RESTRICTED – ADVICE TO MINISTERS

From: Andy Shanks
Legal Assistant to DCA
Date: 11 March 2009

Lord Advocate
Solicitor General

HEPATITIS C: PENROSE INQUIRY
HANDLING OF ADDITIONAL DEATHS: UPDATE

Purpose

1. Further to my minute of 9 January 2009, and following the announcement of the Penrose Inquiry, to provide to with an update of the progress and handling of the six additional deaths, which broadly fall into the same category as those of GRO-A GRO-A

2. To seek your final approval for the proposed handling of these deaths.

Priority

3. Routine.

Background

4. On Monday 12 January 2009, the Cabinet Secretary for Health and Wellbeing announced the formal establishment of the Hepatitis C Public Inquiry to be chaired by Lord Penrose. Further information on the Inquiry, including the full Terms of Reference, is provided in the Sylvia Shearer's minute to the Cabinet Secretary of 9 January 2009. You may also wish to note that a Preliminary Hearing of the Penrose Inquiry has now been fixed for Tuesday 31 March 2009 at 10.30am.

5. The agreed mechanism by which the six additional deaths which, to differing degrees, fall into the same category cases of GRO-A, are to be referred to the Inquiry is outlined in my advice of 9 January 2009. An update on the progress and proposed handling of these deaths can now be provided.

Deaths of GRO-A and GRO-A

6. You will recall that, in relation to the deaths of GRO-A and GRO-A, Crown Counsel are satisfied that substantive Article 2 obligations are engaged – or at least such engagement cannot be excluded from the available facts - and an Article 2-compliant inquiry is required. Therefore, we have briefed Health officials on these deaths, with the specific recommendation that they are examined as part of the Inquiry. If they were not to be considered as part of the Inquiry, Fatal Accident Inquiries would have to be held.

7. As you will recall, it was previously agreed that the deaths of GRO-A and GRO-A should not be referred to in Term of Reference 6 until such time as the up to date

views of the next of kin are obtained. The Procurator Fiscal at Aberdeen has now met with the widow of GRO-A and ascertained her views. The Hamilton office had more difficulty making contact with the family of GRO-A, due to the involvement of Thomsons solicitors. However, Thomsons have now written, confirming the latest views of the family. In relation to both cases, the families wish the deaths to be specifically examined by the Penrose Inquiry.

8. Therefore, we will now provide additional briefing to Health officials on the contact that has been made with the two families. Thereafter, we anticipate that the Cabinet Secretary will effect the inclusion of these additional deaths by a specific amendment to the Terms of Reference, in consultation with the Chair.

Deaths of GRO-A, GRO-A and GRO-A

9. As previously advised, Crown Counsel (James Wolffe) considered three of the remaining four deaths (the deaths of GRO-A, GRO-A and GRO-A) last year and concluded that there is no Article 2 engagement and no consequent need for a Fatal Accident Inquiry, or any other Article 2-compliant Inquiry, to be held. Therefore, we provided full details of the deaths to Health colleagues so they could consider any wider issues surrounding blood products highlighted in the cases that may be of interest to them or the Inquiry. Letters were also sent to legal representatives of the families, confirming Crown Counsel's view in each case.

10. Following your approval of the recommendations in my minute of 9 January 2009, I asked James Wolffe to review his instructions in all three deaths, with reference to the developments in Article 2 jurisprudence since he issued his original instructions. Having considered the available facts and circumstances in terms of the most recent case law, James Wolffe has confirmed that he remains satisfied that there is no substantive Article 2 engagement and no need for a fatal accident inquiry, or any other Article 2-compliant Inquiry, to be held in relation to these deaths.

Handling

11. You have asked that careful consideration be given to the handling of these deaths, in terms of managing any expectations on the part of the families that they will be ultimately examined as part of the Inquiry. Clearly, we should also seek to minimise the possibility that any communication to the families of the fact that these deaths will not be specifically examined by the Inquiry will expose you to future judicial review for the initial decision not to hold a fatal accident inquiry.

12. Having carefully considered the most appropriate method of communicating this information, it is recommended that further letters are issued by the relevant District Procurator Fiscals to the legal representatives of all three families. The legal representatives have requested that all correspondence with the families is made through them. Further to our previous correspondence on the decision that no fatal accident inquiry will be held, these letters should also confirm that the deaths will not be specifically examined at the Penrose Inquiry. It is also recommended that the letters should offer the families the opportunity to discuss the matter with the District Procurator Fiscal, or receive further information by letter, should they prefer.

13. The proposed content of all three letters is attached at **Annex A** for your consideration. This draft has been approved by Crown Counsel, following specific consideration in terms of possible exposure to future judicial review. As you will recall, the terms of the final decision letter issued by the Deputy Crown Agent in 2006 were criticised by Lord Mackay in his opinion in GRO-A.

The remaining death - GRO-A

14. The sixth and final death – that of GRO-A – has now been considered by Crown Counsel and the following instruction has been given.

> *"No Article 2 inquiry is required. The Crown has positively excluded the only potential source of Hepatitis C infection which would potentially involve fault on the part of the state."*

15. One particular aspect of this death investigation is worthy of your attention. During the investigation, an opinion was obtained from consultant hepatologist Dr Andrew Bathgate that the most common source of the hepatitis C was a blood transfusion in 1984. However, this opinion was contradicted by the Scottish National Blood Transfusion Service, who confirmed that the heat treatment given to the batch of blood used in 1984 made it safe from hepatitis C.

16. Therefore, the Procurator Fiscal sought further advice from another source, independent of the SNBTS, to consider the question of whether there was a risk of error in the tests which were applied to the 1984 blood transfusion. Professor Jean-Pierre Allain, a transfusion specialist from Cambridge University, was instructed on the recommendation of Dr Bathgate and concluded that the procedure applied to the product from SNBTS was definitely sufficient to eliminate all possibilities of any hepatitis C infectivity in the light of the knowledge acquired on this virus since its discovery in 1989. He found that the procedure had been applied properly and was therefore effective.

17. Professor Allain is currently the Head of Transfusion Medicine at Cambridge University and was instructed in good faith. However, you will wish to note details of his controversial background, which have subsequently emerged. Specifically, in his former role of head of research for the French blood transfusion service, he was convicted in the mid-1980s for his part in the knowing supply of untreated blood products by the national transfusion service to haemophiliacs. He served two years imprisonment.

18. The conviction was criticised within some parts of the scientific community and Professor Allain was supported by Cambridge University throughout, receiving a full salary while in prison. In addition, the East Anglian Blood Transfusion Service, who employed Professor Allain at the time, also established an independent inquiry into his actions, led by Baroness Warnock. The inquiry concluded that there was no reason to believe he was unfit to hold office. On his release from prison, he returned to work at the University and has been there ever since.

19. I have discussed the involvement of Professor Allain in the investigation of this death with the Deputy Crown Agent. Although the Professor clearly has a controversial

background, no adverse finding has been made in relation to his scientific qualifications or his ability to conduct the verification exercise instructed by the Procurator Fiscal in this case. Therefore, it is respectfully submitted that it is still appropriate for his opinion to form part of the information considered by Crown Counsel in this case.

20. Therefore, in accordance with the deaths of GRO-A GRO-A and GRO-A, full details of the death will now be provided to Health colleagues so they could consider any wider issues surrounding blood products highlighted in the cases that may be of interest to them or the Inquiry. Clear reference in the briefing will be made to the involvement of Professor Allain in the investigation, including details of his background.

Handling

21. In terms of handling, I recommend that a very similar approach is also taken in relation to the communication of this decision to the nearest relatives. A slightly expanded version of the draft letter approved by Crown Counsel is attached at **Annex B** for your consideration.

Conclusion

22. I invite you to note the terms of this briefing, in particular that:

- The families of GRO-A and GRO-A have been contacted by and have confirmed that they would like the death of their relatives to be specifically examined by the Penrose Inquiry (paragraph 7);
- Full briefing on this contact will be provided to Health colleagues (paragraph 8);
- Crown Counsel has reviewed the deaths of GRO-A, GRO-A and GRO-A GRO-A in deaths terms of the most recent case law and is content that no Article 2 inquiry requires to be held (paragraph 10);
- Crown Counsel has now considered the death of GRO-A and has instructed that no Article 2 compliant inquiry is required (paragraph 14);
- Full briefing on this death will be provided to Health colleagues (paragraph 20);

23. I invite you to approve:

- The recommended handling approach outlined in paragraphs 12-13 and 21 above, including the draft letters attached at **Annexes A and B.**

ANDY SHANKS
Legal Assistant to DCA Date: 11 March 2009

Copy List	For Action/Response	For Comments	For Information
PS/CE-CA			X
DCA			X
Director of Communications			X
Paula Black			X
Colin Troup, LSLA			X
Communications			X

ANNEX A

Letter from Procurator Fiscal at Falkirk/Dumbarton/Glasgow A Division

Dear Sirs

DEATH OF GRO-A

I refer to the above death and to previous correspondence on this matter.

As you will be aware, Crown Counsel have considered the circumstances of this death and have concluded that Article 2 of the European Convention on Human Rights does not require a public inquiry or a fatal accident inquiry to be held in this case.

A fatal accident inquiry will accordingly not be held in relation to this death. You will also have noted that the Penrose Inquiry has now been formally established and that the Terms of Reference for the Inquiry do not include this death. However, details of this death were provided to Scottish Government Health Directorate to allow the Inquiry to identify and consider any wider issues surrounding contaminated blood products which might arise from this case.

You have previously requested that further contact with the nearest relatives is made through your office. Therefore, I would be grateful if you could pass this information on to them. If it would be of any assistance, I would be happy to meet with your clients in order to provide further details of the decisions that have been made in relation to this death. Alternatively, I could provide this information in a further letter, if that would be the preference of your clients.

Yours faithfully

ANNEX B

Letter from Procurator Fiscal, Glasgow A Division

Dear Sirs

DEATH OF GRO-A

I refer to the above death and to previous correspondence on this matter.

I have now completed my investigations into this matter and reported the case for the consideration of Crown Counsel. Having carefully considered the available facts and circumstances of this death, Crown Counsel have concluded that Article 2 of the European Convention on Human Rights does not require a public inquiry or a fatal accident inquiry to be held in this case.

A fatal accident inquiry will accordingly not be held in relation to this death. You will also have noted that the Penrose Inquiry has now been formally established and that the Terms of Reference for the Inquiry do not include this death. However, details of this death were provided to Scottish Government Health Directorate to allow the Inquiry to identify and consider any wider issues surrounding contaminated blood products which might arise from this case.

You have previously requested that further contact with the nearest relatives is made through your office. Therefore, I would be grateful if you could pass this information on to them. If it would be of any assistance, I would be happy to meet with your clients in order to provide further details of the decisions that have been made in relation to this death. Alternatively, I could provide this information in a further letter, if that would be the preference of your clients.

Yours faithfully