

**BRIEFING FOR THE PRIME MINISTER - 17 JANUARY**  
**HEPATITIS C - LOOK-BACK EXERCISE AND BBC "PANORAMA"**

**BULL POINTS**

I have great sympathy with those who may have been infected with Hepatitis C through NHS treatment.

UK blood services are among the safest in the world, and since September 1991 when a reliable test became available, all blood donations have been tested for the Hepatitis C virus.

The tests available prior to that date gave rise to unacceptably high numbers of false results and no satisfactory confirmatory tests were available. Expert advice was that these tests should not be introduced because of these deficiencies.

The Government have accepted the recommendation of the Advisory Committee on the Microbiological Safety of Blood and Tissues for Transplantation for a UK wide look-back exercise, to identify and follow up people who may have been put at risk of HCV infection.

Those who may have been infected through blood transfusions are to be traced, counselled and - if necessary - treated.

We shall do all that we can to care for patients who have been infected through counselling and, where appropriate, treatment. A freephone helpline has been set up.

Until recently, as there was no effective treatment for Hepatitis C, to inform people they were at risk, when there was nothing that could be done about it, would increase distress without any benefit.

In addition a look back to identify recipients of blood transfusion who are at risk was considered technically difficult.

There is now some confidence that many, but not all, recipients of blood infected with Hepatitis C can now be identified and Interferon alpha has been licensed for the treatment of chronic hepatitis C. This may be of help to some people.

**BACKGROUND NOTE**

**On Negligence/Compensation**

We do not accept that there has been negligence. These patients will have received the best treatment available in the light of medical knowledge at the time. We therefore have no plans to compensate those who may have been infected with Hepatitis C.

**Panorama programme**

The allegations made on yesterday's Panorama programme "Bad Blood" will have needlessly alarmed many thousands of people who have received blood transfusions that carried no risk of hepatitis C whatsoever.

About 3000 people with haemophilia and about a further 3000 people who had blood transfusions prior to September 1991 are believed to have been infected with HCV as a result of NHS treatment. The Department has denied negligence and Ministers have refused calls for compensation.

It has been known for at least five years that some people will have been infected through NHS treatment and we have expected at any time a campaign to be mounted along the lines of that for HIV. In recent weeks there has been increased media interest and a series of EDMs, an adjournment debate, and a large number of PQs and PO cases. Writs have been taken out against a former regional transfusion centre and we are aware of others being prepared. Panorama screened a programme on HCV and blood transfusions yesterday (16 January 1995). In the view of the Department the allegations made have needlessly alarmed many thousands of people who have received blood transfusions that carried no risk of hepatitis C whatsoever.

The Department cannot dispute that some people have been infected through NHS treatment but deny negligence. The case does not have the same exceptional circumstances as did the HIV infection where those affected were all expected to die very shortly and were subjected to significant social problems including ostracism. Ministers have therefore made clear that they have no plans for a payments scheme. There are practical steps that can be taken to assist those affected and those at risk.

In particular both the DH lawyers and the Advisory Committee on the Microbiological Safety of Blood and Tissues for Transplantation advise that there is a duty of care towards those who may be at risk. Ministers have agreed to the MSBT recommendation that procedures should be put in place to identify those patients at risk ("look back") and that this should be done on a UK wide basis. An ad hoc Working Party has been set up to put together guidance on counselling and treatment options its first meeting is 20 January.

The first anti-hepatitis C tests were reported in the literature in March 1989 but did not become available until later that year. These first tests had too large a number of false positive and false negative results and no satisfactory confirmatory tests were available. Expert advice was that these tests should not be introduced because of these deficiencies. The Department of Health funded several trials of the first and second generation anti-Hepatitis C test kits. Screening was introduced in late summer 1991, following advice from the Advisory Committee on the Virological Safety of Blood (AVSB). Satisfactory kits became available together with confirmatory tests. The screening kits now available are even more accurate than the second generation kits.

Until recently it was considered that look back to identify recipients of blood transfusion who are at risk would be technically difficult; and as there was no effective treatment, to inform people they were at risk, when there was nothing that could be done about it, would increase distress without any benefit. The position is now clearer. Many, but not all, recipients of blood infected with Hepatitis C can be identified. A means of treatment of chronic hepatitis C has become available as Interferon alpha has been licensed, this may be of help to some people.

DH are considering other steps which could be taken to ensure for example that: treatment is made available and that any additional research which might be required to improve the understanding, treatment and management of those affected be investigated. DH is also giving sympathetic consideration to appropriate requests for support from any self help groups which might be able to provide cost effective assistance to their members.