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Health Committee 9 September 2003: Re Hepatitis C

I refer to your letter of 12 March 2004 raising issues in relation to what I said when I attended the above session of the Health Committee.

The fundamental issue here is the extent to which it is relevant to make comparisons between the Hepatitis C Compensation Tribunal in Eire and the Skipton Fund that will shortly be commence making payments in the UK.

I think it would be helpful to set down some of the important facts concerning the Irish situation as I understand them:

- Between 1977 and 1994, a large number of women in the Irish Republic were infected with Hepatitis C from contaminated Anti-D immunoglobulin produced by the Irish Blood Transfusion Service Board (BTSB), and many of them were allowed to subsequently donate blood.

- The events that surrounded the contamination of the Anti-D supply were investigated by an Expert Group which reported in January 1995. It concluded a) that BTSB had breached its own standards in allowing plasma from the original plasma exchange patient to be used for Anti-D production and that her plasma should not have been so used; b) that BTSB then failed to withdraw its Anti-D product and this was a serious omission.

- The Irish government introduced a non-statutory compensation scheme in December of the same year.

- A judicial Tribunal of Inquiry further examined the actions of BTSB and reported in March 1997 (the Finlay Report). It confirmed the findings of the Expert Group and concluded that BTSB had committed 'wrongful acts' in allowing the chain of events to take place and concluded that "very substantial numbers of persons who received contaminated injections of Anti-D subsequently became donors themselves".

- The Irish government passed the Hepatitis C Compensation Tribunal Act in May of that year – putting the compensation scheme on a statutory footing.

I have not seen any documentation that specifically states that the Irish Government established their scheme on compassionate grounds. Equally I am in no position to argue that compassionate motives did not feature in the thinking at the time.

Nevertheless, the fact remains that there has never been a comparable incident in the UK and neither SNBTS nor any of the other UK blood services have been found similarly at fault. In making comparisons between the Hepatitis C Compensation Tribunal Act and the Skipton Fund it is important to note these differences. I think it is entirely appropriate to make the distinction between a scheme that followed hard on the heels of a judicial inquiry that condemned the parent nation's blood service and a scheme where that is not the case. This was the distinction I was trying to make when I addressed the Committee.

Finally, since receiving your letter, I have seen the Official Report of the Health and Community Care Committee's meeting on 16 March 2004. I note that a particular issue that you wished to clarify was whether, when I referred to wrongful practices having been used in the Republic of Ireland, this was merely a "sloppy expression". I can confirm that, in using those words, I was alluding to the conclusions in the Report of the Tribunal of Inquiry into the Blood Transfusion Service Board dated 6 March 1997. In those conclusions the Honourable Mr. Justice T.A. Finlay states in relation to Chapter 4 of the report (*How and why did Anti-D become infected with Hepatitis C*):

The main reasons why these **wrongful acts** were committed were as follows:

An undue emphasis on the necessity to use plasma from therapeutic plasma exchange patients so as to maintain the supply of plasma for the making of Anti-D; An undue and unsupported belief in the probability that the method of production of Anti-D would inactivate any virus that existed; and a reluctance to admit the possibility of having been wrong and the possibility of a failure of the production of Anti-D which would be involved in the recall of the product.

I attach to this letter a photocopy of the Chapter 17, the Summary of Conclusions from the report, for your information. The entire report can be viewed on the web at:
http://www.doh.ie/pdfdocs/finlay.pdf

I hope this is helpful.

MALCOLM CHISHOLM