

1 Wednesday, 28 October 2020

2 (10.00 am)

3 PROFESSOR IAN MAXWELL FRANKLIN (continued)

4 SIR BRIAN LANGSTAFF: Good morning. You are still on
5 oath.

6 Further questioned by MS RICHARDS

7 MS RICHARDS: Professor Franklin, we were discussing
8 yesterday the advice and information that was or was
9 not made available to non-Reference Centre Directors
10 such as yourself. There's one further document I
11 wanted to ask you to look at. It's CBLA0000043_040,
12 please, Henry. This is a letter that was dated
13 9 May 1983. It was sent by Dr Spence Galbraith, who
14 was a director of the Communicable Disease
15 Surveillance Centre of the Public Health Laboratory
16 Service in Colindale, and you will see there his
17 recommendation to the Department of Health was set out
18 in the second paragraph:

19 "All blood products made from blood, donated in
20 the USA after 1978 should be withdrawn from use until
21 the risk of AIDS transmission by these products has
22 been clarified."

23 Then there's a paper in which he sets out his
24 reasons. We just turn to the next page, please,
25 Henry, and we can see there and on the following page

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1 his reasons. I know this has been sent to you in
2 advance of your evidence this week.

3 Was this a document or a recommendation that you
4 were aware of at the time?

5 A. No, not at all.

6 Q. Do you think that, as the director of a large
7 non-reference centre, this is information that should
8 have been shared with you at the time?

9 A. Well, it certainly should have been shared with more
10 people than it probably was shared with. It would
11 have been helpful. I think I would probably agree
12 with Mark Winter that probably this letter should have
13 led to some form of high-level advice to haemophilia
14 doctors, whether sending it direct to each one with
15 the usual rider that each director must come to his
16 own conclusion would have been not terribly helpful.
17 But, yes, I mean, I think this sort of spells out
18 things very clearly.

19 I wasn't terribly clear what actually had
20 happened to this at all, but there was a meeting of
21 the Committee on Safety of Medicines, I think, two or
22 three months afterwards.

23 Q. Yes. 13 July.

24 A. I'm not even sure that that meeting referenced this
25 letter, but I think that meeting must have been, in

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1 some respects, Dr Galbraith's answer, which was that
2 nothing could be done on grounds of supply. Sorry,
3 I paraphrase but --

4 Q. Yes. You're right that the issue certainly was
5 considered at that meeting, and so the material may
6 have been known to Professor Bloom, for example, and
7 Dr Craske.

8 A. Yes.

9 Q. But you, as a centre director, you never became aware
10 at the time that the leading public health facility
11 was making this recommendation?

12 A. No. I think I first heard this -- about this letter
13 from evidence on the Tainted Blood website, I think.

14 Q. I want to turn then to what was or wasn't done locally
15 in Birmingham and the West Midlands region in response
16 to the risk of AIDS.

17 We'll go back to the regional working party
18 meetings. If we start with the meeting in June 1983,
19 SHIN0000030. This, of course, is the meeting. We've
20 already looked at it, but it's before you became
21 director --

22 A. Yes.

23 Q. -- so you weren't in attendance at the meeting. But
24 if we go on to the second page. We looked at this
25 when we were discussing the contracting arrangements,

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1 Professor Franklin, under the heading "Regional
2 contract" and the three points there. If we could
3 just look down the bottom of the page, please, Henry,
4 we can see there there's reference made in the
5 penultimate paragraph to -- Dr Ala's making the point
6 that cryoprecipitate was probably a safer product,
7 Dr Ala asking the working party to advise on
8 heat-treated Factor VIII (so this is June 1983), and
9 then a discussion about more information being
10 required. If we go to the bottom of the page, Henry,
11 two papers being produced, and we then can see those
12 papers referred to at the top of the next page at
13 points 1 and 2. Then it's said that the item will be
14 put on the next agenda.

15 Would you agree that the minutes of that meeting
16 suggest that there was to be no change of approach to
17 the treatment of patients in light of the risk of AIDS
18 at that stage?

19 A. Probably not. I mean, I think the real crux of these
20 decisions really swung around what the efforts were
21 being made towards self-sufficiency and, again,
22 I think that -- if I jump forward to Dr Chisholm's
23 comments in the next year --

24 Q. It was later the same year.

25 A. Later the same year, thank you. It was quite clear

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1 that different regions had different policies on
2 sending plasma to BPL. You read between the lines
3 that because if Wessex was producing unlimited -- it
4 couldn't be unlimited, but lots of cryoprecipitate,
5 then they couldn't have been sending plasma to BPL,
6 couldn't have been sending NHS product, getting NHS
7 product back. And I think that really describes the
8 reasons why the whole self-sufficiency project failed,
9 because there was no central management. It was all
10 left to individual Regional Transfusion Directors,
11 admirable in their own rights, but they would have
12 different priorities.

13 So had my colleagues at that time decided to
14 switch to cryo, then we would have got less NHS
15 Factor VIII, and yet we would definitely have had
16 a shortfall on total units, I think, and we'd have
17 still needed to import to make that up, even for
18 basic -- even the most basic home treatment regime,
19 I would think.

20 So I think to switch from factor concentrate to
21 cryo would have really needed some sort of national
22 push to say that that's what's needs to be done
23 because, otherwise, you're just going to be creating
24 holes in supply elsewhere, and you'd have some regions
25 continuing to have lots of Factor VIII concentrate and

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1 others not.

2 I know you're hearing from Dr Vivian Mitchell
3 from Leicester who I think did use a lot more cryo.
4 So some people did make that decision, but I think
5 this shows that in Birmingham the feeling was to carry
6 on, but probably to carry on in the hope that we would
7 eventually get more NHS material.

8 **Q.** If we move -- again, we've looked at the minutes, but
9 just for this purpose to the following two meetings
10 which are during your tenure as director. The first
11 is SHIN0000029, please, Henry.

12 This is the meeting that you attended. So it's
13 your first attendance at the West Midlands Regional
14 Health Authority Working Party meeting. We can see,
15 if we look down the page, that the issue that was
16 flagged up in that previous meeting doesn't really
17 appear to have been discussed on the agenda. If we
18 just go further down, please, Henry, we can see and we
19 already looked at the reference to regional contracts,
20 so no change envisaged to the contracting
21 arrangements; it's going to continue being Armour.

22 Then we can see there's a discussion at the
23 bottom of the page about supplies from Elstree being
24 maintained on a pro rata basis relating to the amount
25 of plasma sent. We can see it's suggested that the

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1 volume of plasma sent could be increased, which
2 presumably could have generated either more
3 cryoprecipitate or more NHS Factor VIII, but that
4 would mean an increased investment in the cost of
5 bags. Then over the page there's then a discussion
6 about how supplies of BPL Factor VIII will go to
7 individual centres.

8 So would you agree there's nothing further here
9 in terms of any change of approach to treatment being
10 discussed at a regional level?

11 **A.** No, there doesn't seem to be.

12 **Q.** Then the third meeting during this 1983/1984 period is
13 SHIN0000028. This is 14 May 1984. You're not in
14 attendance -- you've sent your apologies -- but this
15 is during your directorship and, again, if we go down
16 the page, we can see there's the usual heading of
17 "Supplies of cryoprecipitate and freeze-dried
18 Factor VIII", but that's just an update about supplies
19 from BPL having reached their optimum.

20 Then if we go to the bottom of the page, and we
21 certainly looked at this yesterday morning, Dr Hill
22 has given figures for the region which show an
23 increase in the usage of BPL and a decrease in
24 commercial Factor VIII.

25 Then if we go over the page, again we looked at

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1 this yesterday, but this shows that there may be
2 a shortfall of BPL product, and that's going to be
3 made up from commercial sources. Then it's the same
4 criteria for looking at the contract for commercial
5 Factor VIII, including, point 3, resisting any public
6 pressure for a change of products.

7 So it would appear from this that as at May 1984
8 there's still no change within the region to the
9 approach to treatment being discussed.

10 **A.** No, I don't think. I just wonder whether, as you
11 point out, I wasn't at this meeting, and maybe
12 I didn't read the minutes carefully enough before I --
13 no, I think my letter to Dr Lane was a year or so
14 later about the supply going up and down, because
15 there was clearly some changes in supply.

16 **SIR BRIAN LANGSTAFF:** Could we just go back to the page
17 before where it deals on 84/3(c): "supplies of
18 cryoprecipitate and freeze-dried Factor VIII." What
19 caught my eye was Dr Ala's report that the new plant
20 at BPL would be operative in 1987/88. Now, this is
21 halfway through 1984.

22 Roughly when, during 1983 and 1984, was it
23 expected by you or your colleagues, do you know, that
24 the new plant would become online?

25 **A.** I don't have any recollection from that time as to

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1 when it would, no. I don't know.
 2 **SIR BRIAN LANGSTAFF:** Thank you very much.
 3 **MS RICHARDS:** Professor Franklin, that's what the minutes
 4 show. We will get to December 1984 when there was
 5 a clear -- a new treatment policy discussed in a
 6 moment. But just looking at the period 1983 to 1984,
 7 as far as you're aware, until December 1984, were
 8 there any measures taken in the Birmingham or
 9 West Midlands area in response to the risk of AIDS?
 10 **A.** No, I don't recall any new measures, no, other than
 11 maintaining batch dedication.
 12 **Q.** You have discussed what might have been the
 13 consequences of an increased use of cryoprecipitate,
 14 in terms of a knock-on effect on supplies of NHS
 15 factor concentrate.
 16 Can you recall whether you and Professor Hill
 17 ever actually discussed the possibility of any kind of
 18 either complete or partial reversion to
 19 cryoprecipitate during that time?
 20 **A.** I don't think I do from then. I think there was the
 21 time when the switchover to heat treatment and the
 22 removal of the BPL product completely we did then,
 23 yes.
 24 **Q.** We'll move on to that in just a moment. Do you recall
 25 whether there was any discussion or consideration of

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1 something like the increased use of porcine products,
 2 for example?
 3 **A.** No, I definitely don't think -- don't remember any
 4 discussion about that, other than for inhibitor
 5 patients.
 6 **Q.** If we come on then to December 1984. Henry, that's
 7 SHIN0000026_002. This is an extraordinary meeting
 8 held on 17 December. The year's not given, but it is
 9 clear from the discussion that it must be 1984.
 10 You're present, Dr Hill is present, and we can see it
 11 says, under the list of attendees and apologies, it
 12 was a meeting to discuss the implication of the use of
 13 Factor VIII concentrate in light of the death of two
 14 haemophiliacs from AIDS.
 15 In the next paragraph there's an acceptance that
 16 the use of Factor VIII concentrate was associated with
 17 a risk of transfusing the AIDS virus, and there's
 18 further discussion in relation to that.
 19 Then we can see -- it's recorded that:
 20 "It was considered imperative that heat-treated
 21 Factor VIII should be made available to haemophiliacs
 22 as a matter of urgency. Unfortunately, the Chairman
 23 informed the committee that this was unlikely to occur
 24 with NHS Factor VIII until 1 April, 1985, but that
 25 Armour heat-treated material would be available in

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1 January 1985. Following discussion, a treatment
 2 policy to cover the interim period was agreed
 3 upon ..."
 4 Then we can see that policy. It was DDAVP or
 5 cryoprecipitate for mildly affected haemophilia --
 6 **SIR BRIAN LANGSTAFF:** I think we're missing it on the
 7 screen.
 8 **MS RICHARDS:** I'm so sorry. The numbered paragraphs
 9 towards the bottom of the page. So:
 10 "DDAVP or cryo for mildly affected haemophilia A
 11 and von Willebrand's patients.
 12 "Newly diagnosed severe haemophiliacs to be
 13 managed wholly on cryoprecipitate.
 14 "Patients with no previous exposure to
 15 commercial Factor VIII should continue on NHS
 16 Factor VIII."
 17 If we go over the page:
 18 "Patients with previous exposure to commercial
 19 Factor VIII should continue on NHS Factor VIII, if
 20 available, and heat-treated commercial Factor VIII
 21 when not."
 22 So it would appear that this is the first change
 23 to treatment policy that takes place in response to
 24 the risk of AIDS. Is that a fair comment, from what
 25 you have read?

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1 **A.** Yes. Well, I would -- Yes, I think so.
 2 **Q.** Professor Franklin, I think you'd asked for a document
 3 to be located for you which is from September 1984.
 4 Is that a document you particularly wanted to comment
 5 on?
 6 **A.** Actually, having seen it, I don't think -- I mean,
 7 I think it was a useful document at the time for the
 8 doctors who used particular batches of Factor VIII
 9 described in that document, but I don't -- it turned
 10 out not to be as interesting as I thought it might
 11 have been.
 12 **Q.** So that there's no mystery, sir, Professor Franklin
 13 had asked to be given a copy of a report from
 14 Dr Craske dated 10 September 1984 showing
 15 investigation in relation to patients who received the
 16 same batches of blood products as the Cardiff and
 17 Bristol cases, but we don't need to refer to it at
 18 this stage.
 19 **A.** Because I thought in the minute -- I was a bit
 20 dissatisfied with the level of detail in the minute
 21 and I wondered if that was corrected by the appendix,
 22 but didn't think it was really.
 23 **Q.** Now, as I understand your evidence, there was a period
 24 then, in the late 1984 or early 1985 period, where you
 25 didn't have enough heat-treated products to fully

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1 implement the policy.
 2 **A.** Well, my recollection of timing is probably helped by
 3 the occasion when I negotiated some extra Factor VIII,
 4 heated Factor VIII, from Armour, and that must have
 5 been the period when we were really, really short,
 6 yes.
 7 **Q.** What you've said in your statement is that, as
 8 a response to this shortfall, there had to be
 9 a suspension of home treatment?
 10 **A.** That's my recollection.
 11 **Q.** Then if we look, please, at the meeting that followed
 12 this December meeting.
 13 It's SHIN0000025 please, Henry.
 14 We can see this is 15 February 1985. Again,
 15 you're in attendance and, if we just go down under the
 16 heading "Supply of Factor VIII", we can see there that
 17 Dr Ala had reported that a supply of heat-treated
 18 Factor VIII had been negotiated with Armour. But
 19 initially there had been a shortfall in early January
 20 which had now been rectified, and then currently no
 21 NHS product available. But there was potentially
 22 going to be some supply on a named patient basis and
 23 increased supplies after April '85. Does that accord
 24 with your recollection of those events?
 25 **A.** Yes.

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1 **Q.** Can you recall what, if any, steps were taken for
 2 patients on home treatment in this December 1984/early
 3 1985 period to recall or ask them to bring back in any
 4 supplies they held of unheated factor products? Was
 5 that undertaken?
 6 **A.** I can't remember whether that was the occasion when
 7 Dr Hill and the nurse conducted a complete recall. We
 8 did call back all of the home treatment -- because we
 9 were suspending home treatment, we called back what
 10 was out in the people's homes. Because we didn't have
 11 enough in the centre to treat acute bleeds. So we had
 12 to bring the stuff back in.
 13 I can't remember whether that was used on people
 14 with acute bleeds. I saw a paper, I think yesterday,
 15 that mentioned that one of the companies was offering
 16 to heat -- might have been Armour -- untreated product
 17 at 4 pence a unit, so we may have sent it back to them
 18 for heating but I don't recall.
 19 **Q.** We know that there were patients at the Children's
 20 Hospital who were infected with HIV and seroconverted
 21 whilst receiving the Armour heat-treated product in
 22 the course of the months that followed. Did that
 23 happen, to your knowledge, with any of the patients at
 24 the Queen Elizabeth Hospital?
 25 **A.** I don't remember that being the case and I think

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1 I would have done. I mean, that was quite -- well,
 2 obviously for the boys it was desperate but, I mean,
 3 it was a huge deal at the time, and my recollection
 4 was that we then had to withdraw all the Armour
 5 product and we had another acute shortage. My
 6 recollection was that we got some support from Alpha
 7 at that time to tide us over while, presumably, new
 8 regional contracts were dealt with.
 9 **Q.** Yesterday I had been about to ask you about a passage
 10 in your witness statement which I couldn't find, and
 11 I've found it now. So if we go to your witness
 12 statement -- it's WITN4032001, please, Henry -- and if
 13 we go to the bottom of page 11, last sentence, you
 14 say -- and this is in the context of a question about
 15 your interactions generally with Professor Hill. You
 16 say:
 17 "When HIV/AIDS became a clinical issue, as
 18 co-directors we discussed our approach and reached
 19 agreement."
 20 What's that a reference to and what period of
 21 time is that a reference to?
 22 **A.** I'm not too sure specifically, to be honest. We would
 23 obviously be very concerned about the product safety,
 24 as I say, and we would have discussed what to do.
 25 It's possible that that might have meant no change but

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1 we would have discussed what to do.
 2 **Q.** For the sake of completeness in terms of treatment
 3 policy, can we just go to UBFT0000263. This is
 4 a document headed "Current Treatment Policy for
 5 Bleeding Disorders", and if we go to the second page
 6 we can see it's authored by you and it's dated
 7 7 January 1986.
 8 **A.** Yes.
 9 **Q.** We don't need to go to the detail of it. By this
 10 point -- and leaving aside obviously the issue about
 11 seroconversion on heat-treated products -- you have
 12 I think both commercial and NHS heat-treated products
 13 in principle available to you?
 14 **A.** Yes.
 15 **Q.** This is the first document, I think, of this kind that
 16 we've seen. As far as you can recall, is this the
 17 first time you put pen to paper to produce a written
 18 treatment policy?
 19 **A.** I really couldn't say one way or the other. I'm
 20 sorry.
 21 **Q.** Then if we just go to the 1986 returns for the
 22 Queen Elizabeth to see what products were being used
 23 then during that year.
 24 It's at HCDO0000373_003, please, Henry.
 25 We can see here the numbers treated. This is

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1 the haemophilia A and carriers of haemophilia A and
2 von Willebrand's patients. So 87 haemophilia A
3 patients, 9 von Willebrand's, no carriers treated.

4 We can see here, in the course of 1986 you've
5 used a very small amount of cryoprecipitate in
6 hospital, NHS factor concentrate, presumably by this
7 time heat-treated, and then Alpha and Armour, with the
8 bulk of it still being Armour.

9 **A.** Yes.

10 **Q.** The Alpha, is that potentially because of the issue
11 that you've described?

12 **A.** Well, I do remember them helping us out because when
13 the Armour -- well, as you have shown, the regional
14 contract was almost exclusively with Armour for
15 commercial. So when the product was withdrawn, we
16 didn't have any. So I remember Alpha helping us out.
17 But this is more -- this looks like rather more than
18 helping out; this looks a bit more of a significant
19 part of the contract. Almost the same as the NHS,
20 isn't it? 80 per cent.

21 **Q.** Can I just move to ask you now about what information
22 should have been and what information was, as far as
23 you recall, given to patients.

24 First of all, do you accept that patients
25 should, at least by autumn of 1983, when you became

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1 director and responsible for the centre at
2 Queen Elizabeth, should have been being warned of the
3 risks of non-A, non-B hepatitis?

4 **A.** Yes. Yes, I do and I think -- well, whether "warning"
5 is the right word --

6 **Q.** Informed?

7 **A.** Sorry?

8 **Q.** Informed?

9 **A.** Absolutely. No, absolutely. And I believe they were.
10 I mean, the -- as I said in my statement, we didn't
11 have new patients with -- certainly not severe
12 haemophilia. Most of them had abnormal liver function
13 tests, and my recollection is that that was discussed
14 with them at clinic.

15 I would add that the issue of HIV -- sorry, it
16 wasn't called that then, AIDS -- became very dominant
17 really immediately I started doing the clinic. So
18 I would have to admit that it probably wasn't a major
19 component of the discussion. Most of the discussion
20 was concerns about AIDS.

21 **Q.** I think if we look at your witness statement -- Henry,
22 back to WITN4032001, please -- and if we go to
23 page 29, the top paragraph is talking about the
24 undertaking of liver function tests, and you say:
25 "... we would have been looking for evidence of

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1 clinical liver disease."

2 Then you say this:

3 "Results would have been explained in general
4 terms. Better or worse. Mild changes. It is
5 unlikely that precise numerical results were provided
6 but I believe I would have done so if asked. Advice
7 about alcohol use was provided."

8 So that's your evidence about the kind of
9 information that might have been given about liver
10 tests?

11 **A.** Yes.

12 **Q.** Liver function tests.

13 As far as you can recall, would you have used
14 the term "non-A, non-B hepatitis" to patients or told
15 them in terms that you believed or suspected that they
16 had non-A, non-B hepatitis?

17 **A.** I think the answer's "yes but". Yes, but probably not
18 to everybody.

19 **Q.** What would the criteria have been as to the
20 circumstances in which you would have said that?

21 **A.** I don't know. I mean, it would have been in general
22 discussion.

23 **Q.** What, if anything, would you expect to have documented
24 in notes. If there had been a discussion about non-A,
25 non-B hepatitis specifically, would that --

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1 **A.** Well, I would have expected to have written down what
2 the liver tests were and that we'd discuss them.

3 Yes, I think that's about it.

4 I mean, I think there is a bit more than just
5 doing the test which I didn't put in there. Obviously
6 one examines patients. When the men were coming up,
7 most of them had problems with joints, so you would
8 check joints, see how their previous problems were
9 getting on, and take the opportunity to examine them
10 for evidence of, at this time, probably just liver
11 disease or skin signs. For example, you would examine
12 the abdomen. So you would look for evidence of
13 clinical liver disease rather than just the abnormal
14 tests.

15 Obviously, later on one would be looking for
16 evidence of immune deficiency as well but not probably
17 immediately after I started.

18 **Q.** Do you accept that patients should have been informed
19 of the risks of AIDS, talking now the period
20 1983/1984, by the time you are director?

21 **A.** Well, yes. I mean, telling people that there's a risk
22 of implies that you're about to do something to expose
23 them to that risk, and unfortunately, as we know, they
24 already were exposed. So I think the main discussion
25 was around what the actual risk was.

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1 Q. Again, would that have been something that, in an
 2 individual patient's case, if you had had
 3 a discussion, would be documented in their notes?
 4 A. Probably not always.
 5 Q. In what circumstances would a discussion about AIDS
 6 have arisen? I think we see from I think it's your
 7 letter to Dr Lane you talk about patients expressing
 8 worries to you.
 9 Let's check that.
 10 Yes, so by May of 1984, in your letter to
 11 Dr Lane, you're talking about -- well, let's just put
 12 it up on screen again.
 13 BPLL0000853_002.
 14 You say halfway down this page in this letter
 15 24 May 1984:
 16 "Almost every adult patient at our clinic asks
 17 about this syndrome and a significant number of
 18 patients have requested to receive only NHS material."
 19 Then you say:
 20 "Our efforts to reassure patients ..."
 21 Can you recall whether you had conversations
 22 about AIDS only with patients who raised it or was it
 23 something you raised of your own initiative?
 24 A. Well, it does say "almost every adult patient", so
 25 perhaps there were some who didn't, but did I raise

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1 it? I can't remember really.
 2 Q. The phrase "our efforts to reassure" might suggest
 3 that you were trying to reassure patients not to be
 4 too worried about this.
 5 A. Well, "reassurance" is a word that comes up frequently
 6 from that period, isn't it? The information we were
 7 getting from the Haemophilia Centre Directors'
 8 Organisation was to carry on using the treatment, that
 9 it was highly unlikely that many people would get
 10 AIDS. All these things were wrong but that was what
 11 was coming out and that was what seemed to me to be
 12 the message.
 13 I think the true likelihood of getting AIDS from
 14 someone who is HTLV-III positive couldn't have been
 15 anticipated at that time. Maybe the worst possible
 16 scenario. We now know that everybody, other than
 17 a tiny number of people have an unusual chemokine
 18 gene, will get AIDS from HIV, and I don't think that
 19 was known then.
 20 Reassurance is -- you can say reassurance is
 21 a sort of panacea and "Go away and don't worry your
 22 head about it", but I think there are other meanings.
 23 I think when we were getting the positive tests back,
 24 I think there was still a role for reassurance in
 25 trying to let people know that we will continue to

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1 look after them. Mark Winter mentioned patients who
 2 had been -- felt abandoned, and I think we did
 3 reassure them that we would be continuing to look
 4 after them and deal with the issues.
 5 But, yes, it's a word that can be -- make it
 6 sound as if you are just trying to fob people on.
 7 Q. Let us come on then to the testings arrangements, so
 8 testing the patients at the Queen Elizabeth Hospital
 9 for HTLV-III. Your statement and your evidence to the
 10 Archer Inquiry indicated you thought that testing
 11 began in the early part of 1985?
 12 A. Yes. I've got evidence that we started certainly in
 13 January. I don't think before that.
 14 Q. The tests that were undertaken for your patients were
 15 by East Birmingham Hospital, is that right?
 16 A. Well, they went to the Regional Virus Laboratory,
 17 which I think was part of the Public Health Laboratory
 18 Service. I don't know why we didn't use Tedder at the
 19 Middlesex or -- as was in the paper that came out --
 20 or Philip Mortimer at the London PHLS. I can't
 21 believe we didn't ask them, and possibly we were
 22 referred to the PHLS in Birmingham. But yes, that was
 23 where it went.
 24 Q. You described in your evidence to Archer test results
 25 coming back with a stamp on them about research

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1 purposes?
 2 A. I did.
 3 Q. First of all, were you undertaking any research?
 4 A. Well, no, I didn't consider it to be research, and in
 5 fact, if I may --
 6 Q. Yes.
 7 A. -- when this was happening -- where are we? Well, at
 8 the Haemophilia Reference Centre Director meeting in
 9 September of 1984, which is HCDO0000416:
 10 "Dr Craske mentioned that he was offering to
 11 arrange for HTLV-III testing on samples from
 12 haemophilia centres if the Haemophilia Centre
 13 Directors would like him to organise this for him."
 14 And that obviously happened because
 15 Geoff Savidge arranged for his patients to be tested,
 16 and he included Mark Winter in that.
 17 In the December meeting of the same -- I think
 18 the same group, which is HCDO0000394_117:
 19 "Dr Craske advised that currently the reagents
 20 are only available on a research basis and that
 21 substantial resources would be required to enable the
 22 proposed workload to be undertaken.
 23 So I think what was going on in '84 was -- you
 24 could argue it was research, but they were testing --
 25 reference centre patients were being tested. And

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1 we've heard some of those were told, Mark Winter's
 2 were told, and others were done on frozen samples.
 3 So I'm making the assumption that the
 4 East Birmingham laboratory was using these research
 5 reagents, it was an unlicensed test and that's why
 6 they stamped them. But I wasn't doing research.
 7 I was trying to find out what was happening.
 8 **Q.** Now do you recall any discussions between you and
 9 Professor Hill about how to go about the process of
 10 arranging for tests?
 11 **A.** Well, I do, and they seem to differ a little bit from
 12 what appeared to happen at the Children's Hospital.
 13 But, yeah, we -- I didn't have samples stored or
 14 frozen on the adult patients -- or if any were,
 15 I didn't know where they were. I didn't have them.
 16 The arrangement was to ask them to come up or to see
 17 them in clinic when they were coming up, ask them if
 18 they wanted a test, take the blood, and send it off.
 19 I think I've said in my statement, nearly all
 20 the men accepted to have the test. There were a few,
 21 I remember, who asked to leave it for a while, but
 22 I think eventually everybody was tested. The samples
 23 then went off.
 24 They took ages to come back -- and evidence in
 25 one case it was up to five or six weeks -- and then

25

1 they came back with these stickers on. So then we had
 2 to give the results, and the idea, the plan was --
 3 which was, I would say, in the vast majority was kept
 4 to -- that we would tell them in the clinic. It would
 5 be me or Dr Hill that would do that, somebody who --
 6 goodness knows we didn't know a lot about AIDS but
 7 somebody who was best able to impart the news rather
 8 than our junior doctor.
 9 We agreed not to send out letters and not to do
 10 it over the telephone and to try not to do it when
 11 patients came up *ad hoc* with bleeds on the ward, in
 12 the clinic area on the ward, the ward room. And the
 13 reason for that was people would come up, well, they
 14 maybe unprepared, and also we didn't want junior
 15 doctors being given the responsibility of imparting
 16 the news and not the nurse either.
 17 So a few men who just didn't come to clinic for
 18 whatever reason had to be told on the ward and (my
 19 recollection) that was by me. So that was the plan,
 20 and I think it was the right plan, but it took too
 21 long and I apologised at Archer that some men had to
 22 wait too long to get the results.
 23 **Q.** If we just take it step-by-step. First of all, we've
 24 evidence to suggest that at the Children's Hospital
 25 there was testing on stored samples. You don't think

26

1 that was the case?
 2 **A.** I don't remember doing that and I think the fact that
 3 we didn't do a great job time-wise suggests that. If
 4 I had had a load of samples in the fridge, we would
 5 have had the answers very quickly.
 6 **Q.** Can I just ask you to look at one document which talks
 7 about stored samples. It's a later document. It's
 8 MRCO0000422_134.
 9 **A.** Yes, I know that one.
 10 **Q.** This is a document from the later part of the 1980s.
 11 If we go to page 3, please, Henry, just zoom in.
 12 This is about a particular research product but
 13 it says:
 14 "We collaborate on this ..."
 15 This is five lines down:
 16 "... with 1) Dr F Hill and Dr I Franklin ... who
 17 hold a series of sera of haemophiliacs prospectively
 18 collected since 1981 and have access to specimens of
 19 spouses of haemophiliacs ..."
 20 That's what this document says.
 21 **A.** Yes, I was shocked when I read that.
 22 **Q.** As far as the Queen Elizabeth Hospital is concerned,
 23 are you aware of a practice of having collected sera
 24 samples from 1981?
 25 **A.** No.

27

1 **Q.** Do you know what the reference to "access to specimens
 2 of spouses of haemophiliacs" refers to?
 3 **A.** Well, no, I don't. I remember there were -- I think
 4 there were four partners, female partners, of men, and
 5 they were referred to the East Birmingham infectious
 6 diseases unit for follow-up of their HIV disease. We
 7 would have taken that sample initially from our
 8 clinic. I didn't keep any samples from them. The
 9 Regional Virus Lab would have done. They used to keep
 10 samples -- I don't know how long for because the
 11 process -- nowadays we have polymerase chain reaction,
 12 all sorts of antigen tests. If you get -- going back
 13 into the early 80s, nearly all of virology was
 14 antibody testing and they -- the virologists wanted to
 15 look at changes in the antibody. So -- most people
 16 are familiar with Covid nowadays, that Covid
 17 antibodies seem to be falling away.
 18 So diagnosing viral infections back then relied
 19 on showing that the antibody was increasing and
 20 therefore the person was infected, not particularly
 21 with HIV but for others. So they did keep samples.
 22 No, I didn't have access to samples and I didn't
 23 have access to the ladies either.
 24 **Q.** Then, in terms of patients' knowledge of the test
 25 being undertaken, if we just look at what you told

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1 Archer, and then I'll ask you about that.
 2 So if we could have, please, on screen, first of
 3 all, ARCH0000443, if we look towards the bottom of the
 4 page -- sorry, if we go to the next page. My
 5 apologies, Henry. Last two paragraphs. So this was
 6 your written statement. You said:
 7 "Testing of patients for AIDS has been a very
 8 controversial area and it is clear now that some
 9 formal consent should have been obtained. However,
 10 that was not the medical policy in the early 1980s
 11 --and not only in haemophilia care."
 12 Then you refer to what happened at a clinic in
 13 a London hospital, and you quote from a book about
 14 AIDS. Then you say:
 15 "This concurs with my recollection of my own
 16 practice. The regional virology laboratory offered
 17 a test in early 1985. I have had sight of papers
 18 suggesting that we collected blood for such a test as
 19 early as January 1985."
 20 Then you say you don't think that you were
 21 testing in 1984:
 22 "I do not think that we tested stored
 23 samples ..."
 24 Go to the next page:
 25 "My recollection is that specific blood samples

29

1 were taken but specific consent was not always
 2 obtained and consent certainly not recorded.
 3 I believe that the reason for taking the samples was
 4 discussed with the patient."
 5 Then you go on to talk about test results coming
 6 back.
 7 If we just then look at your oral evidence to
 8 Archer, that's ARCH0000008 please, Henry. Could we go
 9 to -- it should be page 16, I think. Next page,
 10 please.
 11 If we pick it up towards the bottom of the page,
 12 so you have discussed the quote from the Garfield book
 13 earlier on. Then you say at the bottom of the page:
 14 "My recollection is that there was a regional
 15 virus laboratory and this started to offer a test
 16 sometime in early 1985. It is possible that this
 17 could have been a bit earlier but I do not think we
 18 were testing before that ..."
 19 Then you say:
 20 "As far as I can recall we did not test stored
 21 samples as again Garfield suggests for another
 22 haemophilia centre ... I cannot be entirely certain,
 23 but I am reasonably confident that we didn't do that.
 24 "My recollection is that we did take specific
 25 samples and that the reasons that they were being

30

1 taken was discussed or mentioned but certainly
 2 consent, certainly formal consent as we would know it
 3 in the 21st century, was not done."
 4 Can I ask you just to elaborate upon that,
 5 really. You are suggesting I think in your evidence
 6 to Archer that something would have been said to
 7 patients about the taking of the sample, but you
 8 distinguish it from being consent in the way in which
 9 it would be understood in modern times?
 10 **A.** We certainly didn't ask the men to sign anything. But
 11 my recollection and belief is that they were all told.
 12 I think my hesitation about the stored samples
 13 has perhaps been slightly answered by some of the
 14 evidence that you presented yesterday morning, is that
 15 I did have this sense that maybe Frank Hill had some
 16 stored samples, not on the adults but perhaps on the
 17 others. So I felt that it was probably wise to be --
 18 leave a little bit of room in there perhaps.
 19 I really don't remember sending any stored
 20 samples, I don't remember having a store of them, so
 21 I'm pretty confident that the adult patients that
 22 I looked after and saw were not tested on stored
 23 samples and that they were told what the test was for.
 24 As it says there, right at the beginning, quite
 25 what that was going to mean we didn't know. It was

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1 going to mean they were all going to get AIDS, but ...
 2 And it was recognised that the test was a big
 3 deal. There was already issues from the USA that
 4 people with AIDS, not necessarily tested or otherwise,
 5 but people who had AIDS were being discriminated
 6 against. So, you know, it was known to be a serious
 7 issue.
 8 My recollection -- it's not in here -- but
 9 I think we had to tick a box saying that the person
 10 had been told. It's not exactly consent, is it, but
 11 I think the laboratory required some notification that
 12 the person had agreed to have the test.
 13 **Q.** The terms in which you describe it here, "the reasons
 14 they" -- that's the samples -- "were being taken was
 15 discussed or mentioned". So there might be quite
 16 a difference between discussing something, and the
 17 depth of discussion, and mentioning something, which
 18 is potentially a briefer or more casual reference.
 19 Do you have any clearer recollection of what you
 20 think you did say to patients about the issue at the
 21 time?
 22 **A.** No, I'd be speculating, but I'm sure I was saying that
 23 there was this test for this agent that might be
 24 associated with AIDS.
 25 **Q.** Do you know whether that would have been recorded

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1 routinely in notes?
 2 **A.** You might like to hope so. Am I getting the
 3 impression that there aren't any notes left?
 4 **Q.** There are notes for some patients and not others,
 5 I think.
 6 **A.** I mean, I'm not trying to be difficult but I -- you
 7 know, obviously were there notes it would be useful to
 8 consult them.
 9 **Q.** In terms then of the process -- I'm sorry, before we
 10 come on to the process of informing people of the
 11 results, your statement suggests, although I think you
 12 didn't have access to any particular figures when you
 13 were drafting your statement, that there were, to your
 14 recollection, 65 haemophiliacs at the Queen Elizabeth
 15 Hospital who were positive for HTLV-III?
 16 **A.** That's my recollection of -- that plus or minus a few.
 17 I can't -- I don't have papers that specify the
 18 number.
 19 **Q.** Most of those were men with severe haemophilia A?
 20 **A.** Not all but yes, most.
 21 **Q.** But not all. And I think your statement says there
 22 might have been one or two mild or moderate and maybe
 23 two haemophilia B patients, and you didn't think there
 24 were any von Willebrand's?
 25 **A.** It's my recollection that there were a couple, yes.

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1 **Q.** Then in terms of wives or partners infected, I think
 2 you just gave us the number, four?
 3 **A.** I think it was four, but this is recollection from
 4 20-odd years ago.
 5 **Q.** Then your statement says that the process then for
 6 telling patients, and you have alluded to this
 7 already, was patients were not invited to come in for
 8 a special appointment?
 9 **A.** No, I think --
 10 **Q.** They were told at the next routine point?
 11 **A.** Yes, I think so, yes.
 12 **Q.** Your statement says that you think now that you should
 13 have seen them sooner?
 14 **A.** Yes.
 15 **Q.** Do you have a sense of how long may have elapsed in
 16 cases?
 17 **A.** Well, unfortunately I know one was about four or
 18 five months maybe. The result was five or six weeks
 19 coming back. The person then came to clinic in --
 20 maybe two or three weeks after that, and for some
 21 reason doesn't appear to have been told then, and was
 22 then given a routine three-month appointment, came
 23 back at that one and then was told. So there was
 24 clearly -- again, we don't have the notes on that.
 25 I don't know why that opportunity was missed.

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1 I'd be very surprised if the person involved --
 2 because I remember who it was -- would have refused
 3 the result and said, "I don't want to hear it".
 4 I don't think that would have happened. So I have no
 5 idea really why that opportunity was missed.
 6 **Q.** Obviously not telling patients until their routine
 7 appointment gives rise to the risk that in the
 8 intervening period they may infect others, in
 9 particular those with whom they are physically
 10 intimate.
 11 **A.** Yes.
 12 **Q.** Why didn't you and Dr Hill arrange for special
 13 appointments?
 14 **A.** I don't know the answer to that. I did say in Archer
 15 and I do remember that there was -- we were sort of,
 16 kind of -- oh, well, I certainly was, I can't speak
 17 for Frank Hill -- overwhelmed by the numbers of cases
 18 and the -- the workload, really.
 19 I mean, to actually get someone to tell them --
 20 I mean, I was not -- I was well trained and very well
 21 used to giving bad news from my leukaemia practice and
 22 bone marrow transplant practice. I didn't have
 23 a problem with telling people. It's not a great thing
 24 to do but it's an important thing to do.
 25 So I think it was -- it must have just been

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1 workload. We only had one clinic a week but
 2 I suppose, you know, one could have found a room
 3 somewhere to see people outside that, but we didn't do
 4 that so ... I wish we had but we didn't.
 5 With regard to the public health risk, we did
 6 write out to people in response to the AIDS advice
 7 document -- Dr Hill drafted the letter but it was on
 8 both our behalves -- advising all of the men that they
 9 should use a barrier method of contraception and that
 10 there was a risk that they could be infected.
 11 It's not really an acceptable excuse but I would
 12 also add that later in '85, when they were talking
 13 about bringing in blood donor screening for HTLV-III,
 14 which didn't actually happen until I think
 15 October '85, there was, unbelievably, discussion that
 16 those donors who were positive might not be told.
 17 **Q.** Yes.
 18 **A.** That would certainly be a public health risk. It
 19 doesn't absolve me of that responsibility but we did
 20 write to people.
 21 But, you know, did everybody read letters?
 22 I don't know.
 23 **Q.** There would, therefore, for some patients, have been
 24 a period of time where the hospital knew they were
 25 HTLV-III positive but the patient did not. Do you

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1 know whether in that period of time there was any
 2 practice at Queen Elizabeth Hospital, your clinic, of
 3 writing to GPs, to give that information to the GP
 4 prior to the patient getting it?
 5 **A.** My recollection was that we asked the patients who
 6 were positive whether they wished us to share that
 7 result with the GP. That's my recollection. I think
 8 most of them were accepting of that. I can't remember
 9 whether there were any who always declined to have
 10 that.
 11 So, no, I don't believe we were writing -- those
 12 results didn't go anywhere else other than in the
 13 patient record until the patient was told.
 14 **Q.** Would those results have been more generally available
 15 within the hospital? I'm thinking, for example, if
 16 a patient came into Accident and Emergency, would the
 17 doctors treating that patient in Accident and
 18 Emergency have had access to the fact that the patient
 19 was HTLV-III positive?
 20 **A.** Well, it was -- I can't expect you to know, and I'm
 21 not trying to be awkward, but the Queen Elizabeth
 22 Hospital didn't have an A&E.
 23 **Q.** Okay.
 24 **A.** So the patients all knew to attend directly to
 25 ward East 4B, which was where the treatment room was

1 and where the resident doctor would have been able to
 2 see them initially. That doctor would, in the notes,
 3 have had access to that result.
 4 How often did it happen that the person was
 5 there, came up to hospital and wasn't told? Well,
 6 that would have happened, but it wasn't widely
 7 available, the result. I mean, we were very careful
 8 about confidentiality. We had a big problem with
 9 identifying samples and we took the decision, rather
 10 than identifying samples as being HTLV-III positive
 11 was that all samples taken from the haemophilia
 12 clinic, from whomever it was, were labelled as
 13 high risk. Looking back, we now know they were nearly
 14 all hepatitis C positive as well. That hadn't been
 15 happening before that. So it was the right decision,
 16 but it was the best we could do to try to protect
 17 people's confidentiality.
 18 **Q.** When the patients did come for their routine
 19 appointment and received their results, you said in
 20 your statement that there wasn't time necessarily to
 21 see patients for as long or as often thereafter as you
 22 would have wished to because of resource implications;
 23 is that correct?
 24 **A.** Yes. I mean, when they were told, that would probably
 25 have taken at least half-an-hour, maybe longer. But

1 we didn't have a counsellor, so we weren't able to
 2 offer a sort of series of counselling opportunities
 3 and, as I think I said before, my description of what
 4 I did for patients was to be, hopefully, a caring
 5 physician who was explaining what we were doing. But,
 6 you know, I see counselling as something that's
 7 a non-directed process which enables people to come to
 8 terms with difficulties. I didn't have training to do
 9 that, and I didn't have the time to do that either.
 10 **Q.** Did you -- you'd have known that patients were going
 11 to be receiving, or some patients were going to be
 12 receiving very bad news that their test result had
 13 been positive?
 14 **A.** Yes, yes.
 15 **Q.** For those patients who were tested positive.
 16 **A.** Sure.
 17 **Q.** Was there any suggestion to patients that they should
 18 attend with a family member or partner --
 19 **A.** No, I don't think so because I was aware that that
 20 didn't happen sometimes, and in fact, most of the
 21 time, the men would come on their own.
 22 **Q.** For those patients who may have missed appointments,
 23 didn't attend, do you know whether there was any
 24 systematic attempts to follow them up, whether through
 25 their GP or otherwise?

1 **A.** Well, we knew who they were. They were mainly younger
 2 men. I used the word chaotic lives in my Archer
 3 thing. I rather regret that because I think,
 4 basically, they were young guys trying to get on with
 5 their life, you know. They felt fit and healthy.
 6 But in the end, yes, we did have to -- I can't
 7 remember exactly how. Some of it was done -- if they
 8 came up to the ward, we got a system where the nurse
 9 would contact me, and I would hotfoot it up there.
 10 That wasn't our planned approach, but eventually, by
 11 the time you got sort of into late summer/autumn and
 12 we hadn't tested everybody, that became pretty well
 13 necessary to do.
 14 Sorry, then had the test, been told about that,
 15 and I think we must have done some tests on the ward
 16 because some of these men never came to clinic.
 17 **Q.** There was no practice, as I understand your evidence,
 18 at Queen Elizabeth of seeing patients in any kind of
 19 group session to break the news to them?
 20 **A.** Well, it never -- to be honest, it never occurred to
 21 me, and when I heard that that had happened elsewhere,
 22 I was quite, well, surprised to say the least.
 23 **Q.** Then your statement suggests that, in terms of the
 24 information that was provided to patients with the
 25 initial diagnosis, the impression your evidence gives

1 is that there wasn't necessarily very much information
 2 you were able to impart at that time; is that correct?
 3 **A.** Well, it was clearly bad news. There were lots of
 4 comments about being negative didn't mean you couldn't
 5 be infected, but I think that -- I'm not sure that
 6 ever really came about. So being negative was good
 7 news for as long as it was the case. It was clearly
 8 not -- it was clearly bad news to be HTLV-III
 9 positive, but I think it wasn't clear that the
 10 condition was going to be so universally progressive,
 11 no. So I think there was a sense of reassurance that
 12 later on turned out to be inappropriate, really.
 13 **Q.** Your evidence and some of the documents that the
 14 Inquiry has located suggests that there was a real
 15 concern about lack of resources for social work
 16 support and nursing support and the like; is that
 17 right?
 18 **A.** Definitely, yes.
 19 **Q.** We'll just look at a couple of documents to illustrate
 20 that. Henry, could we have UBFT0000252, please. This
 21 is a paper: "The need for additional resources within
 22 the central Birmingham health authority", and its
 23 co-authored by you and Professor Hill in April of
 24 1986. If we go to the bottom paragraph on this page,
 25 please, Henry, we can pick it up the last six or so

1 lines:
 2 "Of this population [so this is the
 3 Queen Elizabeth's population] 56 are known to be
 4 positive for antibodies to HTLV-III virus and have
 5 clearly been exposed to the causative agent of AIDS.
 6 Because some patients are continuing to become
 7 positive, having been initially found to be negative,
 8 all haemophiliacs are now considered to be high-risk
 9 cases."
 10 Can you recall what that refers to; patients
 11 having been initially found to be negative --
 12 **A.** It does mention both hospitals, so I wonder whether
 13 that's the cases with the Armour heat-treated.
 14 **Q.** Then over the page you explain that one patient has
 15 died of AIDS, one is suspected of having AIDS,
 16 approximately four or five other patients are
 17 suffering from AIDS-related syndromes. Then if we
 18 skip down a few lines, you say that:
 19 "Clearly those patients who are positive for
 20 antibodies will need increased and more detailed
 21 follow-up and counselling. Duration of clinics and
 22 visits to the haemophilia unit on East 4B have
 23 increased significantly. Those haemophiliacs who were
 24 hoping to start or increase their family have been
 25 advised not to have children at the present time

1 because of the risk of intra-uterine spread of the
 2 virus. This has caused very considerable anguish and
 3 increased counselling time. Young male haemophiliacs
 4 who are sexually active but unmarried have also
 5 required detailed and in-depth counselling with regard
 6 to their future behaviour."
 7 So just pausing there, Professor Franklin.
 8 There are other documents including, I think, some of
 9 the meeting minutes that refer to this issue, but the
 10 view was taken, as I understand it, that patients
 11 should be advised not to have children.
 12 **A.** At that time.
 13 **Q.** At that time.
 14 **A.** I mean, not permanently. I think the idea was that we
 15 didn't know how infectious the condition was between
 16 sexual partners and also from mother to child and, in
 17 fact, that became apparent that that was a significant
 18 risk.
 19 **Q.** Then if we go on to page -- to the next page, Henry,
 20 sorry, we can see you say in the second paragraph:
 21 "The problems that exist at present and are
 22 likely to continue for the next few years have so far
 23 not been recognised sufficiently at national or
 24 certainly not at regional level. A report of the
 25 regional management team regarding AIDS makes only

1 scant mention of haemophilia and does not comment on
 2 the need for increased resources. Because of this,
 3 it's been felt necessary to approach the district
 4 health authority with regard to seeing what
 5 improvements can be made in the short-term, since
 6 staff and capital support requested under RCDRS has
 7 been deferred for beyond five years."
 8 Then you set out a number of areas in which
 9 there is a need for increased funding and support. We
 10 can see there's a reference there to the need for
 11 support to the dental department at (c); at (f) the
 12 need for additional social work support or
 13 a counsellor. It's set out in more detail in the
 14 report.
 15 Can you recall what kind of reception your
 16 requests for additional funding and resources got and
 17 how successful they were?
 18 **A.** It was really depressingly unsuccessful really. We
 19 didn't get much support from local colleagues in the
 20 hospital. I mean, basically there was an element of
 21 the regional funding of haemophilia through the
 22 regional Factor VIII contract that you've been
 23 describing. So we did have links with the Regional
 24 Health Authority but this already suggests that we've
 25 not got anywhere with them, although there's no

1 paperwork, I don't think. But I don't think this was
 2 our first attempt to get money.
 3 Locally in the hospital, you normally had to go
 4 through them to get your bids prioritised. That was
 5 all a bit grisly. Not much support from colleagues
 6 who, frankly, I thought should have known better. Not
 7 haematology colleagues; general senior consultants.
 8 So it was really -- and I think this was from people
 9 like myself and Frank who were -- who could -- who
 10 were used to the system. I nearly said "work the
 11 system", but we didn't work this one very well.
 12 I was used to getting funds for bone marrow
 13 transplants and things like that, so I knew who to
 14 talk to, but this just didn't seem to be working. In
 15 fact, I was -- I'm cynical enough -- we did eventually
 16 get some support a year or so later that -- but I'm
 17 cynical enough to think we probably only started
 18 getting that because the AIDS (Control) Act came in,
 19 and the AIDS (Control) Act was going to require
 20 certainly regional health authorities to describe what
 21 they were doing to provide support for people with
 22 AIDS. And I can only assume that the Regional Health
 23 Authority didn't want to say they hadn't done
 24 anything, so we got some -- we got a counsellor and
 25 a bit else. But we got far less than this.

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1 **Q.** I think we'll just look at one further document. It's
 2 UBFT0000159. This is a joint letter from you and
 3 Professor Hill, late November '86, 24 November '86, to
 4 Edwina Currie MP in response, I think, to an issue
 5 that she had raised about a particular constituent, is
 6 how it reads. You say in terms in the first
 7 paragraph:
 8 "We would like to acquaint you with our
 9 difficulties in providing counselling support."
 10 Then you set out some figures in terms of those
 11 affected. Then you say:
 12 "The staff that we have on these units to treat
 13 the medical aspects of the haemophilia before the
 14 advent of AIDS were stretched. Despite this, we have
 15 tried to provide as much advice and counselling as
 16 possible to our patients and their relatives. These
 17 demands have and are continuing to increase as the
 18 patients and their families become increasingly aware
 19 of the consequences of the AIDS virus infection. The
 20 time available for counselling, we admit, is totally
 21 inadequate, and we are constantly aware of our
 22 inability to adequately follow up patients in this
 23 regard. As some leave the clinic, we are concerned
 24 for their safety because of the emotional stress that
 25 such uncertainty creates. With the current high level

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1 of media cover, the demands that remain unfilled are
 2 even larger."
 3 If we go to the next page in the second
 4 paragraph, reference is made to deaths from AIDS.
 5 Then you say -- and reference to the three children
 6 having developed HIV, despite being on heat-treated
 7 products, and you say:
 8 "All of these events have naturally increased
 9 the anxiety of our patients and their relatives.
 10 While we will continue to try to provide the optimal
 11 care with available staff resources, we know that this
 12 will be inadequate, and we may even fail to provide
 13 for some."
 14 Then you enclose a copy of a submission that may
 15 or may not have been the document we just looked at.
 16 Then the next paragraph you say:
 17 "Although the West Midlands is 10 per cent of
 18 the country's population and a similar proportion of
 19 the country's haemophiliacs, we did not receive any of
 20 the recent DHSS allocation of funds to haemophilia
 21 centres because Birmingham is not a designated
 22 reference haemophilia centre, although we provide
 23 services commensurate with that status."
 24 I think there's a particular issue you raise in
 25 your statement about the funding, the DHSS funding.

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1 There was funding provided by the DHSS to reference
 2 centres for some form of counselling.
 3 **A.** Yes.
 4 **Q.** Birmingham didn't get that because it didn't have the
 5 status of a reference centre.
 6 **A.** Yes.
 7 **Q.** Your statement alludes to you later having discovered
 8 there had been some money that was sent back by the
 9 Regional Health Authority?
 10 **A.** Yes. I mean, it's -- well, it's more than depressing.
 11 I mean, it sort of adds to the tragedy. The money for
 12 the counselling to the reference centres was modest,
 13 but even though it was modest, it means that, you
 14 know -- we know where the reference centres were. So
 15 that meant Liverpool, Birmingham, Bristol, Leeds had
 16 nothing. Sorry.
 17 Yes, then I heard about the -- on the TV that
 18 the West Midlands had had money from -- centrally from
 19 Government and sent it back.
 20 **Q.** I think you know no more about that than what you've
 21 described in your statement. You tried to find out.
 22 **A.** I think it related -- I have done a bit more research.
 23 I think it related to a National Audit Office review
 24 of what had happened to the money from the Department
 25 of Health for AIDS and one of the -- some of the areas

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1 had really not spent much of the money at all, and
2 that didn't really seem to bear any relation to the
3 problem with HIV/AIDS in those particular areas.

4 So the Chairman of the West Midlands Regional
5 Health Authority was called up to -- I think it was --
6 it was on television very late at night --
7 a Parliamentary subcommittee, probably audit
8 committee, to account for this and got a very rough
9 time. He got a very rough time, but we still didn't
10 get the money.

11 Frank and I didn't need the money. The patients
12 needed the money. It was very sad. I mean, it got
13 worse. It was worse, actually, because when AZT came
14 in -- and I know that's a little bit controversial for
15 some, but as I mentioned in my statement, it remains
16 an important drug, and it's still on the WHO list of
17 essential medicines. When that came in, we had
18 difficulty prescribing that because it was perceived
19 to be expensive. So you had this group of people who
20 had been infected by their treatment who were then
21 being denied treatment for the disease that they'd
22 acquired. And the same thing then happened with
23 hepatitis C treatment.

24 **Q.** I think after -- well, I will come on to the position
25 in relation to hepatitis C in a few minutes but

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1 I think there was an inquest in late 1986?

2 **A.** Yes, I went to that.

3 **Q.** At which you gave evidence, and we've got some
4 documentation in the bundle of materials in relation
5 to that. Following which the coroner, if we look at
6 this, I think -- it's I think UBFT1 -- no, I've
7 written that down wrong, excuse me for one moment.

8 UBFT0000161. This is a letter dated
9 23 December 1986 -- if we go to the next page, please,
10 Henry -- and it's from the Birmingham and Solihull
11 coroner to the Chief Medical Officer of the Regional
12 Health Authority.

13 If we go further down, it talks about having
14 held an inquest following the death of a 30-year old
15 haemophilia patient at the Queen Elizabeth Hospital on
16 June of this year, and then we can see for the third
17 paragraph:

18 "Dr Franklin tells me that there are no
19 additional resources for counselling these persons and
20 I stated at the end of the inquest that I would be
21 writing to you suggesting that in some way facilities
22 and staff should be provided to assist Dr Franklin and
23 his colleagues in providing an adequate counselling
24 and care scheme for these unfortunate individuals."

25 You followed that up, if we look at --

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1 **A.** Yes, with the Regional Medical Officer.

2 **Q.** Yes. UBFT0000232.

3 On 7 January you wrote to the Regional Medical
4 Officer, and in the second paragraph you say this:

5 "I am sure you are aware that we remain unable
6 to serve the requirements on the haemophiliac
7 population with regard to their AIDS infection. At
8 the Queen Elizabeth Hospital the epidemic continues
9 and we now have an additional AIDS patient on our
10 books and a further patient is currently in hospital
11 under investigation. Therefore our current experience
12 is that the number of patients who will eventually
13 suffer from AIDS is going to be substantial. In
14 addition we remain incapable because of lack of
15 resources to progressively counsel our young sexually
16 active haemophiliacs ..."

17 Next paragraph you say:

18 "I remain very concerned that there still
19 appears to be so little progress in getting facilities
20 for these patients."

21 You did, I think, eventually get funding in the
22 course of 1987 for a social worker?

23 **A.** Yes, we got -- I think we may have got an extra nurse.
24 I'm not sure. We definitely had a social worker, who
25 was excellent, but even that was -- you know,

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1 excellent but insufficient, yes. It did help.

2 **Q.** Then, in terms of the arrangements for the care of the
3 HIV positive patients, do I correctly understand your
4 statement that the haemophiliac patients were not
5 referred to the infectious diseases clinic in East
6 Birmingham Hospital, their HIV care was undertaken by
7 you, and your colleagues at the haemophilia centre?

8 **A.** Yes, it was, yes.

9 **Q.** Why was that?

10 **A.** Well, I think -- there was no haemophilia care or
11 centre at East Birmingham. So had the men gone there,
12 the care would have been split between their bleeding
13 and the HIV issue. At the time when we considered
14 that, the Infectious Disease Unit at East Birmingham
15 didn't have any HTLV-III positive patients.

16 Birmingham's a slightly strange place in a way
17 at that time. I think the -- I mean, I got this from
18 a person, a counsellor, a gay man who was
19 a counsellor, and I went on the course to learn this,
20 and he said, well, most gay men who are out in
21 Birmingham go to London. That's what was told to me.
22 So there wasn't a lot of HTLV-III positivity there.
23 So we felt they didn't have -- it wasn't as if we were
24 sending men to a unit with experience, and they would
25 have needed to come to us for the bleeding problems.

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1 Not only that, the distance between -- as the crow
 2 flies, not much distance between East Birmingham
 3 Hospital and the Queen Elizabeth, but actually it was
 4 a sort of 35/40-minute drive across the city. So it
 5 wasn't an easy thing for them to then go and have
 6 clinic appointments there.

7 I mean, looking back they might have got more
 8 funding. I think Frank and I had the skills to look
 9 after the immune deficiency because we had the skills
 10 to look after immune deficient patients having bone
 11 marrow transplants. So I don't think the problem was
 12 the expertise; the problem was the resources.

13 **Q.** Was there any consideration given, during the period
 14 you remained director, to holding some kind of joint
 15 clinic?

16 **A.** I don't remember there being the idea of having
 17 a joint clinic. That might have been a good idea.
 18 I don't remember joint clinics with anybody at that
 19 time. We certainly asked advice in complex cases
 20 where we couldn't work out what infections somebody
 21 might have. I mean, we were seeing, as in AIDS
 22 everywhere, we were seeing novel infections previously
 23 quite unknown and that was helpful.

24 So yes, we did take advice.

25 **MS RICHARDS:** Sir, I note the time. I'm going to move on

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1 to ask Professor Franklin some questions about
 2 hepatitis C, so is this a convenient point at which to
 3 take the break?

4 **SIR BRIAN LANGSTAFF:** Yes, it is. Shall we come back
 5 at 12.05?

6 **MS RICHARDS:** Thank you, sir.

7 **SIR BRIAN LANGSTAFF:** 12.05.
 8 (11.20 am)
 9 (A short break)
 10 (12.05 pm)
 11 **MS RICHARDS:** Professor Franklin, before we come on to HCV
 12 testing, there's a few other questions, some of which
 13 have been suggested by Core Participants.

14 Could we look, please, at NHBT0046145_017. We
 15 can see this is a letter addressed to you from Dr Ala,
 16 the director of the West Midlands Regional Blood
 17 Transfusion Centre, September '85, and he says that
 18 he's learnt that a plasma contributor to unheated
 19 Factor VIII of a particular batch belongs to a high
 20 risk group is now HTLV-III positive. You are asked to
 21 identify and follow up haemophiliacs treated with this
 22 product. Then it says:
 23 "Dr Craske is prepared to provide advice
 24 regarding follow-up. Would be glad to have a copy of
 25 the relevant patients' names."

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1 If we could then look at the reply that's sent
 2 on your behalf. It's NHBT0046145_002. We can see
 3 from this it's sent by your secretary
 4 18 November 1985. It's addressed to Michelle. I'm
 5 not sure who that is, but this would appear to be
 6 a response to Dr Ala's letter, in any event.

7 **A.** That's Dr Ala's secretary. I know her well.

8 **Q.** It says:
 9 "The haemophiliacs who have been treated with
 10 Factor VIII batch number HL2882 are as follows."
 11 We can see from this, although we have obviously
 12 redacted the names of the patients, that you have
 13 listed, or there has been listed on your behalf, the
 14 names of the patients and their HTLV-III status.

15 Now, do you know whether the patients themselves
 16 were asked to agree to that information being sent to
 17 the regional transfusion centre?

18 **A.** I don't know the answer. I don't remember the letter.
 19 I was surprised to see it. The names shouldn't have
 20 been on. There was no reason for Dr Ala to know the
 21 names, and I apologise to the patients whose names are
 22 on there. I don't understand how that letter went
 23 out, but ...

24 **Q.** More generally, in terms of information that was
 25 provided to other agencies or organisations, we know

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1 obviously that information was sent to Oxford at this
 2 time, later to the UKHCDO National Haemophilia
 3 Database in Manchester. We've seen documents from
 4 other centres, some of which identifies patients by
 5 name, gives patients' details.

6 Can you recall whether you ever discussed with
 7 your patients the sending of information about them to
 8 Oxford and asked for their agreement or not?

9 **A.** If we go back to the pre-HTLV-III testing era, I think
 10 information was shared. I have to say, I think at
 11 that time it was not an unusual practice. There was
 12 an organisation, still is, called the International
 13 Bone Marrow Transplant Registry, and at that time
 14 I was supplying details of patients' transplants to
 15 that organisation, and at that time I don't think the
 16 patients were told. Eventually, that changed and that
 17 did happen. So I suspect that, prior to HTLV-III
 18 testing, that did happen.

19 My recollection with working with Frank Hill,
 20 that we were unhappy to share those sorts of details.
 21 I don't think we would have been unhappy to share
 22 numbers of cases, numbers of people, but there did
 23 seem to be and there is quite a varied mention that
 24 crops up a few times in the papers about the desire of
 25 Dr Craske on the one hand -- I think at one point

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1 Richard Tedder -- saying that they need to have the
 2 names to make sure they're not double counting.
 3 I'm pretty sure that, from the beginning,
 4 Frank Hill and I didn't agree to send those names.
 5 I think I've seen another report from Geoffrey Savidge
 6 saying that he wasn't prepared to do that. What
 7 I can't tell you is when that, if it ever did, get
 8 resolved, but I know it went on for a few years when
 9 we refused to send the names.
 10 **Q.** Do you --
 11 **A.** So we did have an awareness that it wasn't, to our
 12 minds, appropriately secure information that they were
 13 requiring.
 14 **Q.** Do you recall whether you ever discussed with your
 15 patients --
 16 **A.** No, I'm afraid I don't -- well, I think we didn't.
 17 **Q.** Then in paragraph 27 of your statement.
 18 WITN4032001. Yes, sorry, it is page 27, Henry.
 19 It's the third paragraph.
 20 You talk about the "time when HIV became
 21 a recognised additional risk factor for severe liver
 22 disease".
 23 Could you just explain a little more about the
 24 relationship between HIV AIDS and liver disease.
 25 **A.** Well, we started seeing patients, people with severe

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1 liver disease, and they were all people who were
 2 dually infected -- well, they didn't have a test
 3 necessarily for hepatitis C, but they had non-A, non-B
 4 hepatitis, and they had HIV. People who were HIV
 5 negative didn't seem to be getting that.
 6 **Q.** So is this right: there appeared to be a more rapid
 7 development of severe liver disease in patients who
 8 were co-infected?
 9 **A.** Yes. I mean, precisely, I talk about the sort of
 10 temporal thing, but, yes, certainly the ones that were
 11 getting severe liver disease seemed to be the ones who
 12 were HIV positive.
 13 **Q.** I don't know whether you can answer this or not,
 14 Professor Franklin, but do you know what impact liver
 15 disease can have on the body's natural production of
 16 Factor VIII?
 17 **A.** Well, if you do a liver transplant, it immediately
 18 corrects the deficiency, but that doesn't come from
 19 liver cells; it comes from blood vessels, as
 20 I remember -- I think. So I'm not too sure it has
 21 a huge impact, but I may be wrong.
 22 **Q.** We can ask others, in any event, about that.
 23 Can I move on then to HCV testing. Your
 24 statement says you don't recall testing patients for
 25 hepatitis C before you left in 1992. We're hearing

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1 from Dr Wilde who took over at the centre after you
 2 left this afternoon, but his statement sets out his
 3 recollection that the testing, or much of the testing,
 4 had been done before he arrived. Are you able assist
 5 any further with what happened with HCV testing?
 6 **A.** Well, I'd been concerned about this. I can't remember
 7 doing it, and I'm concerned on a number of levels.
 8 One is because the -- looking at the timing, we should
 9 have had testing available. Secondly, I would have
 10 been keen to look at some of my other patients. My
 11 transplant patients, who were heavily transfused,
 12 almost certainly some of them would have been HCV
 13 positive and also my patients with sickle cell
 14 disease, a small proportion of whom are also heavily
 15 transfused.
 16 So I was hoping that there might have been some
 17 documents come through to jog my memories, but I must
 18 apologise, I can't remember.
 19 **Q.** I think would it follow that you can't remember
 20 whether the arrangements were patients notified in
 21 advance, stored samples or specifically taken --
 22 **A.** I can't remember doing the tests, I'm afraid, let
 23 alone whether I told people beforehand.
 24 **Q.** In terms of research, you have referred in your
 25 statement to certain studies or trials with which you

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1 were involved. I'm not going to ask you further about
 2 those.
 3 As far as you can recall, did either the Queen
 4 Elizabeth Hospital or the Children's Hospital have any
 5 involvement in the trials of hepatitis -- so-called
 6 hepatitis-reduced factor concentrates that were being
 7 discussed by UKHCDO in the early '80s?
 8 **A.** Well, you provided information to say that I obviously
 9 contributed to the 8Y study. I don't remember doing
 10 that. But if it says that I did, then I did. But
 11 I can't think it was many patients because the
 12 requirements were for minimal treatment, I think. Not
 13 necessarily previously untreated, but minimal
 14 treatment.
 15 **Q.** When you started as director in autumn '83 and in the
 16 course of '84, can you recall involvement in any
 17 particular trials of studies in that first year and a
 18 half or so of --
 19 **A.** I can't remember any, no. I don't think I did.
 20 **Q.** What general interactions did you have with
 21 pharmaceutical companies in that period '83 to '92 at
 22 Birmingham?
 23 **A.** In terms of Factor VIII, quite limited. We provided
 24 some documentation to do with Cutter. I think, over
 25 time, we did speak to the people. I had a closer

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1 relationship with people from Alpha. Not to do with
 2 their Factor VIII particularly, but with regard to
 3 their immunoglobulin products which I was interested
 4 in using in the bone marrow transplant patients to
 5 prevent cytomegalovirus.
 6 **Q.** Did you receive any kind of funding at QEH from
 7 pharmaceutical companies, whether for training or
 8 educational purposes or funding staff members or
 9 anything --
 10 **A.** I don't remember any, no.
 11 **Q.** If we can have up on screen, it's a document
 12 I referred to during the presentation yesterday
 13 morning, Professor Franklin, so you might have been
 14 seen reference to it then, although it wasn't sent to
 15 you before your evidence. It's ARMO0000370.
 16 This is a letter to Professor Hill from Armour
 17 in March 1985, and it says:
 18 "I've paid our first 1985 donation to your
 19 research fund to the Finance Department of the Central
 20 Birmingham Health Authority."
 21 Did you have any knowledge of a research fund as
 22 part of the health authority or the centre?
 23 **A.** No, but, you know, it doesn't particularly surprise
 24 me. I mean, I knew that Frank Hill had an academic
 25 interest in -- well, more specifically,

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1 von Willebrand's disease but in bleeding disorders,
 2 so -- but I had no knowledge of that, though.
 3 **Q.** Did you have any equivalent fund yourself?
 4 **A.** I had equivalent funds, but not from companies doing
 5 Factor VIII. Did I have any from companies? I don't
 6 remember any. I had funds from individual donors.
 7 There was one father of a patient who had a bone
 8 marrow transplant gave me a very generous donation
 9 which went into one of these funds, but it wasn't for
 10 or in relation to haemophilia care.
 11 **Q.** Do you recall giving any information to pharmaceutical
 12 companies about patients' HTLV-III results, either
 13 individual patient data, or did you communicate how
 14 many patients were HTLV-III positive to pharmaceutical
 15 companies at all?
 16 **A.** I don't think I would have ever have done that. I'm
 17 trying to rack my brains about the Armour episode,
 18 whether we -- it's possible I might have said I don't
 19 think we've got any, we've had any problems, but
 20 I don't remember anything.
 21 **Q.** When you say "the Armour episode", you are referring
 22 to the seroconversion of heat-treated products?
 23 **A.** Sorry, the heat-treated product that had infected
 24 a number of children at the Children's Hospital.
 25 I don't even remember whether we used that batch at

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1 the Queen Elizabeth Hospital but I couldn't possibly
 2 say it would be impossible that I might have said we
 3 haven't had any transmissions.
 4 **Q.** You were asked yesterday by the Chair about a letter
 5 that had been sent to Professor Hill from Treloars,
 6 reporting that one of the Treloars boys who was
 7 a patient of Professor Hill showed sign of AIDS
 8 stigmata, June 1983, and you commented it was vital
 9 information. This may have been implicit in your
 10 answer, but can I just double-check?
 11 Is it the case that you weren't given that
 12 information by Professor Hill at the time?
 13 **A.** I don't remember him mentioning anything about that so
 14 early.
 15 I've been reflecting on the issue overnight, and
 16 I wonder whether he didn't tell me because the young
 17 man was not going to come to my care when he got
 18 older. I don't know. But I would have thought, in
 19 general, it would have been important information to
 20 know that a patient was showing signs of stigmata,
 21 I think was the phrase, of HIV, yes.
 22 **Q.** So, as far as you can recall, that isn't information
 23 that was ever shared with you?
 24 **A.** I don't remember that, no.
 25 **Q.** Can you recall any discussions in the first part of

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1 1980s with Professor Hill or otherwise about pool
 2 sizes and the risks from pool sizes?
 3 **A.** Which year, sorry?
 4 **Q.** In the early '80s.
 5 **A.** Oh, well I was -- my difficulty here is it always gets
 6 a bit tied up with my subsequent knowledge from
 7 working in the blood service, but my recollection was
 8 that the pool size in the UK was lower than -- the
 9 pool sizes from the United States were much higher,
 10 and of course that, for a low level risk, would make
 11 quite a difference. But that's about the level of it.
 12 **Q.** Then, in terms of the early attempts to heat treat
 13 before the December 1984 change of policy, both from
 14 UKHCDO and for West Midlands, in the course of '83/'84
 15 up until December, did you have any discussions with
 16 anybody about using heat-treated products or obtain
 17 any information about the availability of heat-treated
 18 products?
 19 **A.** I don't have any recollection of that. In fact, the
 20 first I realised that some of the haemophilia centres,
 21 like St Thomas' and Sheffield, were using them from
 22 the middle of '84 was when Mark Winter gave his
 23 evidence.
 24 **Q.** You have referred in your evidence already to certain
 25 knowledge about the donor population in the States,

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1 and the World in Action documentary in the 70s and so
 2 on. Did you have any information or seek to find out
 3 any information about the donor pool in the UK and
 4 whether there was any use, for example, of blood from
 5 prisons in the UK?
 6 **A.** At that time, no. There was use of blood from prisons
 7 in the UK. I came to know quite a lot about that
 8 subsequently. In fact, the collection of blood from
 9 prisons in the UK was encouraged by the Home Office as
 10 part of a social inclusion process of -- for people in
 11 prison.
 12 It later became -- not that much later -- it
 13 became clear that there was a lot of hepatitis B in
 14 prisons, in prison populations, and the use of prison
 15 donors was phased out, variously in different places.
 16 I think by '84 it had all finished. But I may be
 17 wrong. I mean, I haven't mugged this up for you.
 18 **Q.** That's later -- knowledge you acquired later, is it,
 19 rather than knowledge you had in '83/'84?
 20 **A.** At that time I think I had no visibility about prison
 21 donors, no.
 22 **Q.** Then you have made reference in your statement to the
 23 precautionary principle, and I just wanted to explore
 24 that a little with you.
 25 As I understand both your statement and the

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1 principle more generally, it's a principle of adopting
 2 precautionary measures when evidence about a hazard to
 3 human health is uncertain or unclear?
 4 **A.** Yes.
 5 **Q.** So in colloquial terms, one could say one errs on the
 6 side of caution?
 7 **A.** Absolutely yes.
 8 **Q.** It means you don't require proof in order to act. You
 9 may act on the basis of suspicion or concern?
 10 **A.** Well, yes, you would work on -- well, you might look
 11 at the worst case scenario and think "what's the best
 12 thing to do to avoid that", yes.
 13 **Q.** So that I can understand the observations you make in
 14 your statement, you contrast some of the
 15 decision-making in the 80s with what happened in
 16 relation to vCJD in the 90s. An approach such as that
 17 seen from Professor Bloom at that October '83 UKHCDO
 18 meeting, "There's no proof", that's not an application
 19 of the precautionary principle?
 20 **A.** No, it's the opposite. I mean, it's saying, you
 21 know -- it's about no proof. It's about -- it reminds
 22 me a little bit about -- everyone here is wearing
 23 a mask, and at the beginning of the Covid-19 there was
 24 no evidence that masks were helpful. However, it
 25 might have seemed intuitive that masks could be

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1 helpful but it wasn't until some evidence appeared,
 2 some months later, that we all wear masks. It might
 3 have been better if we had worn masks from February
 4 onwards, but ...
 5 **Q.** Then, in your statement at page 87 -- Henry,
 6 WITN4032001 -- you have touched on this already but
 7 you have said:
 8 "What happened to the people with haemophilia
 9 was terrible enough regarding the virus infections.
 10 "It was made so much worse by the failure of
 11 authorities at so many levels to provide support for
 12 them or their families."
 13 Then you refer to the refusals of funding
 14 facilities in Birmingham and the West Midlands and
 15 observe:
 16 "Perhaps this had something to do with the
 17 stigmatisation of people with HIV and the then 'guilt
 18 by association' with groups perceived to be unworthy."
 19 Then you contrast that with:
 20 "The response to vCJD, which seemed so
 21 different. A support package was put in place to
 22 provide medical support and financial security to
 23 those affected. There seemed to be an acceptance that
 24 government policy in respect of changes to animal food
 25 practices had contributed to the condition."

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1 Does it follow from the observations you make
 2 there that you think more could and should have been
 3 done to provide both financial and non-financial
 4 support to those who were infected through the
 5 NHS treatment?
 6 **A.** Yes. Yes, I do. I mean, the -- what I perhaps hadn't
 7 realised was that there had been, clearly,
 8 a reluctance to provide funding for haemophilia care
 9 before all this, in the -- I can't remember whether
 10 you included this in your presentation, but in the
 11 papers that were provided it was quite clear that
 12 Dr Hill was trying to get more support. There was
 13 talk about a nurse was funded by The Haemophilia
 14 Society for a year, and then not taken up.
 15 So I think there was clearly a history of that.
 16 You do see comments in -- I can find them for you
 17 later, but comments from people saying, "That's a very
 18 small number of patients for an awful lot of money".
 19 This is -- I'm not talking about HIV here, about the
 20 provision of Factor VIII.
 21 So I don't really understand why there was such
 22 a reluctance to provide the support, particularly by
 23 '86, when the money was available. And -- perhaps
 24 I shouldn't have used the word "stigmatisation", but
 25 I just wonder why there seemed to be such a lack of

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1 humanity shown by people in senior positions in the
 2 West Midlands Regional Health Authority, to be blunt.
 3 And that wouldn't have helped the infection. That
 4 required major Government input from -- well, you've
 5 heard from David Owen. Self-sufficiency earlier, that
 6 would have made a big difference to HIV. It wouldn't
 7 have completely eliminated it but it would have at
 8 least shown the people with haemophilia that efforts
 9 were being made, rather than nothing, and, once it
 10 happened, you'd have thought the least that could be
 11 done would be that you would provide decent services
 12 for people.

13 As I say, I don't want to go on and on. I think
 14 the issue with -- variant CJD, thank goodness, turned
 15 out to be a small-ish problem. I apologise to people
 16 here who have been notified that you might have been
 17 exposed, but it looks as if it's going to have
 18 affected about maybe 200 people at the most in the UK.

19 But the Government didn't know that when they
 20 put the package in place and it could have been many,
 21 many thousands. And so I think that was a good way of
 22 dealing with it.

23 I spoke to one of the members of staff, one of
 24 the nurses at the CJD surveillance unit in Edinburgh
 25 who was responsible for administering the support

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1 scheme, and I found out a bit about it, and it seemed
 2 to be working very well.

3 It's a terrible disease. Terrible in
 4 a different way from HIV, but still terrible and
 5 fatal. It just seems that at every stage there was --
 6 any opportunity was taken not to help.

7 **Q.** My last question, Professor Franklin, is just about
 8 the patients with sickle cell or the bone marrow
 9 transplant patients whilst you were at Birmingham.

10 Do you know whether any of them -- and if so, in
 11 what number -- were infected with HIV or hepatitis C?

12 **A.** No, I don't, but I can estimate that probably about
 13 20 per cent of the transplant patients who are still
 14 alive, survivors, would have been infected. That's
 15 the figure in Glasgow.

16 **Q.** With hepatitis C?

17 **A.** With hepatitis C. We had one patient in Glasgow who
 18 was infected with HIV.

19 **Q.** And the sickle cell patients?

20 **A.** I don't know, but I would imagine -- they were less
 21 heavily transfused but I imagine there would have been
 22 a few that would have been positive, yes.

23 **MS RICHARDS:** Sir, those are my questions for
 24 Professor Franklin. Is there anything, sir, that you
 25 wish to ask?

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Questioned by SIR BRIAN LANGSTAFF

1 **SIR BRIAN LANGSTAFF:** Yes, there is. What I want to do is
 2 to ask you about four matters which arise from some of
 3 the evidence which you have given.

4 **A.** Yes.

5 **SIR BRIAN LANGSTAFF:** The first: did you have any working
 6 knowledge or understanding of hepatitis B when you
 7 took up your post in Birmingham?

8 **A.** I didn't have lot of personal -- well, I did not have
 9 a lot of personal experience other than that
 10 a colleague in University College, working in the
 11 labs, got infected with hepatitis B, and it turned out
 12 that -- later on, that I had been exposed to
 13 hepatitis B. I mean, that just reflects poor lab
 14 hygiene in the late 70s, I'm afraid.

15 I had a very good understanding of the natural
 16 course of hepatitis B from Dr Barbara in my
 17 transfusion training. So yes, it was pretty
 18 reasonable, I would say. The vaccine came in at about
 19 that time, so I had to do a bit of catch-up with that
 20 but, yes, I think we were pretty aware of the risk of
 21 hepatitis B and checking patients and offering the
 22 vaccine when it became available.

23 **SIR BRIAN LANGSTAFF:** So you would have had an
 24 understanding at any rate that it was highly
 25

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1 infectious.

2 **A.** Very, very infectious.

3 **SIR BRIAN LANGSTAFF:** Transmitted by blood.

4 **A.** Yes.

5 **SIR BRIAN LANGSTAFF:** Was sexually transmissible.

6 **A.** Yes.

7 **SIR BRIAN LANGSTAFF:** And people needed to know that they
 8 had it, if they could be told, because they might go
 9 round infecting other people.

10 **A.** Yes.

11 **SIR BRIAN LANGSTAFF:** The reason I am asking about that is
 12 because you told us that you knew very little about
 13 HIV infection when you first came across that, and you
 14 didn't know much about what might be the natural
 15 history of it, what those who suffered from HIV might
 16 expect.

17 **A.** Yes.

18 **SIR BRIAN LANGSTAFF:** And what advice they should be
 19 given.

20 One of the comparisons, which I understand was
 21 made in the MMWR from the earliest days through, and
 22 that you were reading that at the time, was that the
 23 outbreak of AIDS seemed to have quite a lot in common
 24 with the epidemic there had been of hepatitis B.

25 Did that ever occur to you as giving you some

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1 clue as to what might happen with the HIV infection
2 and AIDS -- well, you didn't know necessarily it was
3 HIV infection, but with AIDS and whatever was causing
4 it, in 1983/84?

5 **A.** I'm not sure the two are quite in such good parallel.
6 I mean, there's no doubt that a lot of the hepatitis B
7 cases in the States, there were major epidemics in gay
8 men, and in fact the -- I remember the publications to
9 do with the vaccine in gay men in the States described
10 the number of sexual partners that they had and it was
11 very large number indeed.

12 I'm not quite sure I accept the analogy.
13 I mean, HIV's a lot less infectious than hepatitis B,
14 other than perhaps with gay sex, but -- and also the
15 natural history's quite different. I think when I was
16 saying I did not know much about HIV, I think we
17 didn't know the natural history of the disease. It
18 was -- sort of very early on was -- one thing that
19 I was taught by John Barbara was what the natural
20 history of the disease was. Most people clear it,
21 some people become carriers and remain infectious
22 long-term, and it was known that some people -- well,
23 quite a lot people -- went on to get hepatocellular
24 cancer. So -- does that answer your question?

25 **SIR BRIAN LANGSTAFF:** It does. I was curious about

1 whether that might have given, as it were, some help.

2 **A.** I think -- well, I certainly think the
3 gay population -- I mean, obviously that was a time
4 of -- you know, another tragedy was that -- you know,
5 we had gay emancipation and the beginning of removal
6 of some the stigmata and then -- stigmatisation,
7 sorry, and yet -- and then AIDS comes along. But,
8 yes.

9 **SIR BRIAN LANGSTAFF:** The second matter is something
10 completely different. It arises out of the discussion
11 that you and counsel had about the question of
12 consent, and what you said in your statement about the
13 process of formal consent being rather different in
14 those days. By "formal consent" I think you mean
15 signing a piece of paper?

16 **A.** Yes.

17 **SIR BRIAN LANGSTAFF:** Four different words were used:
18 telling a patient; discussing with a patient;
19 mentioning it to a patient; or agreeing with
20 a patient.

21 **A.** Right.

22 **SIR BRIAN LANGSTAFF:** I just want to be as clear as I can
23 be about what your practice was, and I appreciate it
24 may have differed from person to person, and you're
25 not able to say with certainty it was adhered to in

1 every single case as a matter of rule, but would you
2 say that there are two separate questions? One is
3 consent in the sense of agreement, so somebody agrees
4 to a course of action knowing, broadly, the relevant
5 matters which will tell someone whether they agree or
6 not.

7 **A.** Yes.

8 **SIR BRIAN LANGSTAFF:** That's informed agreement, if you
9 like, and it doesn't matter for the quality of the
10 agreement whether it's recorded or not, it might be
11 said.

12 **A.** Yes.

13 **SIR BRIAN LANGSTAFF:** There's recording, which, if it's
14 not carried out carefully, may become a tick-box
15 exercise and that itself is a danger because it means
16 there's evidence that there has been consent, but
17 actually there hasn't. There's just a box ticked, as
18 it were.

19 So did you -- as far as you can recall, would
20 you have aimed for informed agreement or a tick box
21 exercise or, somewhere between the two, mentioned or
22 discussed -- "discussed" I suspect means informing,
23 but there's no end product to the discussion. It's
24 just chatting about it.

25 **A.** Well, I think we were aware that testing for

1 HTLV-III/HIV was a big issue. So I think I would have
2 been expecting to reach a sort of mutual agreement
3 that this was something that the person agreed to have
4 done.

5 **SIR BRIAN LANGSTAFF:** By saying "reach a mutual
6 agreement", you were discussing the pros and cons?

7 **A.** We would have been discussing the pros and cons. What
8 was -- there wasn't, at that time, clear -- a clear
9 view of exactly what it meant.

10 I know that when you look back it seems obvious
11 that a positive test meant you were infectious. I'm
12 not actually sure it was clear at the time that that
13 was the case. We certainly didn't know that nearly
14 everyone who was positive would go on to get AIDS. So
15 there were these different things.

16 There was a growing awareness of worries about
17 stigma, insurance. So I think it was important that
18 the person agreed. And, as I say, I do remember
19 a small number of people who decided they would rather
20 not have the test at that time but they did come to
21 agree.

22 I mean, consent is really very important. At
23 around that time I was -- I had introduced a formal
24 consent process for bone marrow transplantation,
25 because at that time in the NHS the only consent,

1 written consent, was for operations, and it was
 2 a single sheet of paper and the person was expected to
 3 sign saying that they agreed to whoever did the
 4 operation -- it could be anybody, not necessarily
 5 a named person -- and they were consenting for
 6 anything else to be done that was considered
 7 appropriate.

8 Now that, we now know, is not any sort of
 9 consent, and that's been tested in law and doesn't
 10 work. But that was all there was then.

11 So I produced a document -- I think the hospital
 12 were a bit reluctant for me to produce this because it
 13 had -- it said to the patient that they would lose all
 14 their hair, that they would become sterile, that they
 15 may die, and listed some of the complications.

16 So trying to make sure my patients understood
 17 what was happening to them was important to me, and
 18 I still feel confident today that I got reasonable
 19 informed consent from them, albeit verbally and in
 20 discussion.

21 **SIR BRIAN LANGSTAFF:** Yes, thank you. That answers that
 22 question.

23 Third, you told counsel that you were surprised
 24 by the practice which you understood to have happened
 25 in other centres, or some other centres, of calling

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1 together people in a group in order to inform them as
 2 to HIV status, positive or negative. Can you
 3 elaborate on what you meant by "surprised"?

4 **A.** Well, I was surprised because I was -- I still
 5 struggle with the concept of how you would do that
 6 while protecting people's confidentiality. And the --
 7 I suppose you could ask people to come to a sort of
 8 lecture room and just do a neutral presentation about
 9 AIDS, HTLV-III or non-A, non-B hepatitis, whatever but
 10 I think the difficulty then would be to maintain some
 11 sort of clarity as to what you were trying to get
 12 across if some of those people in the room were
 13 negative and some of the people in the room were
 14 positive or you didn't know. Perhaps doing that
 15 before you knew might work? I would think it would
 16 still be quite difficult.

17 **SIR BRIAN LANGSTAFF:** So you might be calling people
 18 together, saying, "You are at risk"?

19 **A.** Well, maybe the time to do that would be to say, "You
 20 were at risk and there is a test coming". When
 21 I think back, that might have worked. Even so, I'm
 22 not sure. But, yes, I remain slightly surprised that
 23 that happened.

24 **SIR BRIAN LANGSTAFF:** Yes. Thank you.

25 The final question is the discussion you had

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1 about the precautionary principle, and in the course
 2 of which you mentioned, I think, that you knew quite
 3 a bit about -- or just before that, you mentioned you
 4 knew quite a bit about pool sizes, presumably from
 5 your subsequent experience with the Scottish --

6 **A.** Yes. I think it's difficult for me to separate when
 7 I learnt these things, yes.

8 **SIR BRIAN LANGSTAFF:** Your understanding of pool sizes is
 9 that the NHS pool size was smaller than the US pool
 10 size.

11 **A.** Yes.

12 **SIR BRIAN LANGSTAFF:** I am yet to have a presentation
 13 given to me, or information given to me, on what our
 14 researchers have shown as to the development of pool
 15 sizes from the early 1970s through into the early
 16 1980s. But it may very well be that the pool size
 17 used by the NHS Blood Transfusion Service -- I don't
 18 know if you know what happened to it? Do you have
 19 a sense that it increased during that time?

20 **A.** Well, I think, throughout my time in Scotland, my
 21 recollection was that the pool sizes were between
 22 5,000 and 7,000 donors, donations.

23 I don't know what happened in BPL. I suspect,
 24 to be honest, as much of it was to do with the size of
 25 the facility. And the Scottish facility was modest in

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1 size, so -- and we had a modest population to serve:
 2 5 million plus Northern Ireland, so 6 million. So
 3 I don't know the answer.

4 I know when the concentrates were first used --
 5 which was actually in the 1960s; non-commercial in
 6 Oxford -- they were really very small sizes; less than
 7 300, I think.

8 **SIR BRIAN LANGSTAFF:** So in England, at any rate, the pool
 9 sizes may have gone from just less than 300 in Oxford
 10 in the 1960s, as you said, and increased in size into
 11 the 1980s?

12 **A.** Well, I'm sure they did because it's inefficient to
 13 use very small sizes, yes.

14 **SIR BRIAN LANGSTAFF:** So throughout that period, it was
 15 recognised that the larger the pool, the greater the
 16 risk of infection from whatever might be in the pool?

17 **A.** Well, that was what was -- I think there were lots of
 18 things that were believed. I think pool size was one
 19 of them. Smaller pool size, un-remunerated volunteer
 20 donors. So each of those might have an impact on the
 21 risk at the other end. But if you -- unfortunately,
 22 what turned out to be the case was hepatitis C had
 23 a prevalence in the general population of around about
 24 1 per cent. The restrictions on blood donors reduced
 25 that by almost tenfold. So it was around about 1 in

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1 1,000, I think. So even if you've got a pool size of
 2 5,000 versus 20,000, you're still going to be having
 3 virus in there.
 4 What benefit having less virus -- there must be
 5 some -- there might be some benefit. You can't help
 6 thinking it would be better to have less virus than
 7 more virus. But when you come down to HIV, then the
 8 differences would be more relevant. And I think one
 9 of the issues around the Armour heat-treated product
 10 was that -- my understanding is that the plasma had
 11 not been tested for anti-HTLV-III, so it was not clean
 12 plasma going into that process, and the heat treatment
 13 was required to kill too much virus, and it couldn't
 14 do it, so some of it got through.
 15 So at each step, clean donors, good testing,
 16 modest pool size, all of those things are going to
 17 contribute to safety, I think.
 18 **SIR BRIAN LANGSTAFF:** In respect of your discussion about
 19 the precautionary principle, what do you think that
 20 might suggest to the concept of increasing pool size
 21 whilst an appreciation of risk from pool size was
 22 growing?
 23 **A.** Well, I suppose it's a really difficult question
 24 because you have got a continuum between the pool size
 25 of cryoprecipitate, which is between 10 and 20 perhaps

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1 for an adult, right up to 20,000. So the
 2 precautionary principle might suggest we should have
 3 stayed with cryoprecipitate, I suppose.
 4 **SIR BRIAN LANGSTAFF:** Thank you very much.
 5 **MS RICHARDS:** Professor Franklin, is there anything
 6 further that you would like to add?
 7 **A.** No -- I mean, thank you for mentioning my comments at
 8 the end about the appalling thing that happened. It
 9 was a very difficult period, but the patients were
 10 amazing; showed great fortitude.
 11 **MS RICHARDS:** Thank you.
 12 **SIR BRIAN LANGSTAFF:** Yesterday afternoon when I was
 13 apologising to you for bringing you back for a second
 14 day, you told me that you were here to help.
 15 **A.** I hope so.
 16 **SIR BRIAN LANGSTAFF:** Some people might use that just as
 17 a form of words; others to ingratiate. I believe that
 18 you said it because you meant it, and I would like to
 19 thank you for your contribution because it seems to me
 20 you haven't pursued any agenda of your own, other than
 21 helping the Inquiry. You haven't shirked questions
 22 because the answers might be uncomfortable. You have
 23 given us, I think, as I see it, frank (refreshingly
 24 frank), open and honest answers to the questions which
 25 you have been asked, and I think that deserves

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1 appreciation. Thank you very much.
 2 **A.** Well, thank you for your kind words and excellent
 3 chairmanship.
 4 **SIR BRIAN LANGSTAFF:** Well, I hope that's not because of
 5 those words, but --
 6 **A.** No, no. But I've -- you have been very searching but
 7 positive, I think. Thank you.
 8 **SIR BRIAN LANGSTAFF:** Thank you very much.
 9 **MS RICHARDS:** Sir, we have Dr Wilde's evidence at 2.00.
 10 Dr Wilde will be giving evidence remotely for reasons
 11 of geography and the current pandemic.
 12 **SIR BRIAN LANGSTAFF:** Of course.
 13 So 2.00 back here for Dr Wilde.
 14 **(12.50 pm)**
 15 **(Luncheon Adjournment)**
 16 **(2.00 pm)**
 17 **SIR BRIAN LANGSTAFF:** Good afternoon, Dr Wilde. Can you
 18 hear me?
 19 **THE WITNESS:** Yes, I can, sir.
 20 **SIR BRIAN LANGSTAFF:** Now, I'm glad that you are now on
 21 a large screen facing the audience here in
 22 Fleetbank House, a select band of interested people.
 23 You have -- you won't be able to see them for
 24 particular reasons, but you should know that in this
 25 room there is counsel who will be asking you some

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1 questions in a moment or two after you have been
 2 sworn. She is in the front row of a number of rows
 3 which contain a few legal representatives. There are
 4 representatives of the press in a corner of the room,
 5 shorthand writer and a technician whose job it is to
 6 display to us documents which you will see at your
 7 end.
 8 You are being followed remotely by a very much
 9 larger number of people of various different
 10 interests, so your evidence will be screened to them
 11 as you give it, or shortly after you have given it.
 12 There will be a brief time-lag before they see it.
 13 You are our first witness to be heard remotely.
 14 I'm sorry that you can't be with us because of the
 15 Covid restrictions, but thank you very much for giving
 16 evidence from where you are.
 17 **THE WITNESS:** Thank you for allowing me to do so.
 18 **SIR BRIAN LANGSTAFF:** Not at all. You will be sworn in a
 19 moment, and after that, the next person you see or
 20 hear from will be counsel to the Inquiry who will ask
 21 you the questions.
 22 **DOCTOR JONATHAN THORNTON WILDE (sworn)**
 23 **Questioned by MS RICHARDS**
 24 **Q.** Dr Wilde, can you see and hear me?
 25 **A.** Yes. Now, yes.

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1 Q. I'm going to start just by asking you some general
2 questions about your career. You became, I think,
3 a haematology registrar in 1984?
4 A. Yes.
5 Q. You worked at the Northern General Hospital in
6 Sheffield in that capacity between 1984 and 1986 --
7 A. Yes.
8 Q. -- but as I understand it, you weren't involved in the
9 care of patients with bleeding disorders at that
10 hospital?
11 A. No.
12 Q. You then in 1986, October 1986, took up a role as
13 a lecturer in haematology at the Royal Hallamshire
14 Hospital.
15 A. I think it was earlier that year. I think it was
16 March 1986.
17 Q. Can you just help us with this. I think the job
18 title's "lecturer", and we've heard that from other
19 witnesses, but it was essentially a clinical rather
20 than academic post; is that correct?
21 A. Well, no. It was predominantly an academic post.
22 I was the first lecturer in that department and was
23 employed by the University of Sheffield within the
24 Department of Haematology in the Royal Hallamshire
25 Hospital, and so my predominant role was research in

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1 preparation for my MD thesis.
2 Q. You continued in that role until 1988?
3 A. Yes.
4 Q. To what extent at the Royal Hallamshire -- I think
5 your statement describes some clinical work at the
6 haemophilia centre under Professor Preston; is that
7 correct?
8 A. Yes. I was given responsibility for running the
9 weekly haemophilia or bleeding disorder clinic with
10 the unit sister, and I also had on-call commitments on
11 the on-call rota with the registrars and senior
12 registrars.
13 Q. Then you moved to the -- is it the Royal Liverpool
14 Hospital, where you were from 1988 to 1992?
15 A. Yes.
16 Q. That was as a senior registrar. I think you refer to
17 Professor Hay having been the director at the time or
18 the consultant at the time.
19 To what extent did you have clinical
20 responsibilities during that position?
21 A. I can't remember the exact dates of rotation, but we
22 did rotate around the main hospital to Alder Hey for
23 six months, to the Blood Transfusion Service for six
24 months, and to one of the district general hospitals
25 for six months. So I think I was in the Royal

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1 Liverpool Hospital for around two years and the first
2 time there, probably for about, say, up to 18 months,
3 I was predominantly involved in the care of patients
4 on the wards and in the laboratory, and it was really
5 only -- and I think I was doing some
6 haemophilia-related work at that time, especially when
7 there would be inpatients. But once I got my MRCPath
8 examination, around 18 months into the job, I then
9 expressed a wish to have more of an interest in the
10 bleeding disorder service and, therefore, joined
11 Dr Hay, and I'd sit in on his clinics. I must have
12 done some clinics when he was away and obviously taken
13 more responsibility for the bleeding disorder patients
14 at that time, both in the clinic, on the wards, and
15 obviously out-of-hours.
16 Q. Then in November of 1992, you moved to the Queen
17 Elizabeth Hospital in Birmingham as consultant and
18 Director of the Haemophilia Centre.
19 A. Yes. My job description was specifically solely for
20 being the director of haemophilia, but the
21 circumstances at the time were such that I did get
22 involved in other aspects of haematology within that
23 department.
24 Q. You remained in that post until your retirement in
25 2016.

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1 A. Yes.
2 Q. You were -- in that capacity, you were a member of
3 UKHCDO and some of its working parties, and we can
4 come on to consider those in due course.
5 Can you describe, in broad terms, what the
6 facilities and services were at the haemophilia centre
7 at the Queen Elizabeth when you took up your post in
8 1992?
9 A. Yes. At that time, the unit had evolved over the
10 previous few years, once extra funding had been found
11 to run the service. So we were fortunate in that we
12 had two rooms on the third floor of the Queen
13 Elizabeth Hospital. One was an office/meeting room
14 where all the patient notes were kept, and the other
15 room was a clinical room where we would see patients
16 when they came up outside of clinic times, and the
17 ward was just around the corner for in-patient stays.
18 That was very convenient.
19 The outpatients would -- it continued where
20 Professor Franklin and Dr Hill used to do their
21 clinics on the ground floor of the hospital in the
22 haematology out-patient area. So we had a clinic
23 there on a Thursday morning. I was fortunate to have
24 a full-time nursing sister, a full-time staff nurse,
25 a half-time staff nurse, a full-time community sister,

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1 and also an excellent social worker. So I think that,
 2 compared to some other centres in the country, and I'm
 3 sure you're aware there was a great range of
 4 facilities available for haemophilia care in the
 5 country, and I think that, in retrospect at that time,
 6 I was really quite well off in that regard.
 7 **Q.** Your statement refers to there being regular Thursday
 8 lunchtime meetings --
 9 **A.** Yes.
 10 **Q.** -- at which issues relating to patient care or
 11 treatments would be discussed. Was that something
 12 that had already been taking place, or was that
 13 something instituted by you?
 14 **A.** No, I'm aware that -- I'm sure that after their
 15 Thursday morning clinic, Professor Hill,
 16 Professor Franklin would hold that meeting, and
 17 I simply slotted into that when I came along.
 18 **Q.** Did your appointment overlap at all with
 19 Professor Franklin, or had he left by the time you
 20 joined?
 21 **A.** No, he left, I think, around three months before
 22 I started.
 23 **Q.** Roughly how many patients did you have responsibility
 24 for, again, when you took up the clinic in 19 -- the
 25 centre in 1992?

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1 **A.** I don't have the exact figures here, and probably the
 2 most accurate place to find that would be the Oxford
 3 database, but I vaguely recall around 450 patients.
 4 That's a very vague recollection of all diagnoses of
 5 bleeding disorders who were registered.
 6 **Q.** Your statement suggests around 400 when you commenced
 7 post, and then it rose, you've said, to around 700 by
 8 the time you left in 2016.
 9 **A.** Yes, and I think that was simply because I'd obviously
 10 accrued transfer patients over from the Children's
 11 Hospital, and I was making more diagnoses of bleeding
 12 disorders as more and more diagnostic tests and
 13 recognition of bleeding disorders came along.
 14 **Q.** Can I take you back to your time in Sheffield at the
 15 Royal Hallamshire hospital to start with. Your
 16 statement says that you've no recollection of the
 17 particular policies in place at the Royal Hallamshire
 18 for the selection and purchase of products. That
 19 would have been the responsibility, would it, of
 20 Professor Preston at the time?
 21 **A.** Yes.
 22 **Q.** Presumably, by the time you were there, the products
 23 would have been all heat-treated; is that correct, in
 24 terms of factor concentrates?
 25 **A.** Yes.

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1 **Q.** Your statement suggests you recall the use of DDAVP
 2 there but not cryoprecipitate, and treatment there was
 3 not on a prophylactic basis.
 4 **A.** Quite correct.
 5 **Q.** Do you recall receiving any general advice from
 6 Professor Preston about treatment of patients with
 7 bleeding disorders, or, in particular, the treatment
 8 of patients with HIV?
 9 **A.** I mean, not specifically, but, I mean, if there were
 10 any issues, then he was readily to hand, and also
 11 Professor Greaves as well for me to approach them to
 12 give me management guidance on those various issues.
 13 **Q.** When you started at Sheffield in 1986, presumably some
 14 of the patients of the haemophilia centre there would
 15 have learnt that they were HIV positive as a result of
 16 their treatment in the preceding two years.
 17 Can you recall anything about looking after
 18 newly diagnosed or relatively newly diagnosed HIV
 19 patients in Sheffield at that time?
 20 **A.** I think only that we were monitoring them to a degree.
 21 I honestly can't remember a specific test we were
 22 doing at that time. I can't honestly recall whether
 23 we were doing CD4:CD8 counts. And I think it was
 24 a case of listening to them, getting a feel for
 25 whether they were getting any symptoms at all, and

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1 then examining them to see whether they were getting
 2 any manifestations of the disease.
 3 I'll be honest that although we had a case
 4 through, or we had a case through during my time
 5 there, I can't recall any other specific AIDS
 6 diagnoses at that particular time, but there might
 7 well have been.
 8 **Q.** Did you learn anything about the circumstances in
 9 which those patients had been tested and informed of
 10 their diagnosis for HIV?
 11 **A.** I cannot recollect that at all. I took them over with
 12 them knowing their diagnosis.
 13 **Q.** We just had a strange noise on screen. Can you hear
 14 us okay still?
 15 **A.** Yes.
 16 **Q.** Your time at Liverpool would have coincided with the
 17 development of the test for the hepatitis C virus.
 18 Were you involved at all in arranging for the
 19 testing of patients for hepatitis C at Liverpool or
 20 telling them their diagnosis?
 21 **A.** I honestly have no recollection of that at all.
 22 I think that Dr Hay was a very hands-on,
 23 consultant-led consultant, and I think that he took
 24 responsibility for that.
 25 **Q.** Then if we turn then to the Queen Elizabeth Hospital,

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1 you have said that, as director -- so you have said in
 2 your statement, as director, you had sole
 3 responsibility for choosing which factor concentrates
 4 were used. You've said you can't recall specific
 5 products, but you described a general approach in your
 6 statement in terms of how you would decide which
 7 products to use. You'd look at safety, and you'd look
 8 at the particular issue of inhibitors; is that
 9 correct?
 10 **A.** Yes. I think those were general rules that any
 11 director would be employing when they were choosing
 12 products.
 13 **Q.** You have said that if all things were equal as between
 14 those factors, cost would then be the next
 15 consideration?
 16 **A.** Yes.
 17 **Q.** By this time, there were guidelines published by
 18 UKHCDO, or recommendations about products. As far as
 19 you can recall, did you tend to try and follow those
 20 guidelines?
 21 **A.** Yes. I think they came out a bit later, didn't they?
 22 Probably mid-90s that they became established and
 23 published.
 24 **Q.** There are various versions, but broadly speaking, you
 25 would have looked to those guidelines to give you

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1 a steer?
 2 **A.** Yes. I mean, they were very broad and, again, leaving
 3 a lot to the individual consultant to make the choice.
 4 **Q.** We've seen evidence in relation to the practices in
 5 the West Midlands area in the 1980s that there was
 6 a regional contract placed with usually one
 7 pharmaceutical company, certainly in the first part of
 8 the '80s, and there was a role for the haemophilia
 9 centre clinicians to adjudicate upon the different
 10 bids for that contract.
 11 When you took over in 1992, were the contracting
 12 arrangements still along those lines, or had they
 13 changed?
 14 **A.** I'll be perfectly honest that I have no recollection
 15 of what the exact mechanisms were. I was --
 16 I inherited the pattern of Factor VIII concentrate
 17 usage that was there and continued with that and,
 18 obviously, there would have then been changes in time
 19 as new products came along, especially when it came to
 20 recombinant. But I can't specifically recall direct
 21 negotiations with the purchasers as to which products
 22 we would choose in relation to others.
 23 I mean, it sounds somewhat odd, that, but, as
 24 I say, I've just -- I've got a feeling, and you'd be
 25 able to look at the Oxford returns for what products

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1 we were using at that time, but I think that we had
 2 a pretty stable usage of products at that particular
 3 time. And it might well be -- I'm not sure whether
 4 the -- I mean, the prices did vary from time to time,
 5 but I've got a feeling that we were tending to use --
 6 the products that we were using tended to come in as
 7 the cheaper ones on the tenders, and we were sticking
 8 with those. I mean, that's my vague recollection.
 9 **Q.** As we understand it, Professor Hill ceased to do
 10 a clinic at the Queen Elizabeth Hospital in 1992 and
 11 became full-time at the Children's Hospital.
 12 Did you have interactions and discussions with
 13 Professor Hill, nonetheless, although he was no longer
 14 directly involved with your haemophilia centre?
 15 **A.** We must have had discussions about products that were
 16 to be used across the hospital/the region. I think
 17 that we probably both took a lead on that as to what
 18 products the West Midlands would be purchasing.
 19 **Q.** Do you recall any discussions with Professor Hill
 20 about the events of the 1980s and the circumstances in
 21 which so many children at the Children's Hospital had
 22 become infected with HIV?
 23 **A.** I don't recall any specific discussions with regard to
 24 that. I think that when I took over I just accepted
 25 the fact that that was the situation, and I don't

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1 think I ever kind of looked into the history of it
 2 all.
 3 **Q.** You would have had patients coming to you, new
 4 patients at your centre, who would have been treated
 5 at the Children's Hospital and infected with HIV or
 6 hepatitis C as children at the Children's Hospital.
 7 Do you recall learning anything from patients or
 8 discussing with patients their experiences at the
 9 Children's Hospital or their care under
 10 Professor Hill?
 11 **A.** Not specifically, no. I mean, I obviously had formal
 12 referral letters on the patients, which were very
 13 detailed, giving me the full details and obviously
 14 giving me the impression in the letters that the
 15 patients had been tested for the viruses and either
 16 their parents/themselves had been told the diagnoses.
 17 **Q.** You have made some reference in your statement to
 18 awareness of there having been liver biopsy studies
 19 and research into liver damage at the Royal
 20 Hallamshire Hospital under Dr Preston and, indeed,
 21 Dr Hay.
 22 Was that something in which you had any
 23 involvement at all during your time at the Royal
 24 Hallamshire?
 25 **A.** No, I didn't. I was solely responsible for the clinic

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1 and don't recall any specific involvement in those
 2 studies. I think one of them -- or, a lot of the work
 3 I think was before my time there.

4 **Q.** Yes, it was. I'm just wondering whether it had
 5 continued at all, but we can ask Professor Preston or
 6 Dr Hay about that next week.

7 Then just, still sticking with the
 8 Royal Hallamshire for the moment, in terms of the
 9 approach to testing patients -- I'm not talking here
 10 about HIV or hepatitis C testing, but when patients
 11 came to the weekly clinics at the Royal Hallamshire
 12 Hospital that you were involved with, and you
 13 undertook monitoring, testing, liver function tests
 14 and the like, can you recall what kind of discussions
 15 you had with patients and what kind of information you
 16 gave them about the tests?

17 **A.** I think they would have been aware of the tests that
 18 were being taken for their monitoring. I think that
 19 they'd obviously -- prior to me starting, had become
 20 familiar with the kinds of tests that were being done,
 21 and a number of them showed interest in those, the
 22 test results. I can't specifically recall testing any
 23 new patients for the viral illnesses at that
 24 particular time.

25 **Q.** Your statement says you have a vague recollection at

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1 the Royal Hallamshire of there being serum samples
 2 frozen and stored. Can you recall any more about that
 3 or what patients were told about that?

4 **A.** I think -- just as a matter of habit from the clinic,
 5 I think an extra sample was taken. I've no idea -- it
 6 was just something that seemed to be part of the
 7 routine blood-taking. I have no recollection of ever
 8 having been specifically aware of whether or not the
 9 patients had been informed that was the case. I think
 10 at that time a number of centres were collecting
 11 retrospective samples for -- or collecting samples in
 12 that way so they could be retrospectively tested in
 13 the future, to -- if new infective agents came along.
 14 But I think, again, those are questions that will
 15 probably need to be asked of Professor Preston.

16 **Q.** In terms of your own practice then as director at
 17 Queen Elizabeth, your statement says you didn't have
 18 a policy of storing frozen samples; is that correct?

19 **A.** No, I think that that -- to me, that was full of
 20 issues with regard to consent, and I didn't feel it
 21 was appropriate to be collecting those samples in
 22 that, I suppose -- I mean, you could argue that
 23 perhaps this is a bit naive, but I had every
 24 confidence that the treatments we were using then were
 25 safe and that we would never need to be using those

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1 samples anyway.

2 **Q.** As far as you are aware, had there been or was there
 3 when you arrived at the Queen Elizabeth any existing
 4 bank of stored samples?

5 **A.** I cannot recollect that. I can't recollect that there
 6 were freezers in the laboratories full of samples that
 7 were then thrown out. I have no recollection of that.
 8 But I certainly had -- I certainly -- I made
 9 a decision as soon as I became a consultant that it
 10 was inappropriate to be collecting retrospective
 11 samples. I mean, that could be criticised but, as
 12 I say, that was my policy.

13 **Q.** Then, in terms of a routine appointment at the
 14 haemophilia centre at Queen Elizabeth once you were
 15 director, if you had a new patient or a patient,
 16 perhaps transferring from the Children's Hospital to
 17 your care for the first time, what kind of tests would
 18 you be undertaking on a regular basis from 1992
 19 onwards in terms of liver function tests or CD4 counts
 20 for the HIV positive patients? Can you give us an
 21 overview.

22 **A.** I'd obviously be checking a full blood count and I'd
 23 be checking their clotting factor levels.

24 It would be inevitable that they'd come over
 25 from the Children's Hospital or even transferred from

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1 other centres with their viral serology having been
 2 done, because obviously those tests were available at
 3 that time, but I must admit that I would be repeating
 4 those tests to make sure that they were genuine,
 5 because, again, we had a number of false positive
 6 tests in the early days of testing, as I'm sure you're
 7 aware.

8 I'd test their hepatitis B status as well. I'd
 9 do an inhibitor screen to make sure they hadn't got
 10 antibodies against Factor VIII. I'd be doing their
 11 liver function tests, as you say and if they were
 12 HIV infected, then the obviously starting the
 13 monitoring of their CD4/CD8 counts.

14 **Q.** What would you routinely tell such patients about the
 15 purpose of such tests?

16 **A.** I'm sure I'd be mentioning that I was repeating the
 17 viral tests to make sure that they were obviously --
 18 well, to make sure they were genuine. And many of
 19 them were aware that they'd been having their liver
 20 function tests, CD4/CD8 counts done where they
 21 previously were, so I don't think there was anything
 22 new that I was having to tell them in that regard to
 23 the monitoring.

24 **Q.** Do you recall whether you had any patients who had not
 25 been tested for HIV and for whom you had to arrange

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1 a first test for HIV?

2 **A.** Very occasionally a patient would come along that had

3 had product that could have put them at risk, and we

4 then had to counsel them with regard to the testing,

5 and then obviously organise the testing and arrange

6 for them to be informed of the test result in person.

7 **Q.** On those occasions, did you ensure that patients were

8 told in advance that you wished to test them for HIV,

9 and that you secured their consent?

10 **A.** Absolutely. Again, in those days we weren't routinely

11 getting written consent but I would definitely be

12 making sure that I got oral consent from them for that

13 test.

14 **Q.** In terms of hepatitis C, your statement indicates that

15 you thought that the majority of patients had been

16 tested for hepatitis C before you arrived in

17 late 1992. I should say that Professor Franklin

18 doesn't have any recollection, he says, of arranging

19 for tests for hepatitis C.

20 Doing the best you can, Dr Wilde, what can you

21 recall about the position at Queen Elizabeth as

22 regards hepatitis C testing?

23 **A.** My recollection is that I was seeing patients in the

24 clinic who had already been screened for

25 hepatitis C -- and I can see the -- I can -- in my

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1 mind's eye I can see the result in the list of

2 results, in the patients' notes, together with their

3 HIV results, their hepatitis B results. I mean, the

4 test had been available for at least two years before

5 then, and I think -- and they were definitely being

6 tested at the Children's Hospital. So I think --

7 I have to be honest that I think it's unlikely that

8 I was inheriting a cohort of adult patients that had

9 not been screened for hepatitis C.

10 I really -- if that had been the case, I'd have

11 had a great recollection of having to counsel those

12 people to say that we've now got a test for this new

13 virus that is deemed to be the cause of previously

14 known non-A, non-B hepatitis, and then subsequently

15 testing them and informing them of their results.

16 **Q.** There were, I think, some patients who had not been

17 tested and for whom you were arranging tests from --

18 I'm not sure exactly what proportion but your

19 statement suggests a minority of patients -- where you

20 had to arrange tests for hepatitis C testing; is that

21 right?

22 **A.** Yes, these would be patients that will have had

23 product in the past but were not on a regular

24 follow-up in the clinic. They might have moved

25 address, possibly moved away, and they'd been lost

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1 from the follow-up system, and every so often they'd

2 come up and we'd realise that they were potentially at

3 risk because they'd had previous

4 un-virally-inactivated product, and then we would

5 arrange testing for them with, naturally, the full

6 counselling beforehand. But again, I reiterate we

7 were not getting written consent for that testing.

8 Then we'd subsequently inform them of the result in

9 person.

10 **Q.** Would it have been your practice to record in the

11 patient's records the pre-test counselling process and

12 the fact that you were arranging for their testing and

13 had sought their consent?

14 **A.** I would have definitely recorded that they were having

15 a hepatitis C test.

16 **Q.** Would you have recorded -- as a matter of general

17 practice, I'm not expecting you to be able to remember

18 the details of individuals, but as a matter of general

19 practice would you have recorded not just the fact of

20 the test but the fact of a discussion with the

21 patient?

22 **A.** I think at times I would have used the words "fully

23 counselled with regard to hepatitis C", something like

24 that.

25 **Q.** What can you recall about telling patients, whether

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1 they were patients whose test you had arranged or

2 patients who had been previously tested but were

3 unaware of their diagnosis, what can you recall about

4 telling patients that they had hepatitis C in the 90s?

5 What kind of information would you provide?

6 **A.** Well, I think that once they had a positive test

7 result I'd have to inform them that it looked like

8 they'd got chronically infected with the virus and

9 that we would continue to monitor them to see whether

10 or not they were going to go on and develop

11 significant liver disease. I think that had to be

12 part of the counselling to them. If they had minimal

13 evidence of any progression, we would reassure them to

14 that effect.

15 If I was concerned about any of those patients,

16 I would refer them to my hepatology colleagues.

17 I mean, we're talking about this window of time

18 between me starting at the QE and the setting up of

19 this special hepatitis C clinic that I subsequently

20 did. And in that meantime, I think that, as I say,

21 I would still be referring patients I was concerned

22 about to the liver clinic for a more formal work-up

23 and I think -- I think that at that time we might have

24 done one or two liver biopsies to see what the state

25 of the liver was, because, I'm sure you are aware, at

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1 the time that was really the only definitive test we
 2 had to determine how progressed the hepatitis C had
 3 got in individual patients.
 4 **Q.** Were the liver biopsies performed by you or were they
 5 undertaken by the specialist liver clinic?
 6 **A.** No, they were undertaken by the specialist liver
 7 clinic, but obviously with my guidance with regard to
 8 the appropriate factor concentrate replacement
 9 regimen.
 10 **Q.** Then, in terms of the treatments for hepatitis C,
 11 which obviously changed significantly over your time
 12 as director at the centre, the first treatment
 13 routinely used was interferon. What can you recall
 14 about your patients' experiences with interferon?
 15 **A.** Within that time period when we had interferon on its
 16 own, I do recall one or two patients being offered it
 17 by the liver clinic, but on the whole, it was
 18 associated with significant side effects and really
 19 was very ineffective.
 20 I'm sure you are aware from trials that
 21 interferon on its own as a single agent was only
 22 giving around a 10 per cent sustained clinical
 23 response. I mean, a number of them actually tended to
 24 normalise their liver function tests while they were
 25 on it, but as soon as they came off it, then the

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1 hepatitis C came back.
 2 I mean, I think these are the days before we had
 3 PCR monitoring to specifically assess the effect of
 4 interferon on its own, but it was very ineffective.
 5 So patients were going through prolonged treatment,
 6 having very bad side effects with, unfortunately, very
 7 little success.
 8 But then, subsequently, of course, ribavirin
 9 came along, and the combination of interferon and
 10 ribavirin was more superior, and that's around the
 11 time when we become -- we certainly became more
 12 aggressive in our hepatitis C management because, at
 13 this stage, we'd got some more hopeful therapy and, of
 14 course, the hopes of response and sustained remission
 15 were improved even greatly when pegylated interferon
 16 came along in combination with ribavirin.
 17 **Q.** Whose responsibility was it as clinician to prescribe
 18 the interferon, whether on its own or in combination,
 19 and to warn patients of the side effects? Was that
 20 you, was that the hepatologist, or was it a joint
 21 exercise?
 22 **A.** No, it was the hepatologists would do that.
 23 **Q.** What were the arrangements, first of all, in the
 24 course of the '90s, so from late '92 when you arrived
 25 onwards for screening and following up and observing

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1 for signs of liver disease and progression of liver
 2 disease?
 3 **A.** Well, as I say, I'd be seeing patients in clinic every
 4 six months and assessing them clinically doing their
 5 tests, and if I was concerned -- again, very
 6 difficult. You couldn't really tell what was going on
 7 actually in the liver at the time but if I did have
 8 any concerns about a patient, then I would refer them
 9 directly on to the liver clinic and, as I say, some of
 10 those patients then subsequently were worked up and
 11 were offered a course of interferon therapy.
 12 **Q.** There were, your statement says, some patients who
 13 underwent liver transplants in due course.
 14 **A.** Well, in fact, interestingly, I don't -- I'll be
 15 honest that I don't think any of my -- any of the QE
 16 patients, in fact, actually got to the stage of liver
 17 transplantation. Although we were, I suppose,
 18 a national unit for liver transplantation within the
 19 Queen Elizabeth Hospital, I don't recollect any of my
 20 own patients that I was looking after who actually
 21 subsequently went on to have a liver transplant.
 22 **Q.** What were the arrangements for HIV care when you
 23 joined in late 1992?
 24 **A.** The patients were -- the HIV-infected patients, as you
 25 know, were being looked after in the haemophilia

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1 clinic by Professor Franklin and Professor Hill and
 2 I think that they -- Professor Franklin in his
 3 evidence gave the impression that HIV infection was
 4 not greatly established within the non-haemophilia
 5 patients in the West Midlands at that time, and
 6 I think because of my previous experience in
 7 haematology, looking after immune compromised
 8 patients, and my experiences in HIV specifically, both
 9 at the Hallamshire and the Royal Liverpool Hospital,
 10 I was very happy to continue to be looking after the
 11 patients as a number of my colleagues around the
 12 country were looking after the HIV aspects of the
 13 patients' care.
 14 Again, equally, the patients themselves were
 15 more than happy to stay within the haemophilia unit
 16 because they didn't wish to be going to clinics with
 17 the other at-risk group patients. Some of the
 18 patients, as you know, did go -- did subsequently go
 19 for their care to either a GU consultant with
 20 specialist interest in HIV or an infectious disease
 21 consultant who had an interest in HIV.
 22 Again, there was specific aspects about the
 23 management of HIV that fell under the auspices of
 24 haematology. A lot of them had immunological
 25 manifestations which I was readily able to manage and,

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1 of course, I'm sure you're aware that the drugs that
 2 came along, the protease inhibitors, were associated
 3 with a very unusual bleeding pattern in the
 4 haemophilia patients which, again, was probably better
 5 for me to be attempting to manage that. Of course,
 6 a lot of the patients also had thrombocytopenia as
 7 well which came under the auspices of haematology.

8 So I had a great interest in HIV, as I'm sure
 9 you can tell from my witness statement and research
 10 and papers, and so I was very happy and keen to
 11 continue the management of the HIV infected patient
 12 cohort.

13 **Q.** In terms of -- reverting to the HCV patients,
 14 although, of course, many would have been co-infected,
 15 your statement puts early 1994 as the date on which
 16 the joint clinic with hepatology was established. Is
 17 that about right?

18 **A.** Yes, yes. I mean, this was a time when we realised
 19 that a lot of patients that had treatment during the
 20 1980s and had been lost to follow-up, and I felt it
 21 was absolutely vital to be getting all these patients,
 22 inviting all these patients up to the hospital for
 23 appropriate counselling and screening. Many of them
 24 turned out not to actually have hepatitis C, but
 25 a considerable number did have hepatitis C, and we

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1 were able to then manage them appropriately. It was
 2 around the time when interferon ribavirin came along
 3 and, therefore, it was -- seemed far more appropriate
 4 to be more active in managing these patients because
 5 we had the chance of actually curing the infection.

6 **Q.** Did the arrangement for a joint haemophilia liver
 7 clinic continue throughout the time that you were
 8 director, or was there a time when those arrangements
 9 changed?

10 **A.** I think that -- I can't remember the length of that
 11 clinic, but the main exercise was to make sure that we
 12 captured all patients who were known hepatitis C
 13 positive or had been exposed so that we could check
 14 whether or not they were hepatitis C infected. And
 15 when we'd managed to work through all the patients and
 16 manage them as we saw fit at that particular time and
 17 offer them -- I won't go into the specifics about how
 18 we decided whether or not, as you know -- it was liver
 19 biopsy guided as to how we managed these patients.
 20 But, subsequently, we decided that we didn't need to
 21 continue with a liver biopsy approach in that the
 22 treatments became far more effective, and it seemed
 23 far more appropriate to offer the hepatitis C PCR
 24 positive patients the antiviral therapy upfront in an
 25 attempt to cure them all even before the minimally, or

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1 the ones with minimal progression had actually had
 2 a chance to progress any further.

3 **Q.** What were the arrangements at the centre for the
 4 provision of social work, support and counselling?

5 **A.** As I say, I was fortunate throughout my career to have
 6 a number of excellent social workers and, again, as
 7 you know, many of the centres in the country did not
 8 have dedicated social workers, and I think these
 9 people were invaluable to the service. They provided
 10 far more than social support. I mean, they were the
 11 principal counsellors within the unit. Admittedly,
 12 the nursing staff were excellent as well. They were
 13 well trained in the counselling of all the various
 14 problems that arose. But the social workers, as they
 15 progressed through, were again very experienced and
 16 the social worker I had probably for about 15 to
 17 20 years during the latter part of my career was
 18 absolutely brilliant and worth his weight in gold, and
 19 I'm sure the patients will iterate that as well.

20 **Q.** You've said in your statement that there was no
 21 dedicated counsellor or social worker for the specific
 22 care of HIV and HCV-infected individuals, and the
 23 social worker who you mentioned was responsible for
 24 all components of social care relating to bleeding
 25 disorder patients, so it would include but was not

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1 limited to the particular problems associated with HIV
 2 and hepatitis; is that right?

3 **A.** Yes.

4 **Q.** What, if anything, can you recall about the ability to
 5 obtain funding for treatment for HIV and for
 6 hepatitis C? Did you encounter difficulties?

7 **A.** From my recollection, I can't recall specific issues
 8 with regard to HIV because the HIV budget was funded
 9 by the region for all categories of HIV infected
 10 patient, and I can't recall any real specific issues
 11 with regards to that.

12 And, again, the interferon ribavirin was funded
 13 via the liver unit. They would obviously apply for
 14 funding. I think there were initial very early on
 15 problems with interferon ribavirin, but I think that
 16 we were fortunate in that we had permission to use
 17 those drugs at a very early stage, compared to other
 18 units around the country.

19 **Q.** In relation to patients -- those patients for whom you
 20 were arranging their testing for hepatitis C, what
 21 were then the arrangements for informing them of
 22 a positive test result? Did it wait until the next
 23 appointment? Were they called in for a special
 24 appointment? Notified by letter? How was it
 25 undertaken?

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1 A. We'd call them in specially after the test results
 2 were available. I certainly wouldn't be leaving it
 3 from one clinic to the next to inform them and
 4 certainly when we had the joint clinic, we would
 5 either schedule them for a follow-up appointment in
 6 that clinic after we tested them, or I'd arrange to
 7 see them back in the routine bleeding disorder clinic
 8 on a Thursday morning.
 9 So I don't recall there being any significant
 10 delays between the testing and the information because
 11 we obviously had those people at the top of our minds
 12 that we were awaiting test results on them.
 13 Q. For those for whom you were not arranging the testing
 14 but who had been, as far as you understood it, tested
 15 for hepatitis C before you joined, did you become
 16 aware that there were patients who had been tested for
 17 hepatitis C but had not been told their diagnosis, or
 18 had not been told the test result?
 19 A. At the time, I can't recall that that was the case.
 20 I mean, obviously, some of these comments have come up
 21 in witness statements. But at the time, I cannot
 22 recall having had patients that had come through who
 23 were hepatitis C positive that I wasn't aware that
 24 they didn't know that particular diagnosis. But it's
 25 possible that was the case.

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1 Q. Was there any systematic attempt, whether as part of
 2 an organised look-back exercise or otherwise, at the
 3 Queen Elizabeth Hospital to identify all patients who
 4 might have been exposed to hepatitis C and arrange for
 5 them to be tested? And, if so, when was that
 6 endeavour undertaken?
 7 A. That's exactly what we did when we set up the joint
 8 clinic in 1994. We had a look-back through all the
 9 patient records that -- we had an index system, so we
 10 knew who had previously been registered with us and
 11 whether or not they had had clotting factor at the
 12 time that they could have potentially been infected.
 13 Again, we tasked ourselves with inviting them all up
 14 to this joint clinic, and it's possible we might have
 15 missed one or two patients or some of them had moved
 16 and we didn't trace them, but I think we did the best
 17 we could to identify all those patients and offer them
 18 appropriate treatment.
 19 Q. Do you recall, very approximately, how long that
 20 localised look-back exercise took?
 21 A. Well, I mean, it must have taken a few months, I'd
 22 have thought, as we were gearing up to starting that
 23 particular clinic and that would be probably the
 24 latter end of 1993.
 25 I mean, I think I would just say here that, as

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1 you're aware, we had this massive HIV problem in
 2 Birmingham and, as a single-handed consultant, a vast
 3 bulk of my time was taken by managing all the problems
 4 that arose, and I think that certainly hepatitis C at
 5 that particular time was taking a bit of a back seat,
 6 because obviously we had no specific management for
 7 those patients. And it was only when I felt I'd got
 8 control more of the HIV situation that we realised
 9 that there were potentially a lot of people who were
 10 HIV negative who could have hepatitis C infection, and
 11 that's when we set about setting up this clinic.
 12 Q. Can I ask you to give us an overview of the
 13 introduction of recombinant products at Queen
 14 Elizabeth Hospital and what steps were taken to try to
 15 obtain funding for recombinant.
 16 A. I have no specific recollections apart from the fact
 17 that, as you're probably aware, the UKHCDO decided we
 18 should have this gradual introduction -- I think it
 19 was a three-tiered approach, where the children would
 20 be introduced to the product, the recombinant
 21 products, first and then I think it was the younger
 22 adults and then the older adults. So we set about
 23 that exercise as outlined by the UKHCDO guidance.
 24 I think there were initial problems attempting
 25 to get funding for recombinant from the West Midlands

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1 region, and you've obviously got a document to that
 2 effect, but I don't think those were very lasting.
 3 I think that the West Midlands region came on board
 4 fairly quickly after discussions with them and agreed
 5 to fund the recombinant product.
 6 Q. Now, you were centre director and consultant at the
 7 time when the issue of vCJD came to the fore, and I'm
 8 just going to ask you to look at a handful of
 9 documents with me in relation to that.
 10 Henry, could we have, please, VART0000953,
 11 please. I'm hoping this document will appear on your
 12 screen as well, Dr Wilde.
 13 Can you see there, Dr Wilde, minutes of
 14 a meeting of the UKHCDO executive committee on
 15 20 November 1997?
 16 A. Yes.
 17 Q. You've said in your statement -- we know that you were
 18 present your name is on the list of attendees you have
 19 said on your statement that you recall attending
 20 a meeting in 1997 to discuss the question of vCJD.
 21 If we go to -- sorry, Henry, it's page 125.
 22 And we look at paragraph 13 -- if you could zoom
 23 in on that please, Henry -- we can see there,
 24 Dr Wilde, recorded a discussion about providing
 25 information to patients. So it reads:

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1 "The first part of the afternoon session was
 2 spent discussing the problems arising from the recent
 3 withdrawal by BPL of batches of Factor VIII because of
 4 possible risk of transmitting vCJD. Dr Ludlam
 5 expressed concern over advice by BPL to haemophilia
 6 directors that recipients should not yet be informed.
 7 It was acknowledged that there was an ethical problem
 8 in that no diagnostic test was available to exclude or
 9 confirm infection in these individuals. Furthermore,
 10 such information and attendant uncertainty could cause
 11 considerable distress to recipients and their
 12 families. Professor Lee felt that the responsibility
 13 for disclosing such information should rest with the
 14 centre directors and suggested that they should at
 15 least make a record in the case notes.
 16 Professor Savidge indicated it would be better to
 17 inform the patients. Professor Lee suggested the
 18 UKHCDO should prepare a paper for The Haemophilia
 19 Society. Dr Mayne suggested that other blood products
 20 should also be brought to the attention of hospitals'
 21 transfusion committees."

22 So we can see there, Dr Wilde, I think, a debate
 23 over the question of what information to provide -- or
 24 whether to provide information to recipients of
 25 particular batches.

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1 Can you recall anything about your views at that
 2 time of those concerns?

3 A. I think that, as I say, the situation was far from
 4 clear at that time as to -- it was purely hypothetical
 5 that variant CJD could be transmitted and, as you are
 6 probably aware, it was the East Lothian Health
 7 Authority ethical board that had stated that the
 8 patient should not be informed, and that was obviously
 9 passed on to BPL themselves.

10 I think that the majority of us at that meeting
 11 were of the opinion that we should just await
 12 developments, and -- rather than jumping the gun and
 13 informing patients, until we had more information
 14 about the potential for a variant CJD transmission.

15 So my view was just to hold fire and wait and
 16 see.

17 Q. That was November 1997. We can see there was
 18 a West Midlands meeting in January 1998.

19 Henry, could we have BWCT0000036, please. We
 20 can see, Dr Wilde, this is the West Midlands Regional
 21 Working Party on the Treatment of Haemophilia. We
 22 have looked at minutes of this working party from
 23 the 80s with Professor Franklin yesterday and today.

24 Dr Hill's in attendance, you're in attendance,
 25 and we can see from the first paragraph that the

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1 meeting's been called to consider recombinant --
 2 because there had been a refusal to fund it -- but
 3 also to consider the issue of vCJD transmission.

4 Henry, could we go to the next page, please.

5 The paragraph halfway down the page, beginning
 6 "Dr Wilde reported", could we just zoom in on that.

7 The minutes contain various different clinicians
 8 reporting the current situation in their units and
 9 this is yours, and you deal here with a both
 10 recombinant and the vCJD issue. The minutes say:

11 "Dr Wilde reported that the QE Haemophilia
 12 Centre was grossly overspent. Until this financial
 13 year, the contract with the Purchasers for provision
 14 of Haemophilia Services had been largely open-ended,
 15 but the Hospital had signed off the contract with the
 16 Purchasers for the current financial year without
 17 Dr Wilde's knowledge, and the agreed budget had been
 18 set too low. In addition, considerable expense had
 19 been incurred in the purchase of the recombinant
 20 Factor VIIa for the management of a patient with
 21 a Factor VIII inhibitor. The QE Chief Executive had
 22 subsequently instructed Dr Wilde to postpone any
 23 elective surgery for haemophilia patients for the time
 24 being. He had also advised Dr Wilde not to inform the
 25 relevant patients that they had received Factor

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1 concentrate from the batches recalled by BPL.
 2 Dr Wilde and the Chief Executive were due to have
 3 a further meeting to discuss the present situation
 4 within the next few weeks. Patients had been
 5 discussing the potential problem of [new variant]
 6 CJD -- some wished to change to American concentrate
 7 whereas others were happy to remain on Replenate."

8 And then the minutes refer to an offer from
 9 Alpha to supply high purity concentrate.

10 Now can I just ask you about the various matters
 11 set out in that record.

12 First of all, can you recall anything about the
 13 issue about the contract and the haemophilia centre
 14 being overspent?

15 A. I think that this was a new -- from what I recall,
 16 this was a new Chief Executive (who was a clinician)
 17 and I think he ran a very tight ship, and he was
 18 acutely aware of the vast expense of haemophilia as
 19 part of the Trust budget, and I think he wanted to
 20 make sure that he had the monies to finance
 21 haemophilia during that subsequent financial year, or
 22 during that financial year, and had therefore, it
 23 seems like, taken it upon himself to have made sure
 24 that the contract was signed for that amount of money,
 25 to ensure that money was there.

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1 I don't think that it was appreciated that the
2 West Midlands -- certainly the people I dealt with at
3 the West Midlands region -- were, and I have to say
4 this, that right the way through they were very fair
5 and they were very amenable, very good to work with.
6 They appreciated the ups and downs of the cost of
7 haemophilia treatments from year to year. You could
8 not budget/predict. And therefore we had this, as
9 I said at the top, an open-ended agreement, whereas if
10 we were underspent in a year, they would claw monies
11 back, if we overspent, then they would make sure
12 monies were available.

13 That arrangement was in existence up until this
14 financial year, and subsequently carried on in the
15 future, and it was a very advantageous to all of us,
16 within -- all the treaters within the West Midlands.

17 But, as I say, at this particular time,
18 obviously unbeknown to me, there was a fixed amount of
19 money in the pot, and I wasn't aware at the time that
20 any more monies wouldn't be made available. So I had
21 to -- to placate the Trust executive, I had to make
22 sure that there was a clawback on the use of
23 concentrate, make it more economical, and in fact, as
24 it transpired, this was just a little blip by an
25 expensive inhibitor patient early on in the year and,

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1 of course, that was the problem -- this was early on
2 in the financial year -- which looked as if the
3 projected overspend was going to be massive. But that
4 problem sorted itself out, and we managed to get back
5 on course such that we came within budget during that
6 particular financial year. So that's to explain the
7 economics in that regard.

8 **Q.** Then the advice that you were apparently given by the
9 Chief Executive not to inform the relevant patients
10 that they'd received factor concentrate from the
11 batches recalled by BPL.

12 Can you recall what the concerns were from the
13 Chief Executive's perspective and whether you accepted
14 and adhered to that advice?

15 **A.** I must admit that that was my opinion at the
16 particular time, and I think he was a clinician who
17 was obviously acutely aware of the potential for
18 giving information about a hypothetical situation and
19 causing undue concern and alarm and, therefore, he
20 gave me that directive which I must admit that I did
21 go along with.

22 **Q.** We know that in 2001 there was a process that you were
23 involved with in notifying patients about vCJD. Could
24 we go to WITN1387003, please, Henry. If we go to the
25 next page, we can see this is a letter from you dated

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1 29 January 2001. The subject is "New variant CJD and
2 BPL factor concentrates". You have set out in the
3 letter some information about new variant CJD:

4 "So far, approximately 80 people in the UK have
5 been diagnosed as having nvCJD. However, there's no
6 evidence that this condition is transmissible by blood
7 or blood products. No patient with haemophilia has
8 been reported as having developed variant CJD."

9 Then you say:

10 "We've recently been informed by the UK Bio
11 Products Laboratory that some batches of Factor VIII
12 and Factor IX concentrate made by them in 1996 and
13 1997 contained plasma from a blood donor who's
14 recently developed new variant CJD. I am writing to
15 inform you that, having checked through our records,
16 it would appear that you've received product from one
17 of the implicated batches."

18 Now, pausing there, does that second paragraph
19 refer to the discussions about product recall that
20 we've already looked at from 1997 and 1998, or was
21 this a further problem that had come to your
22 attention?

23 **A.** No. There were more batches that were subsequently
24 found by BPL and, of course, there was a change in the
25 stance of the UKHCDO then, such that the guidance

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1 decided -- or rather they decided as a group that we
2 should ignore the East Lothian advice, and it was then
3 up to ourselves to decide whether or not we should be
4 informing patients. A number of my patients were
5 aware of the variant CJD issue, so I'd made
6 a decision, as many of my colleagues around the
7 country did, that we should start to inform our
8 patients about this particular situation.

9 So I think it was the fact that there were more
10 batches that were implicated, and that potentially
11 meant there were more patients who had had these
12 batches and were, therefore, potentially at risk of
13 the infection. So my stance -- and this letter's
14 actually a UKHCDO letter that was drafted. I'm not
15 sure who actually wrote it, but the Chairman allowed
16 us to use the letter but putting our own hospital
17 header on it for the circulation to patients.

18 I'd made a decision that I was going to let all
19 my patients know whether or not they had received
20 implicated batch. Some of my colleagues decided that
21 they would throw it to the patients and ask them
22 whether or not they wanted to know and I think that
23 one or two colleagues perhaps decided still to defer
24 and not to actually let patients or inform patients of
25 this situation.

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1 **Q.** You refer in the third paragraph, or the standard
 2 letter refers to an information sheet from
 3 The Haemophilia -- sorry, an information sheet about
 4 vCJD and a statement drafted by The Haemophilia
 5 Society, which we've got on the following two pages.
 6 Do you recall what the reaction of patients
 7 receiving this letter was. Without identifying any
 8 single patient, what was the overall reaction, can you
 9 recall?

10 **A.** I think that patients took it remarkably stoically.
 11 In fact, I think they were, on the whole, a very
 12 pragmatic bunch. They'd already been through
 13 HIV/hepatitis C, and I think their attitude was, "Oh,
 14 yeah, another possible infection." And I think
 15 that -- I mean, I tried to reassure them because,
 16 obviously, many of them had direct communication with
 17 me, personal conversations and, again, we had to
 18 reiterate -- I mean, just to say that, right from the
 19 start, that I never -- I was never really concerned
 20 that variant CJD was going to be a problem. I felt
 21 that the way that the blood was being processed and
 22 produced that it was very unlikely that this prion
 23 protein would actually get into the factor supply.
 24 And I was really, I suppose, trying to reassure them
 25 in that regard that I felt obliged to inform them of

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1 the risk but that so far none of the patients who had
 2 received these products had actually gone on to
 3 develop variant CJD and, because of the timelag then
 4 between the donations and the information being sent
 5 to them, it was getting to the extreme limit of the
 6 conventional incubation for the variant CJD infection.

7 **Q.** There's a document you completed, a Haemophilia
 8 Society questionnaire, I just wanted to ask you about.
 9 Henry, it's HSOC0004241.
 10 So we can see this is completed by you. It's
 11 a Haemophilia Society questionnaire. The date looks
 12 as though it's 17 December 2001.
 13 It says:
 14 "Looking back to the period from January 2001 --
 15 following notification from BPL that a plasma donor
 16 had been diagnosed with vCJD ..."
 17 Then you are asked a series of questions. You
 18 received the information from BPL, your patients were
 19 affected.
 20 Then there's this question:
 21 "Did you notify (a) only those who had received
 22 implicated product or (b) did you notify your whole
 23 patient group?"
 24 You have ticked "Whole patient group", and the
 25 reasons are given:

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1 "Blanket' informing of patients preferred, in
 2 particular 'non' affected patients to reassure them."
 3 Can I just ask you to explain what that refers
 4 to and what your reasoning was.

5 **A.** Right, so I sent out that letter to the individuals
 6 who we had identified as receiving the implicated
 7 batches. Then I also sent out a letter to individuals
 8 who had not had implicated batches -- they might not
 9 have even ever had NHS concentrate anyway -- and that
 10 was a case of telling them and of course, equally,
 11 I decided this had to be done by letter because we
 12 couldn't possibly get all the patients up individually
 13 to counsel them in person in a short period of time,
 14 because it was absolutely vital, especially from the
 15 health issues, the public health issues that arose,
 16 that we should inform them immediately really, and the
 17 best way of doing that, we felt on balance, was by
 18 letter. So that was my thinking.

19 **Q.** Then if we go to the third page, please, Henry, the
 20 question is asked at the top:
 21 "If this situation arose again, what -- if
 22 anything -- would you do differently or do you feel
 23 could have been improved about the response?"
 24 And you've said:
 25 "Ideally, personal counselling but as so many

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1 patients 'affected' this was simply not possible due
 2 to the immediacy of information dissemination
 3 required."
 4 **A.** I think that sums up what I've just said in my
 5 statement.
 6 **Q.** Then there was a 2009 notification that -- there may
 7 have been others as well, but if we just go to --
 8 I will just find the reference.
 9 Henry, it's ABMU0000060.
 10 You have said in your statement that you vaguely
 11 recall a 2009 letter, which I think you decided not to
 12 send; is that correct?
 13 **A.** Yes, I think many of my colleagues decided not to send
 14 it as well because, again, it was quite an
 15 out-of-the-blue letter really and, as you see, the
 16 date, February 2009, was getting on for -- well,
 17 I mean, it's ten years, really, since the original
 18 notification, and I felt this letter was very -- well,
 19 somewhat confusing and potentially alarmist to the
 20 patient group. I don't think we were under any
 21 definitive obligation to send this letter out.

22 **Q.** Just so that we can see, it's a letter from the Health
 23 Protection Agency to all UK Haemophilia Centre
 24 doctors:
 25 "Post-mortem finding of asymptomatic variant

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1 [CJD] abnormal prion protein in a person with
 2 haemophilia."
 3 It records that a person with haemophilia had
 4 been found to have evidence of infection with the
 5 agent that causes vCJD in his spleen at post-mortem.
 6 Then it refers to that patient having been
 7 treated with batches of UK-sourced clotting factors,
 8 including one that was manufactured using plasma from
 9 a donor who went on to develop vCJD. The haemophilia
 10 patient -- so the plasma donor developed symptoms of
 11 vCJD.
 12 "The haemophilia patient was in his 70s when he
 13 died of a condition unrelated to vCJD, 11 years and
 14 one month after receiving the batch of implicated
 15 Factor VIII. He had no signs of symptoms of vCJD or
 16 other neurological disease when alive."
 17 So you took the decision not to send this. Do
 18 you know what the pattern was more generally across
 19 your fellow Haemophilia Centre Directors?
 20 **A.** I can't specifically answer that but I think --
 21 I think you'd have to ask the individual directors as
 22 you interview them -- my vague recollection is that
 23 not many of my colleagues would have sent this out to
 24 patients.
 25 **Q.** There was a further letter from the Health Protection

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1 Agency in June of that year.
 2 HSOC0002429. Do you have that, Henry?
 3 HSOC0002429. Thank you.
 4 This is a follow-up letter about the same
 5 patient, reporting that there had been investigations
 6 into the possible routes of infection for the patient
 7 and, if we go on to the following page, we can see
 8 a risk assessment concludes -- and it's the bit in
 9 bold in the third paragraph:
 10 "... the patient was more likely to have been
 11 infected by a batch of Factor VIII that was not
 12 sourced from a pool containing plasma from the donor
 13 known to have vCJD than by one of the two batches
 14 sourced from the pool containing plasma from the known
 15 donor who did develop clinical vCJD."
 16 As you have not sent out the February 2009
 17 letter, does it follow that you didn't send out this
 18 letter?
 19 **A.** No, I thought this was a letter of information to the
 20 directors rather than to be sending it to patients.
 21 Is that correct? I might be --
 22 **Q.** That may well be right. It is certainly addressed to
 23 directors.
 24 **A.** Yes.
 25 **Q.** If we go on to the third page there's a bit about

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1 other information that patients may wish to know.
 2 Toward the bottom of the page, Henry.
 3 **A.** I think it was more giving us information that we
 4 could or we may or may not wish to pass on to
 5 patients. I took this to mean, this study to mean
 6 that it was perhaps likely that there could be variant
 7 CJD in donors who did not go on to develop variant
 8 CJD, i.e. that there may well be individuals who've
 9 actually got the prion protein but simply don't
 10 progress to variant CJD, which obviously is quite
 11 concerning because obviously those donors could
 12 potentially, hypothetically, be asymptomatic and
 13 continuing to potentially infect the donor pool.
 14 But, as I say, I thought this was all
 15 hypothetical. And, again, I iterate that this was so
 16 far down the line beyond the potential for variant
 17 CJD -- the incubation period for variant CJD that
 18 I didn't get over concerned about it within my patient
 19 group.
 20 **MS RICHARDS:** Sir, I note the time. I'm going to move on
 21 to a different topic. I have a few further questions
 22 for Dr Wilde -- not many -- but I need to have the
 23 opportunity to ascertain from legal representatives of
 24 Core Participants if they've anything further to
 25 suggest. So could we take the break at this point

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1 perhaps for 30 minutes?
 2 **SIR BRIAN LANGSTAFF:** Yes. We will come back then at just
 3 after 3.45.
 4 **MS RICHARDS:** In half hour's time, Dr Wilde, we'll resume.
 5 **SIR BRIAN LANGSTAFF:** Dr Wilde, we often have a break in
 6 the mid-afternoon -- in fact, normally -- and in this
 7 occasion, we will have a break for half an hour.
 8 I hope that's all right. We look forward to seeing
 9 you back online at 3.45.
 10 **A.** Okay. Thank you very much.
 11 **SIR BRIAN LANGSTAFF:** But you're giving evidence. You
 12 should not discuss with anyone, whoever they happen to
 13 be, the evidence which you have given or which you
 14 think you may yet be asked to give.
 15 **A.** That's fine. Okay. I'm aware of that.
 16 **SIR BRIAN LANGSTAFF:** Thank you.
 17 **A.** Thank you very much.
 18 **(3.16 pm)**
 19 **(A short break)**
 20 **(3.45 pm)**
 21 **MS RICHARDS:** Dr Wilde, we're ready to resume. Can you
 22 hear and see me?
 23 **A.** Yes, I'm here, thank you.
 24 **Q.** Just a handful of further questions, Dr Wilde.
 25 In your witness statement you were asked about

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1 what might have been recorded on death certificates
 2 where patients of the centre had died in consequence
 3 of HIV or HCV, and you said that you have a vague
 4 recollection in the early years of your appointment,
 5 due to the stigma of viral infections and to protect
 6 the dignity of the individual and the wishes of the
 7 family. You didn't specifically mention HIV and HCV
 8 infections on death certificates, although you thought
 9 that for HIV infection you would probably have used
 10 a term such as retroviral disease.

11 Is that right, first of all?

12 **A.** Yes, that's correct.

13 **Q.** Do you know at what point approximately that that
 14 would have changed so that the specific viruses giving
 15 rise to death would have been recorded?

16 **A.** No, I can't honestly remember that. I mean, it did go
 17 on -- as I say, we had a number of deaths during the
 18 early to mid-'90s. Possibly towards the end of the
 19 '90s, I might well have reverted, but I think it was
 20 common policy around the UK to, as I say, protect the
 21 dignity of the patients and their relatives by not
 22 referring specifically to HIV and I think, to a lesser
 23 extent, hepatitis C as well.

24 **Q.** Without please mentioning any individual names, do you
 25 recall whether there were any inquests at which the

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1 local coroner investigated the circumstances in which
 2 patients had become infected with HIV or hepatitis?

3 **A.** To my knowledge, I'm not aware of that at all. I'm
 4 sure that if that had been the case, you'd have had
 5 documentation that you'd have presumably shown me.

6 **Q.** I'm not aware of it, Dr Wilde. I was just asking
 7 whether you have any recollection of being asked to
 8 participate in any such inquests?

9 **A.** No.

10 **Q.** Then in paragraph -- in your witness statement, and
 11 it's paragraph 78, you refer to the policy in relation
 12 to the retention of medical records. You've said in
 13 the early years when you were director, the policy at
 14 the haemophilia centre was to retain all written
 15 medical records of patients who had been infected with
 16 transfusion transmitted viruses indefinitely after
 17 death. Those were physical hard copy records, as I
 18 understand it, to start with?

19 **A.** Yes.

20 **Q.** But you then say:

21 "When the Trust went to a paperless medical
 22 record, it was agreed that those record files would be
 23 retained centrally by the Trust."

24 But it's come to your attention that some
 25 records following the deaths of patients have been

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1 destroyed; is that right?

2 **A.** Yes. I'm led to believe that, as I say, in the course
 3 of time following the introduction of the electronic
 4 patient record, I think there were major issues with
 5 storage with regard to the old records. And I think
 6 somebody must have made a decision that -- because the
 7 patients were no longer alive that the notes no longer
 8 needed to be -- the hard copy of notes no longer
 9 needed to be retained. I mean, those notes were
 10 certainly, as far as I'm aware, not made in electronic
 11 record.

12 **Q.** Do you know when that change of approach occurred, the
 13 result that there were written medical records
 14 destroyed? Were you still director at the time?

15 **A.** Well, yes, I think I would have been. I'm not sure
 16 that -- as I say, I think it's something that would
 17 have happened without my -- without being brought to
 18 my attention.

19 As I say, when we had hard copy, we used to keep
 20 the notes of deceased patients in filing cabinets on
 21 our old unit. I think that there was a change when we
 22 moved to our new unit -- we simply couldn't
 23 accommodate them -- and this would be around 2012,
 24 which I'm sure they'd have then gone to central
 25 record, and I can only assume would have then been

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1 destroyed in a time period after that which could have
 2 well been before my retirement in 2016.

3 **Q.** Then still on the theme of records, the information
 4 that was sent by you as director to Oxford, or to the
 5 National Haemophilia Database, were patients informed
 6 that information about them was being sent to Oxford
 7 or to the database, and were they asked to consent to
 8 that?

9 **A.** With regard to the annual returns that we sent every
 10 year -- and again I cannot remember -- I'm sure we
 11 stopped sending named patient individual data because
 12 I think that -- I don't think Oxford could cope with
 13 that. So I think we sent data, aggregate data, with
 14 regard to numbers of units used by patients, but not
 15 on an individual named patient basis.

16 I mean, as far as I'm aware, as in many other
 17 centres in the country, the patients never gave
 18 expressed consent to us sending that data, but, having
 19 said that, when we -- as far as the green cards -- I'm
 20 sure you are aware of the green card system. We went
 21 through a process of renewing everybody's green cards
 22 during the 1990s because, obviously, we had new
 23 details of certainly myself and the centre contacts.
 24 And when I saw patients, issuing them with the cards,
 25 I would say that -- well, we would be formally

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1 registering them with the Oxford database, and then
 2 subsequently the Manchester database, and that was
 3 solely that they would be given a code. I'm sure they
 4 were given a kind of -- I think it was a number,
 5 letter/number code which would then identify them
 6 centrally so that if they had any problems at other
 7 centres and they weren't able to contact -- or other
 8 centres couldn't contact ourselves directly, and this
 9 would obviously apply to all the other centres in the
 10 country, then somebody could contact the central
 11 database, initially in Oxford then in Manchester, to
 12 get the patient's details, the diagnosis and usual
 13 treatments that they have.

- 14 **Q.** Thank you --
 15 **A.** But then they didn't(?) give written informed consent
 16 for that information to be sent on them to the
 17 databases.
 18 **Q.** Then just returning to the topic of vCJD, are you
 19 aware of other factor concentrates used in the '80s
 20 which were suspected to give rise to the possible risk
 21 of transmission of vCJD, specifically Replenate and
 22 Replenine. Do you recall anything about that?
 23 **A.** I think they were on the list of products that we were
 24 informed of by BPL. Is that correct? I think you've
 25 probably have had that list, haven't you, of the

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- 1 various batches that we were informed had been
 2 contributed to by a donor who subsequently went on to
 3 variant CJD, and I think that they were within the
 4 batches. I think that was the 8Y product, and I think
 5 also the high purity; the Replenate, Replenine.
 6 **Q.** You're not aware of any separate exercise in relation
 7 to vCJD notification, other than those that we've
 8 discussed in your evidence before the break?
 9 **A.** Not that I'm aware of.
 10 **Q.** You referred to the stoicism of a number of your
 11 patients. Again, without please mentioning any
 12 patients by name, do you recall that there were some
 13 patients, including I think some of your patients, who
 14 became so concerned about vCJD and the risks of other
 15 virus transmission, such as parvovirus, that they went
 16 on a treatment strike because of the non-availability
 17 of recombinant? Is that something you recall?
 18 **A.** No, I don't recall any of my patients doing that, no.
 19 **Q.** Then, again, without mentioning any particular
 20 patients, please, how common -- was it common for
 21 there to be misdiagnosis of patients with bleeding
 22 disorders, who then received treatment that may have
 23 infected them, and then it subsequently transpired
 24 that they did not have haemophilia or whatever the
 25 specific bleeding disorder was?

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- 1 **A.** I recall one case of an individual who I think was
 2 transferred over to me who had previously been
 3 diagnosed with -- I think it was a haemophilia B, and
 4 when we tested him his Factor IX level was completely
 5 normal. And there is a condition, I'm sure you're
 6 aware, where you can have a low factor during
 7 childhood but then, when adolescence kicks in, the
 8 Factor IX level is then normalised.
 9 I'll be honest, my recollection -- I cannot
 10 remember whether that case was a genuine mistaken
 11 diagnosis at the time he was a child or whether he had
 12 one of these rare forms of Factor IX deficiency and
 13 I honestly can't remember whether or not that patient
 14 actually had any treatment. But off the top of my
 15 head, that's the only case I can remember of
 16 a misdiagnosis.
 17 **Q.** So you don't recall any wider pattern?
 18 **A.** No.
 19 **Q.** As part of the look-back exercise in relation to the
 20 patients at the centre for the purposes of hepatitis C
 21 testing, did that involve invitations to partners or
 22 family members also to be tested for hepatitis C as
 23 far as you can recall?
 24 **A.** Yeah, I think when we identified individuals who had
 25 got hepatitis C infection we did -- yes, we did invite

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- 1 partners, if they so wished, because we thought they
 2 could potentially be at risk. But we certainly
 3 wouldn't be testing children.
 4 **Q.** Then the final topic I wanted to ask you about was
 5 about relationships with pharmaceutical companies.
 6 It's a general question rather than specifically
 7 relating to your own practice, Dr Wilde. You've given
 8 details of your own involvement with pharmaceutical
 9 companies in your statement. But you say in your
 10 statement there was a close relationship between the
 11 UKHCDO executive and pharmaceutical companies with
 12 regard to issues arising with individual blood
 13 products.
 14 What do you mean by there being that close
 15 relationship between the UKHCDO executive and
 16 pharmaceutical companies?
 17 **A.** Well, I think there had to be an open relationship
 18 with regard to sharing of data, and really just an
 19 open frankness with regard to issues that may well
 20 have arisen with regard to individual blood products,
 21 so that the companies could then address issues in
 22 discussion with the UKHCDO.
 23 **Q.** There was, I think, a point in time at which those
 24 involved with UKHCDO had to complete annual
 25 declarations of interests; is that right?

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1 A. Yes, yes.
 2 Q. Do you recall whether there was ever any discussion
 3 amongst the UKHCDO executive or any of the working
 4 parties about whether there was a conflict of interest
 5 between clinicians receiving funding from
 6 pharmaceutical companies for research on the one hand
 7 and clinicians choosing the products for use on the
 8 other? Was that risk of conflict of interest or
 9 subconscious bias something that was explored by
 10 UKHCDO?
 11 A. I'm not aware of that at all. I mean, certainly in my
 12 own practice I never, ever had any involvement in
 13 companies in that regard.
 14 MS RICHARDS: Thank you, Dr Wilde. Those are the
 15 questions I had for you.
 16 Sir, do you have any questions for Dr Wilde?
 17 SIR BRIAN LANGSTAFF: No, I don't.
 18 MS RICHARDS: Is there anything you would wish to add,
 19 Dr Wilde?
 20 A. I think simply to reiterate the fact that the whole
 21 infected blood issue has been a massive tragedy for
 22 this patient cohort. I think that, again, I'd like to
 23 say that I was proud and felt very privileged that
 24 I was appointed as a consultant in Birmingham to look
 25 after such a wonderful group of patients. I think

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1 that over many, many years I had very good personal
 2 and professional relationships with very many of them,
 3 and again I felt proud to be their consultant.
 4 And, equally, I'd like to just say that my team
 5 during the years I was there were absolutely
 6 wonderful, and I'd like to think that between us we
 7 gave the vast majority of times the very highest
 8 quality of care that they could receive.
 9 MS RICHARDS: Thank you Dr Wilde.
 10 Sir.
 11 SIR BRIAN LANGSTAFF: It remains for me to thank you,
 12 Dr Wilde, for being with us. It's a pity you can't be
 13 with us in person but we are very glad that we have
 14 been able to have you remotely. So thank you for your
 15 time and thank you for telling us about your own
 16 experiences in Birmingham after 1992. So thank you
 17 very much.
 18 A. Thank you, sir.
 19 MS RICHARDS: Sir, that completes the evidence for today,
 20 and then tomorrow we resume with Dr Parapia, who was
 21 the director at Bradford Haemophilia Centre, and he
 22 will be giving evidence in person here.
 23 SIR BRIAN LANGSTAFF: So 10.00 tomorrow?
 24 MS RICHARDS: Yes, sir.
 25 SIR BRIAN LANGSTAFF: 10.00 tomorrow.

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1 Thank you all.
 2 (4.00 pm)
 3 (Adjourned until 10.00 am the following day)
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<p>MS RICHARDS: [18] 1/7 9/3 11/8 53/25 54/6 54/11 70/23 82/5 82/11 83/9 131/20 132/4 132/21 141/14 141/18 142/9 142/19 142/24</p> <p>SIR BRIAN LANGSTAFF: [46] 1/4 8/16 9/2 11/6 54/4 54/7 71/2 71/6 71/24 72/3 72/5 72/7 72/11 72/18 73/25 74/9 74/17 74/22 75/8 75/13 76/5 77/21 78/17 78/24 79/8 79/12 80/8 80/14 81/18 82/4 82/12 82/16 83/4 83/8 83/12 83/17 83/20 84/18 132/2 132/5 132/11 132/16 141/17 142/11 142/23 142/25</p> <p>THE WITNESS: [2] 83/19 84/17</p> <p>'</p> <p>'80s [4] 60/7 64/4 94/8 137/19</p> <p>'83 [5] 60/15 60/21 64/14 65/19 66/17</p> <p>'83/'84 [2] 64/14 65/19</p> <p>'84 [6] 24/23 60/16 64/14 64/22 65/16 65/19</p> <p>'85 [4] 13/23 36/12 36/15 54/17</p> <p>'86 [3] 46/3 46/3 68/23</p> <p>'88 [1] 8/20</p> <p>'90s [4] 93/22 106/24 133/18 133/19</p> <p>'92 [2] 60/21 106/24</p> <p>'affected' [1] 128/1</p> <p>'Blanket' [1] 127/1</p> <p>'guilt [1] 67/17</p> <p>'non' [1] 127/2</p> <p>-</p> <p>--and [1] 29/11</p> <p>.</p> <p>... 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