2136S/DAN/9-25/EH/CP/3

Department of Health

Eileen House 80-94 Newington Causeway London SE1 6EF

Telephone 01-972 2000

Mr R Panton
SHHD
Room 158
St Andrews House
EDINBURGH
EH1 3DE

Your reference

Our reference

Date LIE 10

27 September 1990

Dear Mr Panton

HIV/HAEMOPHILIA LITIGATION

I am enclosing for your information copies of 2 letters dated 26 July 1985 concerning the recall of Batches of contaminated Factor VIII.

You will wish to be aware that we will be disclosing these letters to Plaintiffs Solicitors in the near future.

Yours sincerely

GRO-C

MRS M T GIBSON

ENC

BLOOD PRODUCTS LABORATORY

National Blood Transfusion Service

Director:
R.S. LANE, MD MRCP MRCPath.

Telephone : 01-953-6181

Dagger Lane,
Elstree,
Borehamwood,
Herts WD6 3BX.

Our Ref : J85/181

4078

26th July, 1985

cc Mr Williams

Dr.Jean Harrison,
National Blood Transfusion Service,
N.E.Thames Regional Transfusion Centre,
Crescent Drive,
Brentwood,
Essex
CM15 8DP

Dear Dr.Harrison,

Advice of Transfusion Incident
and Product Recall Notice -
HLA & B3185; PFC 795

I have been informed by Dr.John Craske (advisor to Haemophilia Centre Directors on hepatitis and AIDS matters) that a patient treated at the London Hospital between 21st and 30th Nov. 1984 has developed a glandular fever like illness with associated symptoms and serology consistent with HTLV-III infection.

The batches implicated are HLA and HLB3185 and PFC batch 795. You received 574 vials of HLA3185 and 522 vials of HLB3185 as your August allocation and 947 vials of PFC 795 as your September allocation. Clinical records indicate that the patient in question received no other blood products during the relevant period of time.

I would be grateful if you would advise the directors of haemophilia centres to whom these batches were supplied of the need to follow up patients treated with the concentrates. Dr.Craske will advise on a suitable protocol for follow-up. In order to exclude the possibility that vials from these batches remain unused I would be grateful if you would secure an inventory of use of the product; unused vials from any of the batches should be returned to BPL addressed for my attention.

I apologise for having to involve you in a considerable amount of work but I am sure you will appreciate the requirement.

Yours sincerely,

(dictated by Dr.Snape but
signed in his absence)

T.J.SNAPE
Head of Quality Control
jg

CC : Dr.R.S.Lane
Dr.R.Perry (PFC)
Dr.J.Craske
Dr.A.Smithies
Incident File J85/181

BLOOD PRODUCTS LABORATORY

National Blood Transfusion Service

Director:
R.S. LANE, MD MRCP MRCPath.

Telephone : 01-953-6191

Dagger Lane,
Elstree,
Borehamwood,
Herts WD6 3BX.

Our Ref : J85/181

26th July, 1985

Dr.J.A.F.Napier,
National Blood Transfusion Service,
Welsh Regional Transfusion Centre,
Rhydlafar,
Cardiff,
CF5 6XF

4079

Dear Dr.Napier,

Advice of Transfusion Incident
and Product Recall Notice : PFC 795

I have been informed by Dr.John Craske (advisor to Haemophilia Centre Directors on hepatitis and AIDS matters) that two batches of NHS factor VIII concentrate are uniquely implicated in symptomatic HTLV-III infection in a haemophiliac. 140 vials from one of these batches, PFC batch 795, were despatched to you on 19th September, 1984 as part of your allocation for that month.

I would be grateful if you would advise the directors of haemophilia centres to whom these batches were supplied of the need to follow up patients treated with the concentrates. Dr.Craske will advise on a suitable protocol for follow-up. In order to exclude the possibility that vials from these batches remain unused I would be grateful if you would secure an inventory of use of the product; unused vials from any of the batches should be returned to BPL addressed for my attention.

I apologise for having to involve you in a considerable amount of work but I am sure you will appreciate the requirement.

Yours sincerely,

(dictated by Dr.Snape but
signed in his absence)

T.J.SNAPE
Head of Quality Control
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cc : Dr.R.S.Lane
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Dr.J.Craske
Dr.A.Smithies
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