Falconer S (Sandra)

From: Falconer S (Sandra)
Sent: 29 April 2005 15:37
To: Minister for Health and Community Care
Cc: Shearer S (Sylvia); Macleod AK (Andrew); Campbell D (Douglas) (Special Adviser); PS/HD Health; Lodge T (Trevor)
Subject: Evidence to Health Committee re public inquiry April 2005

Evidence to Health Committee r...

Julie

I refer to the Health Committee's letter of 24 March. The letter gives the Minister the opportunity to submit written evidence ahead of the meeting on 10 May. I therefore attach a draft letter, which has been cleared by Andrew Macleod, for the Minister to send to the Convener if he wishes.

Sandra

SCOTTISH EXECUTIVE

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Our ref:

May 2005

Thank you for your letter of 24 March formally inviting me to a meeting of the Health Committee on 10 May 2005 to give oral evidence on infection of Hepatitis C as a result of NHS treatment with blood and blood products.

I am happy to accept your invitation and note the specific purpose of the session is to consider the case for an independent public inquiry in light of the information recently made available under the Freedom of Information Act.

I also welcome the opportunity to submit written evidence in advance of the meeting and this is attached.

ANDY KERR

ANNEX A

HEALTH COMMITTEE MEETING 10 MAY 2005 WRITTEN EVIDENCE FROM MINISTER FOR HEALTH AND COMMUNITY CARE

SCOTTISH HAEMOPHILIA GROUPS FORUM CALL FOR A PUBLIC INQUIRY INTO TRANSMISSION OF HEPATITIS C THROUGH NHS TREATMENT WITH BLOOD AND BLOOD PRODUCTS

1. I have every sympathy with those affected with Hepatitis C through NHS treatment. However, I remain to be convinced of the usefulness of a Public Inquiry into this matter. I am not convinced that there are any lessons to be learnt that have not already been learnt.

2. I acknowledge that some clinicians had serious worries about the seriousness of Hepatitis C infection as early as the mid 1970s (and in consequence about the use of commercial products). But many experts also took the view that it was a mild, non-progressive condition and the benefits outweighed any adverse consequences. This divergence of opinion continued until at least 1985 after which an increasing number of experts came to regard it as a serious disease with significant long term consequences. That view did not come to be universally held in the relevant medical and scientific communities until after 1989. Numerous published articles in eminent medical journals, such as the Lancet, in the 1970s and 1980s that record information, interest and controversy on this issue. This was also the conclusion of Judge Alison Lindsay in the 'Report of the Tribunal of Inquiry into the Infection with HIV and Hepatitis C of Persons with Haemophilia and Related Matters' (September 2002) in Ireland.

3. There was knowledge of a possible link between treatment with blood clotting factor concentrates and Hepatitis as early as 1975 and this was regularly discussed at annual meetings of the Congress of the World Federation of Haemophilia. These meetings were organised by the World Federation of Haemophilia (WFH). The UK Haemophilia Society was a founder member of the WFH and will have seen the conference abstracts even if they did not attend. The debate which took place was therefore a wide and open debate which extended beyond the scientific community to public and patient groups.

4. Also product information leaflets contained statements that the risk of transmitting hepatitis could not be excluded. This information was directly available to all clinicians involved in the treatment of haemophiliacs with these products and also to the substantial proportion of patients who were practising home therapy (40% in 1978).

5. Copies of published articles in medical journals (e.g. the Lancet) – demonstrating that the risk of HCV infection was widely and publicly acknowledged and that there was a wide range of opinion – were lodged in Parliament's Reference Centre in October 2000 as part of the documentation supporting the SE "Report on the Heat Treatment of Blood Products for Haemophiliacs in the 1980s". Some may question the report because it was conducted by the Executive but as far as I am aware no one has disputed that the evidence and documentation supported the findings of the report.

6. I am not convinced that any officials or NHS staff acted wrongly in the light of the facts that were available to them at the time. Indeed following consideration of the Heat Treatment report mentioned at 5 above the previous Health Committee concluded that the allegation that the SNBTS was negligent during the 1980s in allowing Hepatitis C infected blood to enter into circulation was dealt with fairly exhaustively. The Committee also raised doubts as to the usefulness of carrying out any further inquiry on the questions of fault on the part of the SNBTS.

7. The resource implications of holding a Public Inquiry are high. Many people involved at the time are either dead or retired, and it would be difficult to carry out a thorough investigation and examination of the issues. Also a Public Inquiry would not necessarily succeed in establishing clearly roles of responsibilities in the events that took place and the accountability of individuals and organisations.

8. Officials within the Health Department continue to respond to requests under the Freedom of Information and I have requested that they be as open and transparent as possible. I have also commissioned a literature review of all of the files held with a view to publishing relevant documents. This should provide a full picture from the written record of what happened.

9. Frequent comparisons are made with Ireland but the situation is very different. I enclose an extract at Annex B from the Extract from the report of the 'Tribunal of Enquiry into the Blood Transfusion Service Board' [The Finlay Tribunal] which explains how the blood supply in the Republic became contaminated.

10. In conclusion, it would be difficult to to conduct an inquiry at this distance in time. We are not convinced either that there is anything significant to be learned from an inquiry, or that it will be helpful in establishing responsibility.

ANNEX B

SCOTTISH HAEMOPHILIA GROUPS FORUM CALL FOR A PUBLIC INQUIRY INTO TRANSMISSION OF HEPATITIS C THROUGH NHS TREATMENT WITH BLOOD AND BLOOD PRODUCTS

1. The payments in the Republic of Ireland are originally linked to incidents involving the contamination of the Anti-D supply as detailed below (Anti-D is a manufactured blood product obtained from women at the end of their pregnancy). People who had received the contaminated Anti-D then went on to donate blood – thus potentially contaminating the whole blood supply.

2. Extract from the report of the 'Tribunal of Enquiry into the Blood Transfusion Service Board' [The Finlay Tribunal]:

- The primary cause of the infection of Anti-D with Hepatitis C was the use of blood or plasma from Patient X (in 1976), a person undergoing therapeutic plasma exchange treatment who developed jaundice and hepatitis
- The use of this plasma was clearly in breach of BTSB's own standards for donor selection.....
- BTSB failed properly to react to reports made to them that recipients of the Anti-D made from the plasma of Patient X, had suffered jaundice or Hepatitis C.
- BTSB failed to properly investigate the possible existence of complaints by other recipients of Anti-D which were suspected of being contaminated.
- BTSB failed to recall the contaminated batches which had been issued and to prevent issue of any further batches made from plasma obtained from patient X.
- BTSB acted unethically in obtaining and using plasma from her without her consent
- A further cause of infection of Anti-D with Hepatitis C was the use of plasma from Donor Y (in 1989) who was undergoing a course of therapeutic plasma exchange and whose plasma was subsequently used, notwithstanding that it had been tested for Hepatitis C, and in four separate tests proved positive

The main reasons why these wrongful acts were committed.....