to patients who were deemed to be in the "at risk" group of acquiring variant CJD infection as they had received factor concentrate manufactured from plasma donors who subsequently went on to develop vCJD. The patient was in this group hence the counselling advice.

Section 3 : Other Issues

9.

N/A

Statement of Truth

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

Signed _____ GRO-C _____

Dated _____9/7/2020_____