Ref: Cana911 LIE 10

**IN CONFIDENCE**

Mr J Canavan EHF1A

From: Dr A Rejman MEDISP3
Date: 12 November 1990

Copy: Mr R Powell SOLB3

**HIV HAEMOPHILIA LITIGATION**

1. I have read through the suggested compromise.

2. There are several Points that I would suggest need amendment.

3. My understanding of the Macfarlane Trust is that payments from them are to go to haemophiliacs themselves or to their families if they are deceased. Mr Canavan needs to check whether the Macfarlane Trust can pay any sum to infected intimates or to Category G Plaintiffs. The exact mechanism of paying differential sums would need to be worked out, to avoid "Mac 3" being necessary.

4. Point 3 For purposes of equity it is suggested, and we agree, that payments should be made to all infected haemophiliacs and not just to the ones in the litigation. It is not stated what it is proposed to do about infected intimates or people who could consider themselves to be in Category G who are not currently Plaintiffs. Is there any risk that these people also will wish to claim from any proposed settlement?

intimate, not themselves infected but by reason of relationship is at risk of HIV

5. Point 4 If Category G is at all accepted, and I think it should not be, then I think these payments should be made only to sexual partners and should specifically exclude all parents, siblings and others. As you are aware, there are several cases where two or more individuals are claiming on the back of one infected haemophiliac. Surely this is wrong. In addition I think Category G payments should not be paid to Plaintiffs where the infected haemophiliac has died, and in some cases the surviving spouse has had negative HIV tests several years after his death and would already receive a payment in respect of the deceased.

6. As regards the infected intimates it might well be made a condition that there should be some proof required, since as you know there is one case where two girlfriends are supposed to have been infected in quick succession by one haemophiliac who is now, conveniently, deceased. There are also two cases of supposed in utero infection, which have subsequently tested negative and as such should be excluded.

7. I am very unhappy about Para 6. What guarantee is there that an individual will not put herself at risk and subsequently become infected and then claim a sum in the future? Among the ISCs that I have read, there are several cases where wives have put themselves at risk against the express advice of their medical attendants. How would one deal with such individuals? It would be easier to state that there is a cut off point after which time no additional infected intimates are accepted.

8. Point 8 I think this should be totally resisted. What number, and in particular which cases, do the Plaintiffs believe would be covered by this? The whole Point of any potential agreement would be that the Litigation would stop completely. A major reason put forward for any settlement is to stop problems for HAs of having to defend their actions, doctors etc. Would the Central Defendants be removed from the list of Defendants in these cases, or would the Department still have to continue work on the Litigation?

9. Point 10 I believe that MCA will have very strong views about such an action. There must be no suggestion whatsoever that there was any negligence, and stated as such by the Plaintiffs.

10. Point 12 I think this should be resisted fully. Any such statement would suggest that these individuals are not already getting the best possible treatment, and might lead to absurd demands for all sorts of fancy drugs to be used as well as, for instance, giving high purity FVIII at whatever cost to these haemophiliacs. This really would be committing the Department to something totally outside its remit.

GRO-C

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EH

I = dead haemophiliacs with HIV
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female