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WITH COMPLIMENTS IN CONFIDENCE

Date: 4/IX/89

To: Mr. T. L. Teal,
Manager (Administrative Services),
N. R. H. A.

Re: AIDS/HIV Litigation

( ) 1 Yours of ..... acknowledged
(✓) 2 Attached for your information
( ) 3 Attached for your instructions
( ) 4 Attached cheque in settlement of your account
( ) 5 Attached for your attention
( ) 6 Please reply to ours of .....
( ) 7 Please see note overleaf
( ) 8 Please sign and return
( ) 9 Please receipt and return
( ) 10 Please telephone

Northern Regional Health Authority
National Blood Transfusion Service
Regional Transfusion Centre
Holland Drive, Barrack Road, Newcastle upon Tyne NE2 4NQ Telephone 091 2611 711

Our Ref. HLL/DD Your Ref.

Mr R B Slack
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Solicitors
7 Osborne Terrace
Newcastle upon Tyne NE2 1NE

1 September 1989

Dear Mr Slack

RE: HIV LITIGATION

Attached is a fairly brief set of answers to the questions put by you recently (through Mr Teal). As I only became Director/General Manager in late 1988 my involvement with, and hence knowledge of, certain aspects of this Litigation is limited.

For another reason I went through a large quantity of files created by the last Director and some files dating back to her predecessor, who retired in 1979. It was clear from my examination of the files that very little was put to paper by the previous Director, or if it was, no copies now exist at the Transfusion Centre.

It may be possible to salvage something from copies of correspondence held at the RHA. This may prove to be important because I understand that, due to 'pressure' from the Haemophilia Centre Director in Newcastle, a decision was made to import Factor VIII rather than fund the Transfusion Centre for collection of more plasma which, in turn, could be converted into Factor VIII.

After answering your questions (in Appendix 1), there is a second Appendix which contains some comments as they apply to the 'Advice' prepared by Yeaman for Wessex RHA.

Yours sincerely

GRO-C

H L Lloyd
Director/General Manager

cc Mr T L Teal

APPENDIX 1

1. BTC Responsibilities in Relation to the Haemophilia Centre

The Transfusion Service responsibility to the Haemophilia Centre in this Region is little different to its responsibility to any other Health Service Department or Unit. We provide, within our capabilities, the products that are requested by the Haemophilia Centre. Some of the products we provide are locally produced, including cryoprecipitate and individual packs of fresh frozen plasma.

As far as the supply of Factor VIII and Factor IX are concerned, we have acted purely in a handling intermediary position between the Blood Products Laboratory at Elstree and the Haemophilia Centre. Because we have a vehicle travelling to Elstree carrying raw plasma to that factory, and the van is then returning to Newcastle, we bring back all the Factor VIII and Factor IX allocated to the Northern Region and then despatch it to the Haemophilia Centre. At various times we have held some of this product in stock, awaiting instructions from the Haemophilia Centre to have it sent across. As mentioned elsewhere, there have been times when it has been necessary to remind the Haemophilia Centre that supplies of NHS Factor VIII are available and awaiting collection.

2. The procedure for obtaining Factor VIII falls into two parts.

(a) The NHS Factor VIII, as mentioned in paragraph 1 above, is collected from the Blood Products Laboratory at Elstree and despatched to the Haemophilia Centre. The quantities of Factor VIII received from Elstree have, at various times, depended on quota systems. Mention is made in Appendix 2, paragraph 1.3.2, of how this quota system operated for much of the 1980's. There is still a quota system for this Factor VIII but now it is on something more akin to a population basis, and is not directly related to the quantity of plasma being sent by each Transfusion Centre.

(b) Commercial Factor VIII
The Transfusion Centre has never played any part in the purchasing of Commercial Factor VIII. As far as I am aware, all purchases of Factor VIII from the commercial market are currently made by the Pharmacy Department at the Royal Victoria Infirmary. It may be that prior to their involvement the Haemophilia Centre was in a position to purchase, or at least order, directly from the commercial companies.

It is worth noting that purchases of Factor IX and the supply of Factor IX from Elstree have followed similar patterns to Factor VIII. However, in the recent past, there have been instances I believe of the RVI purchasing Commercial Factor IX when, in fact, a heat treated National Health Service product from Elstree was available.

3. As the Transfusion Service has not been involved in ordering there is no relevant documentation available at the Transfusion Centre.

4. Have there been at any time pressures from the Haemophilia Society regarding Factor VIII?
The Haemophilia Society has been an extremely active pressure group on many aspects of haemophilia care. I suspect that if we look back through the publications of the Haemophilia Society we will find articles which indicate that the Haemophilia Society has advocated certain types of treatment. It would be worthwhile obtaining, if possible, a complete set of the Haemophilia Society's publications.

5. To what extent were there shortages of Factor VIII?
Factor VIII has, since the 1970's, been produced by the Blood Products Laboratory at Elstree in quantities less than those required for the treatment of the haemophiliacs in this country. The level of shortage in each Region has varied because of the supply of raw plasma, from which Factor VIII is made. As mentioned elsewhere, I believe that this Region took a decision in the 1970's to purchase Commercial Factor VIII rather than invest in the Transfusion Centre, with a view to producing more plasma.

To give you an idea of the extent of the shortage, the target set for this Region in terms of raw plasma was 28,000Kgs. It was estimated that 28,000Kgs., when processed at Elstree, would provide sufficient Factor VIII to meet the needs of all haemophiliacs in this Region. This estimate was carried out at a time before heat treatment was being mooted. This Region was producing something of the order of 9,000 or 10,000Kgs. of fresh plasma. Thus the amount of Factor VIII available to this Region from Elstree was only a fraction of the requirements of the haemophiliacs in the Region. During the mid-1980's when the quota system, generally referred to as "pro rata", was in use, while the amount of plasma supplied by the Northern Region stayed static, the quantity of Factor VIII provided from Elstree actually declined. This was a feature of the pro rata system that was introduced. These shortages were compounded by the limited processing capacity of the old factory at Elstree and the relatively poor conditions at the old plant.

6. What difference does it make to the life of a haemophiliac?
Although I am not a Specialist in the treatment of haemophilia, in broad terms haemophiliacs can be sub-divided into three categories. (a) severe (b) moderate (c) mild. Taking these in reverse order, a mild haemophiliac would lead a normal life although occasional incidents, such as a tooth extraction or an operation, could lead to serious bleeding. In general, these haemorrhages could be controlled by the use of quantities of fresh frozen plasma produced locally by a Transfusion Centre or, in the era before blood components were available in this form (i.e. pre-1970), fresh whole blood could be used. Therefore, for this group, Factor VIII Concentrates would make little difference to their life expectancy or life quality.

(b) Moderately severe haemophiliacs - In this group the patient may experience occasional spontaneous bleeding. The type of bleeding seen in this group of haemophiliacs is mainly bleeding internally into joints such as the knee, ankle or elbow. In this group these bleeds would be rare and would quite likely be treated in the Haemophilia Centre. Because their bleeds are rare they are less likely to be on home treatment. They are, however, quite likely to be treated with Factor VIII Concentrate and prompt treatment with Concentrate would stop the development of long-term joint damage. A person in this group who did not experience any undue trauma, or did not require any surgery, would probably lead a life with near normal life expectancy but would over the years be subjected to increasing joint problems leading to pain and incapacity. If, however, anyone in this group had for instance a road traffic accident, a head injury or required surgery, then they would require Factor VIII Concentrates. If these have not been available then life threatening bleeding could have occurred. It is conceivable that after 1970, when locally produced products such as cryoprecipitate were available, these people could have been treated with cryo-precipitate and they would have, in the majority of cases, survived these traumatic episodes.

(a) The severe haemophiliac - In this group of patients severe repeated and spontaneous bleeding occurs. Again, the bleeding is typically into joints but in this group bleeding may be very frequent. Without treatment these people had a limited life expectancy and I believe frequently died before reaching maturity. Many would have died in their teens. Bleeding into the joints would have led to severe crippling arthritis with associated pain. If they had required surgery, or had been involved in some form of trauma, then they would have been treated with cryoprecipitate but, prior to the availability of cryoprecipitate, they would almost certainly have died from the severe bleeding. The use of fresh whole blood, as practised prior to the availability of cryoprecipitate, would not I think have saved them. Some in certain circumstances might have survived, but there would have been a definite mortality.

We can therefore break down the difference to the life of haemophiliacs into three severity groups and can consider three treatment eras. The first era was when only fresh whole blood was available. Its efficacy was limited although, in some circumstances, it did stop life threatening bleeding. Fresh whole blood contains Factor VIII but the Factor VIII deteriorates rapidly on storage under the conditions used for storing ordinary donations of blood. The second era was when blood components were available. The specialist blood component concerned is cryoprecipitate. The production of this was made possible in significant quantities by the conversion from glass blood collection bottles to the modern plastic containers. This allowed the plasma to be separated from the blood donation. The plasma was then deep frozen and allowed to thaw slowly under controlled conditions. At a certain phase in this thawing two components became separated. There was a liquid and a solid component. The solid component, known as the cryoprecipitate, could be separated and contained relatively large quantities of the original Factor VIII. This Factor VIII could then be maintained in a deep frozen state. When this became available it was used as the mainstay of treatment of haemophiliacs. It was not normally used in a home treatment setting. The third phase came with the production of Factor VIII Concentrates. The Factor VIII Concentrate was

presented as a dried powder which could be reconstituted with sterile water. Once this product was available relatively large quantities of Factor VIII could be provided in small volumes. The product was stable when stored at around 4° Centigrade. It thus became possible for Factor VIII to be stored in a patient's home and for the patient to administer the Factor VIII himself. Virtually all severe haemophiliacs now have home treatment. It is generally recognised that the prompt treatment of a bleed is much better than delaying until the patient has attended a Haemophilia Centre to obtain treatment. In the case of children it is quite common for the parents to administer the Factor VIII.

7. What was the decision process regarding settling sources of Factor VIII?
In this Region Factor VIII purchases were entirely within the province of the Royal Victoria Infirmary. As mentioned previously, I am not clear as to who decided which particular product was used.

8. Were there any instructions from outside the BTC about obtaining Factor VIII?
Again, I am not sure whether instructions about obtaining Factor VIII came from any other sources. Although the Regional Health Authority funded the RVI specifically for its purchases of coagulation factors such as Factor VIII, I doubt whether they had or exercised any influence on what Factors were purchased. I have already mentioned the possibility that a decision was made to purchase commercial products, rather than investing in the Transfusion Centre.

9. When did the BTC become aware of AIDS?
I was not actually working within the Transfusion Centre when AIDS first became known.

10/ As mentioned in paragraph 9 above, I was not in the Transfusion
11/ Centre at this period and I would have to do some further research
12. to find out the answers to these questions.

13. Decisions about what is used in the treatment of a haemophiliac.
I can confirm that the Haemophilia Centre are entirely responsible for the decision making about what product is to be used in the treatment of any particular haemophiliac.

APPENDIX 2

1. Background Notes

1.1 The Northern Regional Blood Transfusion Service (NRBTS)

The NRBTS is directly funded by the Regional Health Authority (RHA). Until 1988 the 'responsibility' for the NRBTS at RHA level was held by the Regional Medical Officer.

The NRBTS has a Director who is medically qualified. Dr Sheilagh Murray was Director until 1979 (from about 1960, I think). From 1979 to 1988 the Director was Dr Anne Collins.

The Director is the Budget Holder and is responsible for the Transfusion Service, although he/she can only influence the funding process/capital investment.

Unlike the five Scottish Transfusion Centres who are run as a National Service, the English Centres are all run independently. Until recently the Directors of these Centres met about four times per year. A representative of the (then) DHSS attended these meetings.

The policies of all the English Transfusion Centres differs to varying degrees. It would appear that there was only a modicum of co-operation between Centres and Directors were not bound to abide by any decision made at the Directors' Meetings.

1.2 Factor VIII Purchasing

This Transfusion Centre has never had any role in the purchasing of Commercial Factor VIII. We have only acted as an intermediary in moving F.VIII produced at Elstree on to the Haemophilia Centre.

Some Transfusion Centres have been responsible for purchasing all Commercial Factor VIII, i.e. they have been responsible for the supply of sufficient Factor VIII whether it was the NHS product from Elstree or commercial product.

1.3 Supply of NHS Factor VIII

1.3.1 The Blood Products Laboratory, Elstree
It was acknowledged that BPL was poorly funded for many years, especially with regard to Capital Investment.

The production depended on plasma supplied by the Transfusion Centres in England and Wales.

1.3.2 Quota Systems

As demand for F.VIII grew, it became clear that Elstree could not produce sufficient for English/Welsh demand. In the early 1980's two programmes 'Stop-gap 1' and 'Stop-gap 2' were instituted to increase processing capacity within the old buildings. The new factory opened last year.

Transfusion Centres were urged (by the Department and by Elstree) to send more plasma.

A situation then arose whereby Elstree could not process all the plasma coming from the Transfusion Centres.

A quota system for finished products was introduced. It is commonly referred to as 'Pro rata.'

It worked thus:

Take total plasma input from all Transfusion Centres. Calculate what percentage of this total NRBTS supplied. The quota of finished products for NRBTS was this same percentage of the total output of Elstree.

e.g. If out of every 100 Tonnes of plasma sent to Elstree, 3 Tonnes came from NRBTS, then NRBTS's percentage is 3%.

So out of every 100 vials of Factor VIII produced, 3 would be sent to NRBTS.

In the 1980's many other Transfusion Centres sent more plasma. Some increased plasma supply dramatically. NRBTS did not increase its plasma supply until about 1987/88. Thus, with a static production of plasma by NRBTS and an increasing supply from other Centres, NRBTS's percentage fell. Thus, whilst standing still on the production front, we obtained less and less finished product.

1.3.3 Plasma Production by NRBTS

During the period in question - late 1970's up to 1985 (when HIV testing was introduced) - the NRBTS remained static on the plasma production front.

This may have been a Policy decision by the RHA. Records need to be searched, including RHA Minutes and the Regional Medical Officer's files, to find out if this Policy was an active one.

Three possibilities occur to me:

(a) The Haemophilia Centre Director wanted to purchase more Commercial Factor VIII, arguing that it was a 'better' product. This was translated into an increased Factor VIII budget for the Haemophilia Centre and no additional funding for the NRBTS.

(b) The RHA were unhappy at the way the NRBTS was run and believed that NHS money would be better spent on commercial products than on the NRBTS.

(c) The Director of the NRBTS may have advised the RHA that Elstree could not 'deliver the goods.'

An extension of (c) is that if all Transfusion Centres had increased plasma supply there would still have been a need to purchase commercial products, as the capacity of Elstree was way below the demand from England/Wales.

2. Notes on 'Advice'

2.1 Haemophilia Centre Directors

The use of a Haemophilia Centre Director to prepare a report (see p.2 para 3 of 'Advice') has problems.

(a) Each Haemophilia Centre operates (operated) differently.

(b) Each Transfusion Centre operated differently.

(c) I seem to recall that the Haemophilia Society recently said that they have no intention of taking action against them. I presume they do not wish to harm their Patient-Doctor relationship.

2.2 Re: The response to the risks of Hepatitis and AIDS to Haemophiliacs (Para 5)

2.2.1 Hepatitis

There are several types of hepatitis. At that time these were A, B and Non-A, Non-B.

Hepatitis A is not normally considered as a blood borne infection. Hepatitis B is blood borne and can be fatal. The NRBTS introduced Hepatitis B testing in late 1971 (albeit on a limited scale). All blood was tested, I believe, from some time in 1972. The testing available at that time was relatively insensitive and some Positives would have been missed. Imported products would, even if tested, have had similar problems with an incidence of hepatitis transmission. It was recognised that imported material had this higher risk, although arguments may have been put forward over better standards of hepatitis testing in the States. Hepatitis B is more prevalent in certain groups, such as I.V. drug users and homosexuals. The I.V. drug users were probably included in the plasma donor programmes in the States, as donors were paid. Thus, at that time in the early 1970's even with Hepatitis B testing, imported products were more likely to be capable of transmitting Hepatitis B.

Non-A, Non-B Hepatitis probably represents more than one virus. Hepatitis C has recently been identified and formed one of these Non-A, Non-B hepatitides. A test for Hepatitis C has just been developed.

2.2.2 Haemophilia Centre Policy

Despite the known problems with hepatitis in Commercial Factor VIII, I believe that the Haemophilia Centre was at times reluctant to use the Elstree Factor VIII. They could probably have used more cryoprecipitate (a locally 'made' product which can be used instead of Factor VIII) but again chose to use more Commercial Factor VIII.

If this is the case, then much of the argument about the commissions and omissions of the NRBTS (and the RHA) become much less relevant.

2.2.3 AIDS - Co-ordinated Response
(Page 6, para 5)

As far as I am aware, action on the introduction of measures to combat HIV infection was co-ordinated at least in England and Wales. The use of information leaflets was standardised and the introduction of the HIV test for all blood donations was fully co-ordinated in England and Wales. Testing was introduced from October 1985.