FOR INFORMATION & COMMENT

RESTRICTED - POLICY

GRO-C: Morven

02/06/09

MS(PH)

Dear Dawn,
Here is a further submission on the response to the Response. I have made some comments and queries. Please let me know how you want to proceed. Thanks,

GRO-C: Morven

From:	Rowena Jecock
Cleared by:	Ailsa Wight
Date:	2 June 2009
Copy:	As attached

Government response to Lord Archer – next steps

1. Reaction to the Government package announced in response to Lord Archer's report has been limited, but negative. The main areas of criticism are:

- Although we are increasing the payments to HIV patients from an average of £6,400 a year to a flat rate for everyone of £12,800 per annum this was considered to be nowhere near enough (Lord Archer described it as "tossing a bone to a dog")

- That we should be increasing payments now to hepatitis C patients and their dependents – rather than just promising to review the Skipton Fund in five years time.

- The level of payments should be closer to the amounts paid in Ireland which are claimed to be an average of £1m per person (for both HIV and hepatitis C sufferers) and up to £5m per person in some cases.

2. You have asked us for more detailed information as to why the situation here is different from Ireland, together with possible options for handling the criticism around the Skipton Fund.

Why Ireland is different

3. The Government here has never accepted any liability. We believe that people were offered the best treatment available at the time and that as soon as blood screening tests were available they were implemented. There were attempts to bring litigation against the Government by those infected with HIV in the early 1990s but these were withdrawn following legal advice to the plaintiffs that they were unlikely to win their case. However as a gesture of goodwill, the Government established the Macfarlane and Eileen Trusts at that time for those infected with HIV – and the Skipton Fund in 2004 for hepatitis C. Payments from all these funds are ex gratia goodwill payments only. We have not been able to ascertain why the level of payments for the Macfarlane and Eileen Trusts were set as they were - levels of payment were determined between Trustees and claimants. The level of payments for the Skipton Fund is explained at para 8.

4. In Ireland also, the State did not explicitly admit liability. However, contrary to the position in the UK, the Irish Blood Transfusion Service (IBTS) was found, by a judicial inquiry, to have been responsible on two occasions (1977 and again in 1991) for failures which resulted in the large-scale contamination with hepatitis C of a blood product used to treat pregnant women. This finding resulted from the IBTS's failure on both occasions to follow its own guidelines that blood from previously-transfused individuals should not be used for the preparation of blood products because of the increased risk of infection. The report of this Finlay inquiry concluded that "wrongful acts were committed". The Irish Government therefore set up a hepatitis C compensation scheme in 1997 for the infected women following this conclusion, and because of the threat of litigation (which the Irish Government believed it would lose). The compensation scheme was later extended to all people infected with hepatitis C through blood products and blood transfusion, as some infected women had donated blood and thereby infected others. **Annex A** contains a Hansard extract from 2004, in which Lord Warner contrasts the position in Ireland with that in England for hepatitis C.

We could talk about how the UK introduced HepC testing of donations in 1991 and that the introduction of heat treatment in 1985 had removed the hepatitis risk from blood products.

Perhaps we could look at NHSBT's implementation of their guidelines. If we can say they are rigorous in implementation then that makes the UK case more robust.

5. Haemophiliacs with HIV in Ireland initially received similar ex-gratia payments to those in the UK, but successfully campaigned to be included in the more generous hepatitis C scheme. If you were to decide to increase significantly the payments to hepatitis C patients and/or their dependents, it seems reasonable to assume that the HIV community would push for similar increases.

Skipton Fund – payments for those infected with hepatitis C

6. Following your earlier decision, we have announced that we will review the Skipton Fund in five years time when it will have been in existence for 10 years. However, you are worried that we will not be able to maintain this position and that we may need to announce that we will review the Fund now if we come under sustained pressure. If so, it would clearly be important to keep this to an internal review so that we maintain control of it.

Is this something you would like to consult Sir Robert Owen about?

7. However this is a risky strategy. If we were to announce a review, we would be pressed to say how long it would take - and there would be an expectation that it would be no more than about three months, if that. Any such public announcement would inevitably raise expectations of further funding. We need to be clear that the outcome would have to be increased funding as it simply would not be possible for the review to conclude that funding should remain the same. We would therefore need to determine what the options for increased funding might be, and whether they are affordable, ahead of any announcement. It would clearly be a disaster to raise expectations and then not be able to meet them.

8. The Skipton Fund makes stage 1 payments of £20k to people infected with hepatitis C from contaminated blood, and stage 2 payments of £25k if they go on to develop serious illness such as cirrhosis or liver cancer. You asked for more information about why the payments were set at that level. As explained the decision on the level of payments was made by the Scottish Government – and John Reid simply decided to follow suit. We understand that Scotland asked Lord Ross for advice. Lord Ross advised that eligibility should extend back to widows and also that payments for severe cases should be considerably higher than £50k. However the Scottish Government decided these recommendations were simply unaffordable and instead took a pragmatic decision based on what was affordable.

The key options for increasing payments now, should you wish to do so, are:

<u>Option 1</u>
Give all stage 2 claimants £12,800 per annum (ie the amount that Macfarlane and Eileen Trust recipients will receive in future).
Estimated cost – **up to £10m per annum recurrent**
(Note – this could increase as more people progress to stage 2)

<u>Option 2</u>
Give all Skipton Fund claimants (ie stage 1 <u>and</u> stage 2 claimants) £12,800 per annum
Estimated cost - **£52m per annum recurrent**

<u>Option 3</u>
Double stage 2 payments to £50k for all past and future cases.
Estimated cost - **£19.3m one off plus £2.5m per annum recurrent**

<u>Option 4</u>
Double stage 1 payments to £40k for all past and future cases.
Estimated cost - **£81.2m one off plus £2.3m recurrent**

<u>Option 5</u>
In addition to, or instead of, these options we could rectify the anomaly whereby the estate of an infected person who died before August 2003 received nothing, while the Skipton payments are made into the estate of a person who dies after that date. This would benefit those who benefited from the deceased's estate, including widows and dependents. We do not have reliable figures but estimate that there could be up to 1,200 estates eligible for £45k each.
Estimated cost – **up to £54m one off (assuming current level of payments)**

<u>Option 6</u>
Rather than giving each estate the full amount of £45k we could try and cut this total down by giving them only a stage 2 payment of £25k. This

would inevitably be heavily criticised though so is probably not worth considering as an option.
Estimated cost – **up to £30m one off (assuming current level of payments)**

9. **Annex B** gives details of how these options are calculated, plus pros and cons. The biggest problem is that they are all sizeable sums so finance colleagues have confirmed that **any of these options would need to be agreed by Treasury.**

10. The issue on which we receive most criticism is that families and dependents of those who died before August 2003 do not benefit (options 5 & 6). We would be heavily criticised for announcing any further funding that did not include this as a minimum, although there would be significant difficulties in verifying the eligibility of claims, given the time that has elapsed. Implications for the devolved administrations will also need to be considered, as the Skipton Fund is UK-wide, and in Scotland, the eligibility arrangements specifically for payments are established independently in primary legislation.

11. Any increased funding we were to announce is of course likely to be criticised as insufficient, in exactly the same way that doubling the size of the HIV payments has been. If we were to agree payments to widows and dependents (option 5 or 6) we would be attacked for not increasing payments to current recipients as well (options 1-4). You will want to consider very carefully therefore whether you want to go down this route particularly in view of the size of the sums involved.

This is an important consideration. You may wish to discuss the amounts etc with SofS to see how he is minded re any additional funds.

Stakeholder views, and engagement, following publication of the Government response

a) Macfarlane Trust/Eileen Trust

12. We have spoken to the Chief Executive of the Macfarlane and Eileen Trusts, and the Chair of the former, who advise that they are not campaigning organisations and cannot make a public statement of support for the increased funding, but nor will they criticise the position. They made the point that the recipient community will see the increased funding as little more than a 'catch-up exercise' for constrained funding over the past five years, and are unlikely to express gratitude for it.

13. We have opened discussions with the Trusts about implementation of the increased payments.

b) Haemophilia Society

14. You asked what prompted the Haemophilia Society to be highly critical that a minister did not attend Lord Archer's inquiry. A letter from February 2007 from Lord Archer to the then SofS does not seek ministerial participation, asking only "if someone from the department

can be available". SofS' reply confirmed the Department's willingness to assist and offered "an early meeting between officials", which took place. It appears that the Haemophilia Society had received a different understanding of the position from Lord Archer's inquiry team. We have corrected this misunderstanding. Do you want to write to Chris James about this?

15. Feedback from the CE of the Haemophilia Society, is that members are particularly disappointed that the Government response does not address their financial needs. They do not consider the increase in their funding for those with HIV to be sufficient. The main grievance though, appears to be in relation to hepatitis C, where those affected believe the current financial relief provided through the Skipton Fund to be inadequate, and also unfair, particularly because of the ineligibility of widows/dependents of those who died before August 2003. The promised review of the Skipton Fund in 2014 has not been well-received because those now seriously ill with complications of hepatitis C are unlikely to benefit from it.

Do you want the team to do further investigation to find out why the relief is seen to be inadequate? Eg ~~is the~~ do the recipients have substantial costs to be covered due to their infection?

16. You are keen to ensure that the funding for the Haemophilia Society is used for activity that contributes to agreed outcomes in support of longer term sustainability to enable the Society to work towards a more secure future. We have discussed this with the Third Sector Partnership Team (TSPT), who advise that we can restrict how the monies are used through the formal grant agreement that will govern this award.

17. We plan to meet with the Society's CE on 11 or 12 June to discuss their use of the additional funding, and how we will work with the Haemophilia Alliance. There is a meeting of the Haemophilia Society Trustees on 13 June to discuss the Government's response, after which there may be a further statement from the Society.

c) UK Haemophilia Doctors

18. The Chair of the UK Haemophilia doctors' organisation has confirmed that they will not make a public statement about the Government's response, but privately has said that he is disappointed only that nothing has been done to address the needs of those dependents not eligible for relief through the Skipton Fund. He is pleased with the proposal that Government work with the Haemophilia Alliance.

FOI Case: CMO advice to Ken Clarke

19. You asked about the internal review of an FOI decision in 2007 to withhold advice in 1991 from Sir Donald Acheson to Ken Clarke, when he was SofS. The advice contains no new information (it simply offers a personal view that the Government should offer financial assistance as a good will gesture) and the Department initially favoured release. However it was withheld at Ken Clarke's own request as he felt it fell under the FOI exemption of advice to Government in the formulation of policy. The Attorney General's position, reflected in a response due to

be issued imminently, is that this advice should continue to be withheld, citing the exemption under the FOI Act at Section 36 (prejudice to the effective conduct of public affairs). Attached @ Annex (D).

Wider Handling

20. It is possible that debates will be secured in both the House of Lords (Lord Darzi's commitment of 28 April), and the House of Commons (Harriet Harman's comment of 21 May). Relevant Hansard extracts are **at Annex C.**

21. We will develop robust lines for parliamentary use, especially during the Second Reading of the Health Bill, which begins on 8 June. We will also work with COMMS in anticipation of further media interest.

Conclusion

22. As we have previously advised, Lord Archer's report did not reveal anything new about these tragic events. It remains the case that people were given the treatment that was considered to be the best available at the time. However much one would like to increase the financial assistance offered to them on humanitarian grounds, we have real concerns about affordability given the current financial situation. We therefore recommend holding the line you have already decided and announced re the Skipton Fund.

Do you want to draw attention to the fact (that is already in the public domain) that the Haemophilia Society supported continuing treatment with Factor 8 despite known risks?

23. If however you feel that this position is untenable then we would advise against making any public announcement about a review for the reasons set out in paras 7-11 above. It would be preferable to continue discussing options for increasing funding internally and seeking agreement with SofS and HMT if you wish to pursue this, with a view to making an announcement about widening eligibility / increasing funding in due course should SofS and HMT agree.

Rowena Jecock
GTN GRO-C

Copy:
Penelope Irving
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Marc McGonagle
Catherine Hawes
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Ted Goff
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Kate Pike
Judith Moore
Paula Cohen
Graham Kent
Simon Burke

[redacted]

ANNEX A

HANSARD EXTRACT, 2004, REFERRING TO HEPATITIS C 'COMPENSATION SCHEME' IN THE REPUBLIC OF IRELAND

Hepatitis C

Lord Morris of Manchester: My Lords, I beg leave to ask the Question standing in my name on the Order Paper. In doing so, I declare an interest, not a financial one, as president of the Haemophilia Society.
The Question was as follows:

To ask Her Majesty's Government whether they will reconsider their decision to exclude the widows of patients infected with hepatitis C by contaminated National Health Service blood and blood products from help under the ex gratia payments scheme.

The Parliamentary Under-Secretary of State, Department of Health (Lord Warner): My Lords, the Government have great sympathy for the pain and hardship suffered by the widows of those inadvertently infected with hepatitis C. However, it has always been clear that the ex gratia payments scheme known as the Skipton Fund is not designed to compensate for bereavement. As such, there are no plans to reconsider that decision.

Lord Morris of Manchester: My Lords, while again I acknowledge the breakthrough achieved by John Reid's announcement of the scheme, can my noble friend say what it will cost and from which budget or budgets? Meanwhile, how can any of us justify excluding widows? Is not theirs the cruellest loss, having seen a husband and father die what my noble friend Lord Winston describes as a,

"slow, agonising death from cirrhosis or liver cancer due entirely to contaminated NHS blood products"?

Infected with hepatitis C, they were denied life assurance, and the onset of liver disease forced many into early retirement, so impoverishing their families. Where is the natural justice in including widows in the existing ex gratia scheme for HIV infection, while excluding them from this scheme? And where is the morality in denying parity of treatment to widows in identically the same tragic position?

Lord Warner: My Lords, again I pay tribute to the work done by my noble friend and the Haemophilia Society in pursuing the issue. But the underlying principles of the scheme that has been announced is that it should be targeted to help alleviate the suffering of people living with inadvertent—I stress, inadvertent—hepatitis C infection. The fund is not designed to compensate for refusal of cover, loss of earnings or bereavement. I understand the problems that my noble friend has outlined, but my understanding is that hepatitis C does not automatically preclude someone from gaining life assurance.

It is difficult to predict the cost of the scheme and the number of people who will benefit, but our best estimates are that between 6,000 and 7,000 people will benefit from the scheme. I can reassure my noble friend that the department will honour all valid claims.

Lord Addington: My Lords, does the Minister not agree that we have heard in the past a great deal of resistance to our making any payment to those infected with hepatitis C in very similar terms to that which we have heard to giving it to families of those who have died as a result of the infection? Under those circumstances, would it not be sensible to consider making a payment to those who are suffering financially in exactly the same way?

Lord Warner: My Lords, I am in danger of repeating myself. We have made absolutely clear the basis of the scheme: to alleviate suffering among those who are living and have suffered as a result of the infection. It is not a compensation scheme. All credit is due to my right honourable friend the Secretary of State for Health, who decided last summer to bring the scheme into operation.

Earl Howe: My Lords, when the noble Lord, Lord Morris, asked a similar Question some time ago, the Minister commented that the equivalent schemes for compensating haemophiliacs in Canada and the Irish Republic, which are much more generous than the scheme that the Government have now proposed, were based on the fact that the governments of those countries had accepted liability for the damage that took place. Can the Minister confirm the Answer that he gave before, because my information is different from his?

Lord Warner: My Lords, I am grateful to the noble Earl for giving me the opportunity to clarify the issue. My understanding of the position in Ireland, which has been corroborated by officials in the Department of Health and Children in Dublin since my last utterances on the subject in the House, is that the Irish Government set up their hepatitis C compensation scheme following evidence of negligence by the Irish Blood Transfusion Service. A judicial inquiry, the Finlay report, found that "wrongful acts were committed". It is important to stress that the blood services in the UK have not been found to be similarly at fault. Compensation is therefore being given in very different, specific circumstances in Ireland that do not apply in the UK. I do not believe that the Irish scheme creates any precedent for us.

The awards being made in Canada follow a class action brought against the Canadian Government. The compensation from the federal Government is limited to those infected between 1986 and 1990. Subsequent inquiries found that wrongful practices had been employed, and criminal charges were made against organisations including the Canadian Red Cross Society. Those conditions in Ireland and Canada do not apply in the UK.

Lord Ackner: My Lords, I appreciate that, whenever I hear the Government express sympathy, I irritate them by pointing to the millions of pounds a year spent on victims of violent crime for whom the Government have not the slightest responsibility, whereas in this case the Government actually injected the substance. But for the fact that negligence must be proved, they would be liable.

Secondly, will the Minister explain, not why damages for bereavement are not provided, but why no damages for loss of dependency are provided? That is a separate head of damage which, if there were liability, would have had to be accepted by the Government.

Lord Warner: My Lords, I always bow to the noble and learned Lord in his knowledge of the law, but it is not my responsibility to answer for criminal compensation schemes. I am sure that my noble friend Lady Scotland will read his comments with interest. A line must be drawn somewhere on eligibility for this scheme. As I said in answers to previous supplementary questions, there was no case of negligence by the National Blood Service. The lines have been drawn on the basis that I have explained, and there is nothing more that the Government can say on this issue.

Lord Denham: My Lords, the Minister cannot say that it is not his department that is concerned. The noble Lord answers in this House for Her Majesty's Government.

Lord Warner: My Lords, I confirm that I answer for Her Majesty's Government, but the subject of the criminal injuries compensation scheme is outside the remit of the Department of Health.

A noble Lord: My Lords—

Lord Warner: My Lords, may I finish? The subject is also wide of this Question.

ANNEX B

Skipton Fund – Options for further funding

1. Background

The Skipton Fund makes payments to people infected with hepatitis C from contaminated blood and blood products. Every person in the UK who was alive on the 29 August 2003 and whose Hepatitis C infection was found to be attributable to NHS treatment with blood or blood products before September 1991, are eligible for the payments. It pays in two stages:

[redacted]

Stage 1 – £20k on diagnosis of hepatitis C infection
Stage 2 – £25k if people go on to develop serious illness as a result, namely cirrhosis or liver cancer.

Payments are made only to those infected with hepatitis C. There are no payments to dependents, including to those of people who died before the fund was announced on 29 August 2003.

The current one-off payments are made irrespective of whether the infected individual is subsequently cleared of the virus following treatment.

So far, 4,057 people have received stage 1 payments, with 769 of these people also having received a stage 2 payment. As these are one-off payments, the Fund has no information about how many of these people are still alive.

New registrations are infrequent now, but there could still be some in future. Up to 20% of stage 1 recipients could progress to stage 2 over the next decade.

We have announced that we will increase funding for infected HIV patients covered by the McFarlane and Eileen Trust to £12,800 per annum.

2. Future options

We have suggested various options for increasing payments to those infected with hepatitis C, or possibly to their estates. In summary they are:

<u>**Options 1 & 2**</u>
Make a recurrent payment of £12,800 to each of the current infected individuals:

This would provide a similar regular payment to that announced for the HIV-infected beneficiaries of the Macfarlane and Eileen Trusts.

Option 1
Give all current (769) and new stage 2 claimants £12,800 per annum as is being done for those infected with HIV.
Estimated cost: £9.9m per annum recurrent (on current numbers) plus residual additional recurrent implications for new registrants

Option 2
Give all current (4,057) and new claimants £12,800 per annum as is being done for those infected with HIV.
Estimated cost: £52m per annum recurrent (on current numbers) plus residual additional recurrent implications for new registrants

Pros:

- This would introduce a regular additional payment to those infected with hepatitis C. Option 1 would specifically help those with severe disease. It is questionable whether many of those in receipt of stage 1 payments would be unable to work as a result of having hepatitis C.

Cons:

- Would in essence be reviewing the Skipton Fund ahead of 2014
- Would require recurrent funding
- Would have funding implications for the DAs
- Would potentially pay out to those who have subsequently been cleared of the virus following treatment

Options 3 & 4
Give additional stage 1 and/or stage 2 one-off payments via the Skipton Fund to current infected individuals:

This would in essence increase (double) the current payments for stage 1 and stage 2 claims. It would be hard to give this as a one-off extra payment to just current recipients as any new stage 1 or stage 2 claimant after the specified date would then not be eligible if it is given as a time-limited one-off payment only

Option 3
Double stage 2 payments to £50k for each of the 769 (current figure) recipients.
Estimated cost: £19.3m one-off payment plus £2.5m recurrent implications based on current level of 100 new stage 2 claimants per annum

Option 4

Double stage 1 payments to £40k for each of the 4,057 (current figure) Skipton Fund recipients.

Estimated cost: £81.2m one-off payment plus £2.3m recurrent implications based on current level of around 115 new stage 1 claimants per annum

Pros:

- This would be a doubling of the current payments and would go towards addressing the financial concerns of infected hepatitis C individuals. Option 3 would specifically help those with severe disease.

Cons:

- Would in essence be reviewing the Skipton Fund ahead of 2014
- Would require a significant one-off funding plus residual additional funding to allow for new claimants
- Would have funding implications for the DAs
- Acceptance of either of options 3 or 4 would not benefit deceased individuals (options 3 and 4 are based on current stage 1 and stage 2 payments)

Options 5&6

Make a one off payment to the estates of people who died before 29 August 2003 as a goodwill gesture:

We do not know how many eligible hepatitis C infected individuals there are who died before the cut-off date of 29 August 2003. Our cost estimate therefore assumes one-quarter (1,200) of the estimated total of pre-1991 treatment-acquired hepatitis C cases died before 29 August 2003.

Option 5

Give a stage 1 and stage 2 payment (£45k) to the estates of each infected individual as a goodwill gesture.

Estimated cost: £54m one-off payment

Option 6

Give a stage 2 payment only (£25k) to the estates of each infected individual as a goodwill gesture.

Estimated cost: £30m one-off payment

Pros:

- This would rectify the anomaly that no payment has been made to those infected individuals who died before the 29 August 2003 cut-off date and would go towards addressing the concerns of the campaigning widows

- Option 5 would bring the deceased infected individuals in line with claimants after 29 August 2003
- It would require a one-off payment only
- It would not set a precedent for paying to dependents as this would go to the infected person's estate, not directly to the dependent
- It would not alter the existing payment arrangements of the Skipton Fund, which could still be reviewed in 2014 as announced

Cons:

- There would be significant administration costs and difficulty in verifying the eligibility of claims, given the time elapsed
- We do not know how many people would fall into this category, so the cost may be more than our estimate
- We would need to consider the financial implications for the DAs
- We would need to agree how such claims would be substantiated retrospectively
- We would need to check if this would financially affect the deceased's estate (e.g. inheritance tax)
- All beneficiaries of the deceased's estate would benefit, not just needy dependents.

ANNEX C

1. HANSARD EXTRACT FROM HEALTH BILL DEBATE, HoL REPORT STAGE, 28 APRIL 2009

"**Lord Darzi of Denham:** I assure noble Lords that my right honourable friend the Secretary of State is looking at the most appropriate means of strengthening representation for haemophilia patients and ensuring that advice is provided to those best placed to act on it for the benefit of patients. This is being considered together with the other recommendations from the noble and learned Lord, Lord Archer, for improving support more widely to the haemophilia community. I personally commit to do everything possible to ensure that the Government respond fully to the noble and learned Lord's recommendations in advance of the Whitsun Recess, if not the week before. Furthermore, we will of course assist as far as possible in securing a debate on the Government's response."

[redacted]

2. HANSARD EXTRACT FROM BUSINESS QUESTIONS, 21 MAY 2009

"**Dr. Brian Iddon (Bolton, South-East) (Lab):** Yesterday, on the day after world hepatitis day, the Government made a written statement on Lord Archer's report about contaminated blood. Although I congratulate the Government on moving forward on this issue, what most angered the community that is interested in the subject yesterday was that the Government are still not prepared to match the modest compensation scheme that is available in the Irish Republic. To give us a chance to question Health Ministers, which we were unable to do yesterday, will my right hon. and learned Friend please give us a debate in Government time on contaminated blood

Ms Harman: I think that may be a very appropriate subject for a Westminster Hall debate. I shall raise the matter with the Secretary of State for Health. As my hon. Friend mentioned, there was a written ministerial statement responding to Lord Archer's report. He will know that we have increased the amount of compensation for those who have been unfortunate enough to receive contaminated blood, and we have increased the amount of funding that goes to the important work of the Haemophilia Society. We will further review the situation in respect of those who have contracted hepatitis."

Harriet Harman's response gives the impression that we are going to review the Skipton Fund now. The briefing we provided for use at business questions said:

'We have committed to review financial assistance to those affected by hepatitis C in 2014, which is 10 years after the establishment of that financial relief scheme.'

Annex D

Department of Health

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webbere@ GRO-C

DH case ref: 288056R

May 2009

[redacted]

Dear Mr Webber

FREEDOM OF INFORMATION [FOI] ACT 2000: REQUEST FOR INTERNAL REVIEW DH CASE REF: 288056R

I am writing following my previous email to you of 20 April, which explained that we had referred the case to the Attorney General (AG), who acted as a qualified person under Section 36 of the Freedom of Information Act. The purpose was to secure an opinion from the AG as to the effects of your request for disclosure of advice received from the Chief Medical Officer in August 1990, regarding the litigation over the infection of haemophiliacs with HIV through contaminated blood products. This follows your request for an internal review on 21 August 2008 into the handling of this case. I am sorry it has taken so long to provide you with a response, but we needed to consult widely on this case as it raised a number of complex issues. In addition, you will recall that we were unable to trace your original request for an internal review. Consequently, we had not initiated an internal review until we received your letter of 12 February.

Following referral for advice to the Attorney General the Department of Health considers that we continue to maintain our position in withholding the document under the exemption under the FOI Act at Section 36 (2) (b) (i) & (ii) (prejudice to the effective conduct of public affairs). Therefore, I should re-iterate the Department of Health's position as set out in our letter of 1 August, in that these are qualified exemptions and attract the public interest test to determine whether the balance of the public interest lies in favour of disclosure or non-disclosure. After careful consideration, our conclusion is that its disclosure "would, or would be likely to inhibit the free and frank provision of advice or free and frank exchange of views for the purposes of deliberation". In addition, we consider that the exemption under Section 35 (1) of the FOI Act in the alternative is also relevant, which sets out:

Section 35 (1) Information held by a government department or by the National assembly for Wales is exempt, if it relates to:-

(a) the formulation or development of government policy
(b) Ministerial communications
(c) the provision of advice by any of the Law Officers or any request for the provision of such advice, or
(d) the operation of any Ministerial Private Office

Again, to re-iterate our previous conclusions set out in our original response of 1 August 2008. These conclusions were based on the balance of public interest that favoured non-disclosure for the following reasons:

- The role of the Chief Medical Officer (CMO). This is a unique role within Government and one on which Ministers are particularly reliant for independent and expert advice. We considered that disclosure would make it more likely that advice in the future would be less detailed, frank and candid if there was a risk that advice would not remain confidential. It is in the public interest of good governance that Ministers are able to receive uninhibited advice of this nature so that fully informed decisions can be taken. This does not mean that no advice from the CMO can ever be disclosed. However, we considered that the particular circumstances of this case, as elaborated below, move the balance of public interest strongly away from disclosure;

- The Information Commissioner's Office has recognised in previous cases that where advice is given in the context of litigation, a particular weight is given to the public interest in withholding the information. This is owing to the public's interest in ensuring a fair judicial process where all parties are able to debate their case in litigation internally and in confidence; and

- Furthermore, we consider that the public interest in openness surrounding the infection of haemophiliacs with HIV through contaminated blood products has already been served by the disclosure of thousands of documents covering the period 1970 to 1985 when most of the contamination took place. Litigation in this matter was settled, and payments were made to those who were affected through the MacFarlane Trust (Special Payments Trust).

For the reasons cited above, we consider that the public interest in withholding the requested information continues to outweigh the interest in disclosure of the advice.

The internal review, which you requested is now complete. If you are not content with the outcome, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at:-

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

Yours sincerely,

TONY DOOLE
Senior Casework Manager
Freedom of Information Team

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