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CONTAMINATED BLOOD PRODUCTS and CALLS FOR A PUBLIC INQUIRY.

Issue

1. SoS is attending the Select Committee on Health on 25th July 2007.

2. Mr David Amess, (Con) Southend West, is a member of the Select Committee and Chair of the All Party Hepatology Group. He gave evidence at Lord Archer's non-governmental public inquiry on contaminated blood products on 11th July.

3. He indicated in his testimony to the inquiry that he would raise the question of a government sponsored public inquiry into how patients became infected with hepatitis C following NHS treatment with blood and blood products with SoS at the Select Committee on Health to be held on 25th July.

Lines to Take

4. The line to take as agreed with Ministers previously is:

The Government has great sympathy for those infected with hepatitis C and HIV. The Government has considered the call for a public inquiry very carefully. However, we believe the Government of the day acted in good faith, relying on the technology available at the time and therefore we do not consider that a public inquiry would provide any real benefit to those affected.

Background

5. There are a number of haemophilia lobby groups who believe that there should be a government led public inquiry into the issue of contaminated blood products and hepatitis C. The Department's position that an inquiry is not necessary was not helped by the loss/destruction of some papers covering the period in question, about which we have been quite open.

6. Most patients with haemophilia treated with blood products (clotting factors) in the 1970s through to the mid 1980s were infected with hepatitis C virus (originally known as Non-A, Non-B hepatitis (NANBH)) and many with HIV/AIDS virus. It was not possible to produce effective clotting factors for the treatment of haemophilia that were free from that risk until 1985 when heat-treatment was introduced.

7. The risk from NANBH was known from the late 1970s but it was considered a mild and benign disease. In the early to mid 1980s, there was an emerging recognition of the long-term clinical significance of NANBH. By 1985, it was realised that progression from mild NANBH to a more severe outcome of cirrhosis may be protracted and long-term studies were needed to more clearly understand the infection. .

8. In 1989, around 770 haemophilia patients who were infected with HIV through contaminated blood products and 190 of their partners and close relatives took legal action against the Department of Health, the Welsh Office, the Medicines Licensing Authority and Committee on Safety of Medicines to claim compensation for damages, alleging negligence. The Government denied liability. This litigation was settled out of court and a settlement of £44m agreed on the basis that no further action would be pursued. The £44m was paid in 1991 and is administered through the Macfarlane Trust (see para 10 below).

9. As a result of this litigation exercise we know that various relevant Department of Health papers were destroyed in error. An internal audit review was undertaken in 2000 to establish why these files were destroyed, and the review, which was released in May 2007, concluded the papers were destroyed in error. A further internal review (see para 11 below) has since located a number of these papers.

10. The Macfarlane Trust was set up to provide financial assistance for haemophiliacs infected with HIV through contaminated blood products. The Eileen Trust was later set up to provide assistance to non-haemophiliac patients infected with HIV through blood transfusion. More

recently, in 2004, the Skipton Fund was established to provide ex gratia payments for those infected by hepatitis C.

Current Internal Review

11. In 2006 the Department commissioned a review of documents held between 1970-85 relating to blood safety, in order to identify those relating to NANBH, later known as hepatitis C. It was known that there were two instances in the 1990s where papers relating to the safety of blood were destroyed in error and the review was initiated following the return of some 600 documents by a firm of solicitors in May 2006.

12. The review of the documents relating to NANBH (hepatitis C) was issued on 22 May 2007 to Lord Archer's non-governmental public inquiry and other interested parties, together with relevant documents referenced in the report. The review concluded that there was no evidence of any wrongful practices being employed.

13. The review identified some further 4000 documents relating to the safety of blood and blood products in these years, held in unregistered files. These mainly refer to the UK's drive to achieve self-sufficiency in blood products, to the reorganisation of the Blood Products Laboratory, and to measures taken to safeguard the blood supply and blood products from contamination by HIV/AIDS, hepatitis and hepatitis B.

14. In view of the public interest in these documents, these documents are being prepared in line with the Freedom of Information Act with the aim of releasing as many as possible. The documents are being issued at broadly monthly intervals from June 2007, both to Lord Archer's inquiry directly and onto the Department of Health's website.

15. It is not possible to state that all documents, previously recorded as missing, have been located. However the review, published on 22nd May, concluded that a very substantial number relating to the time in question have now been located.

Government Backed Public Inquiry

16. The Haemophilia Society believes that there should be a full Governmental public inquiry into the issue of contaminated blood products and hepatitis C, and argues that their case is supported by the fact that relevant papers are missing. They have lobbied extensively to that end.

17. Successive Secretaries of State have resisted calls for a government backed public inquiry into how patients became infected with hepatitis C following NHS treatment with blood and blood products prior to the introduction of heat treatment to eliminate the hepatitis C virus on the following grounds:

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- A full judicial inquiry would be a major, costly and time-consuming exercise that would depend on the recollections of witnesses about events that took place twenty or more years ago. This would make it difficult to construct a clear and detailed picture of what took place.

- An inquiry would not add significantly to our current understanding of how the blood supply became infected with Hepatitis C, or the steps needed to deal with problems of this kind now or in the future.

- A public inquiry could undermine public confidence and affect the donor population, thus putting at risk the supply of blood to the NHS.

- There are many conflicting demands upon NHS resources and it was felt that the current ex gratia payment scheme (Skipton Fund (para 10 above)) should be aimed at assisting those currently living with hepatitis C as a result of this treatment.

- There is no evidence that any wrongful practices were employed. The release of a significant number of papers, with a minimal number withheld, could provide much of the information sought by interested parties.

- It should be noted that the no-fault compensation to haemophiliacs infected with HIV through contaminated blood products was based on the assessment that those who contracted AIDS would die within two years. With the improved treatment of AIDS, many people have lived longer than this.

18. There are a number of examples of countries such as France, Ireland and Canada where trials/inquiries have led to large compensation amounts. The circumstances are different as fault was determined, though the lobby groups do not make that distinction.

Lord Archer's Non-Governmental Public Inquiry

19. Lord Archer is chair of a non-governmental public inquiry into contaminated blood and blood products. The inquiry was opened on the 27th March 2007 and was estimated to take 3 to 4 months. We expect this to be extended until around the end of the year.

20. The Department is co-operating with the inquiry. Officials met with Lord Archer and colleagues on 25th April 2007 and a further offer to meet has been made.

21. Around 1,600 papers, identified during the internal review (paras 11 to 15 above) have already been released to the inquiry; the remainder will be released as soon as they have been prepared. It is our intent to release as many of these papers as possible, including submissions to Ministers and policy formulation.

22. The Haemophilia Society has submitted evidence to the inquiry and provided a copy to the Department. The focus is on a series of delays: in achieving self-sufficiency in plasma products, introduction of heat-treatment to inactivate HIV, introduction of screening tests for hepatitis C and HIV.

Devolved Administrations

23. Prior to the change in administration in Scotland, the line taken by the Minister for Health and Community Care in Scotland was identical to that taken by the then SoS.

24. The Scottish National Party's manifesto however includes a commitment to a public inquiry into hepatitis C. The Scottish Government's position is that they do not wish to duplicate work and will wait the conclusion of Lord Archer's public inquiry before taking a final decision on this.

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