Witness Name: Jonathan Simons
Statement No.: WITN0440001
Exhibits: None
Dated: 23rd April 2019

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF JONATHAN STEVEN SIMONS

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 27 March 2019.

I, Jonathan Simons, will say as follows: -

1. My full name is Jonathan Steven Simons. My date of birth is GRO-C GRO-C 950 and my address is known to the Inquiry. I am a Senior Investment Manager at Charles Stanley & Co. Ltd.

2. I intend to speak about conversations with NBTS staff and other donors regarding the importation of American blood donor products to the UK and the perceived risks.

3. I began as a full-blood donor on 14th March 1969, having been recommended to become a plasmapheresis donor by a fellow student in my final term at secondary school.

4. My first donation was followed by a move to the weekly sequence of plasma-donation at Edgware NBTS starting on 25th June, 1969

5. Thereafter, I was a regular donor; there, and subsequently at Colindale and latterly Margaret Street, (with occasional donations of platelets at UCLH), achieving awards for 50, 100, 250, 500 and 750 donations.

6. A very friendly relationship built up over time with the Donor Centre staff, both nurses and doctors, and this was a very positive reinforcement of how valued the donors were regarded by the NBTS.

7. In Autumn 1969 I became an undergraduate at University College, London, and continued as a regular plasma donor – accumulating many puncture scars on the visible veins on both arms, which can still be seen today. I began to carry my donor certificate book with me at all times, as I felt that I needed some proof that these puncture marks were not drug-related injection scars, but from genuine blood donations.

8. There was a general awareness of the transatlantic hippy culture, especially West Coast, i.e. California. Part of the "penniless hippy student" lifestyle was the fact that American hospitals would pay cash for blood donations, enabling funds to be raised by people without other means of support. This was also the case for prisoners in US jails, where opportunities for earning small amounts of cash were very much in demand.

9. Over time, it became apparent from comments made by NBTS staff to donors that the supply of Factor 8 – the clotting protein used to treat haemophiliacs – was not sufficient from UK sources, and we were told that the NHS would be importing this product from America. I do not recall the names of any of the NBTS staff who made these comments. I also do not recall the dates that any specific comments were made.

10. I had many conversations with nurses and doctors (whose names I cannot recall) on the matter, as it was common knowledge that the payment to donors would inevitably lead to infected blood being donated, especially from prison inmates. My initial awareness of this was in the early 1970s.

11. The American Health system was even then contrasted unfavourably with the UK's NHS and especially the NBTS, where volunteer donors, acting altruistically, were the source of whole blood and therapeutic blood products.

12. The increasingly detailed pre-donation questionnaire introduced in the AIDs awareness environment was seen as attempting to prevent potentially infected blood from entering the system, and it was often said that the US had no such screening process. The protocol when attending to make a donation was to read and then sign the questionnaire which was then kept by NBTS staff. Copies for donors were not provided, either before or after signature, so I do not have a copy of any of the questionnaires I have signed over the years.

13. The assumption was that any blood imports from America came with a very high risk of contamination, and that far more rigorous testing on each donation pack of blood was essential if the risk to recipients was to be eliminated, or at least minimised.

14. Unfortunately, the general opinion of NBTS staff was that such comprehensive testing would be regarded as too expensive, and therefore not implemented. There would then be a significantly raised risk to people treated with blood or blood products from this source. In repeated conversations over a considerable period of time NBTS staff and donors were unanimous in the opinion that this was unacceptable, with clinical safety given a very much lower priority than cost-saving.

15. This was universally agreed to be the typical attitude of "bean counters", i.e. the accountants and associated management levels in the NHS/NBTS who were remote from both the donor network and the patients being treated. This was, admittedly, a very cynical attitude to take, but events have proved this to have been disastrously correct, with lives lost and blighted because of the failure to acknowledge, let alone

accept and manage, the risks of which ordinary donors as well as "front-line" NBTS staff were aware of at the time.

16. In 1995/1996 my wife, who was also a plasma/platelets donor, was told that she was no longer needed for that, as the supplies from the USA would be the source of NHS treatments from then on. Again, this was the topic of conversation between nurses, doctors and donors at that time, and no documents were involved – at least from the donors' viewpoint. I recall this date because the NBTS logo design was changed from the crowned intertwined hearts to the current 'cartoon' version at this time. I have reviewed my Certificate books and can see that the change occurred sometime between 24 October 1995 and 23 January 1996.

17. In my opinion, the senior and executive levels of the NHS/NBTS must be held personally and professionally fully culpable for their decisions:
    - to even consider importing blood and blood products from America, when the risks were already widely known;
    - for not immediately thereafter implementing a comprehensive screening process to identify and reject any infected or contaminated donations and/or products;
    - for ignoring the valid concern of clinicians, or over-riding them on financial grounds;
    - for deliberately (as has been widely reported in the Press) obstructing enquiries including the wilful destruction of material evidence relating to this issue.

18. Had a comprehensive screening process been in place in the 1970s it is possible that contaminated blood and products would have not been in widespread use in the UK, and the subsequent tragedy largely avoided.

Statement of Truth

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

Signed GRO-C

Dated 23rd April 2019