Witness Name: David KIRBY
Statement No.: WITN3911001
Exhibits: WITN3911002
Dated: 10th December 2019

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF MR DAVID KIRBY

I provide this statement in response to requests under Rule 9 of the Inquiry Rules 2006 dated 3 October 2019, 6 November 2019 and 15 November 2019.

I, Mr David Kirby, will say as follows: -

Section 1: Introduction

1. I confirm my personal details as follows:
   Mr David Kirby

   My professional address is:
   Luton & Dunstable University Hospital NHS Foundation Trust,
   Lewsey Road,
   Luton
   Bedfordshire LU4 0DZ.

   DOB: GRO-C 1973

2. I am a Consultant in Emergency Medicine with dual accreditation in Paediatric Emergency Medicine. I qualified as a doctor in 1996. I hold the qualifications of Bachelor of Medical Science, Bachelor of Medicine, Bachelor of Surgery, Membership Diploma of the Royal College of Surgeons of England and Fellowship Diploma of the Royal College of Emergency Medicine. My GMC registration number is 4326096. I am employed by Luton & Dunstable University Hospital NHS

Foundation Trust, having been appointed as a Consultant in 2008. I am the Operational Medical Director for the Trust. In this role I hold responsibility for operational performance of the Trust.

3. I have been asked to provide a statement on behalf of the Trust to respond to specific matters raised within the witness statement of W3023, dated 29th May 2019, regarding his care and treatment. In this statement I respond to three specific questions raised by the Infected Blood Inquiry (the Inquiry) with regard to points made in W3023's statement. I attach to this statement as Exhibit 1 a document requested by the Inquiry.

4. The information provided within this statement is based on information within W3023's medical records, who provided consent for access, and following review of the Trust's archives and systems.

Section 2: Response to Criticism of W3023

1. ***At paragraphs 11-14 of his statement, witness W3023 describes being requested to make an appointment about his blood test results in early 2003. At the appointment he was told that he had hepatitis C ('HCV'). He had initially tested positive for HCV in September 2000. Witness W3023 states he was shocked and angry, and questioned how this had happened when blood is screened for HCV and he had been attending regular check-ups. Please comment on this.***

> 11. In early part of 2003, when I was 29 years old, I received a letter from L&D requesting me to make an appointment to see Dr GRO-D as something had been spotted in my blood test results. The letter also stated that I had missed several appointments but this was untrue.
>
> 12 I attended the appointment where it is recorded in my records that I "was *unfortunately unclear as to the reason for [my] attendance and when [Dr* GRO-D *explained it* was *because my liver function tests were abnormal and that [I] had been found to be Hepatitis C (HCV) positive in September 2000, [I] appeared rather shocked'*
>
> 13. I was indeed shocked and very angry. I questioned how this could be when blood is screened for HCV and I had been attending the regular check-ups. I could not believe that I had HCV. The infection was not explained to me and the doctor's view was *'aren't you aware of this already'*. He did not say when the hospital knew about the infection. He did not give me any information about it and there was no advice given regarding the risk of infection to others.

14. My records show that on 13 May 1993 my blood was tested and found to be HCV antibody negative. Further that the testing continued until around 19 March 1999 when a routine blood test showed raised liver enzyme, which indicated something was wrong. Also Dr Thompson, the Haematologist at L&D noticed my iron level was raised in my blood; however, he did not ask me back to inform me. My blood was again tested for HCV in or around 15 September 2000 when it was found to be HCV positive. But I was not told until the appointment referred to above, i.e. three years later in 2003.

Response: According to hospital records W3023 was receiving care at the Luton and Dunstable Hospital for leukaemia, and had been under the care of Dr Thompson, Consultant Haematologist from December 1992. Hepatitis C was first detected after testing in September 2000 and it is accepted that W3023 was not informed of this until April 2003.

When this oversight was recognised, W3023 was referred to the Gastroenterology clinic under the care of Dr GRO-D who confirms that W3023 was shocked and unclear why he was required to attend this particular clinic appointment. Dr GRO-D explained at that consultation that his recent blood results had confirmed abnormal liver function tests and he had been found to have Hepatitis C.

A liver biopsy was performed in July 2003 following which W3023 was referred to the Royal Free Hospital. Documentation contained within the medical records indicates that active treatment was not started until August 2004 on medical grounds.

A letter to Dr Thompson, dated 22 September 2004, which the Inquiry holds, indicates that it was accepted there was a delay in informing W3023 of his results. This letter also acknowledged that steps had been taken by the Trust to make improvements to processes around review of laboratory results as part of the learning resulting from this matter.

2. ***At paragraphs 18-19 of his statement, witness W3023 states that he was tested without his knowledge or consent, and that Luton and Dunstable Hospital knew he was infected with HCV but didn't tell him until several years later. Please comment on this.***

18.1 do believe that I was tested for HCV without my knowledge. The hospital knew I had been infected with HCV and I was not told till several years later; they withheld information from me.

19. The tests were therefore undertaken without my consent and without me being given adequate information.

Response: In responding to the above I have consulted with my consultant colleagues in Haematology, Microbiology and Gastroenterology currently practicing at the Luton and Dunstable Hospital. They confirm that current medical practice would include a consultation with the patient including an explanation of the tests together with verbal consent for testing; this would then be clearly documented in the notes.

The Trust's view is that, at that time (2000), it would more likely than not to have been the usual practice to obtain informed consent from a patient when undertaking such a test. I have failed to find confirmation that consent was obtained from W3023, and for which the Trust apologises to W3023.

3. ***At paragraph 28 of his statement, witness W3023 says he speculates the delay between him testing positive for HCV and the hospital telling him of the result was to allow for the limitation period for bringing a claim to expire. Please comment on this.***

> 28. Around the time of the BBC Panorama documentary (circa 2016-17) I requested my full medical records from L&D and it is clear there was a delay in the hospital finding out that I had HCV and them telling me. I do not know why this was but speculate that it was to try to allow the expiry of the limitation period to bring a claim to expire.

Response: Our records confirm that W3023 made a formal complaint against the Trust on 23 December 2003 and this complaint was closed in January 2004. It is not known when W3023 first instructed his solicitors, however the Trust first received notification of a potential claim in August 2004.

There is no evidence or suggestion that the failure to inform W3023 of the results of his test was a deliberate act. It is far more likely to have been a genuine error of omission on the part of the Trust, which we accept and unreservedly apologise for.

4. ***The enclosed letter dated 22 September 2004 from Denise Foster to Dr Thompson refers to a memorandum of Dr Thompson dated 9 September 2004. Please provide a copy of the memorandum as an exhibit to your witness statement***

Response: The memorandum is included as Exhibit WITN3911002

5. ***The memorandum of Dr Thompson dated 9 September 2004 refers to steps taken to improve the review and follow up of laboratory results for patients. Please detail what these steps were.***

Response: Having undertaken a review of documentation available to us associated with this matter I regret we cannot find any further documented evidence as to the exact improvement activity that was undertaken at that time.

Statement of Truth

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

Signed David Kirby

Digitally signed by David Kirby
DN: cn=David Kirby, o, ou, email=GRO-C GRO-C c=GB
Date: 2019.12.10 14:01:29 Z

Dated

Table of exhibits:

Date	**Notes/ Description**	**Exhibit number**
9th Sept 2004	Memorandum Dr Thompson to Denise Foster	WITN3911002