Deponent: Deborah Webb
On Behalf of: Defendant
Date: 16.02.2010
Statement: First

IN THE HIGH COURT OF JUSTICE **CLAIM NO: CO/9344/09**

QUEEN'S BENCH DIVISION

ADMINISTRATIVE COURT

BETWEEN

THE QUEEN
(ON THE APPLICATION OF ANDREW MICHAEL MARCH)

v

THE SECRETARY OF STATE FOR HEALTH

WITNESS STATEMENT
OF DEBORAH WEBB

I, DEBORAH WEBB of the Department of Health, Wellington House, 133-155 Waterloo Road, London SE1 6UG will say:

INTRODUCTION

1. I am a Principal Civil Servant working in the Health Protection Division of the Department of Health. My line manager is Dr Ailsa Wight, Deputy Director and Head of Infectious Diseases and Blood Policy within the Health Protection Division at the Department. A team of four people mostly worked on the Government response to Lord Archer's report – the Director of Health Protection (Liz Woodeson), the Deputy Director (Ailsa Wight), the Head of the Blood Policy Team (Rowena

Jecock), and myself. I was involved in drafting part of the Government's Response document which is the source of the Claimant's challenge in this case.

2. I make this witness statement from my own knowledge, except where I have relied on other sources of information in which case I say so and state the source of that information.

3. I make this witness statement in relation to the judicial review brought by Andrew March against the Department.

4. I have read the Detailed Grounds and confirm that the facts stated in the Detailed Grounds are correct to the best of my knowledge.

5. In this witness statement I refer to certain documents contained within the Claimant's bundle already lodged at Court, as **[CB]** followed by the tab number. I also refer to documents lodged on behalf of the Defendant, as **[DB]** followed by the tab number and page number in that bundle.

BACKGROUND

6. I set out below my understanding of the background.

7. During the 1970s and early 1980s, many patients, mostly those with haemophilia and other bleeding disorders, became infected with HIV and/or hepatitis C through NHS treatment with blood and blood products. Over 4,600 patients became infected with hepatitis C, and 1,200 with HIV. This was before tests on blood donations for these viruses were available and before the introduction of heat treatment of blood products (which destroys viruses) in 1985. Some patients were infected with both HIV and hepatitis C.

8. Reliable tests for HIV and hepatitis C were developed in 1985 and 1991 respectively, and since then all blood donations collected in the UK have been screened for both HIV and hepatitis C.

9. The history of the Government's attempts to pursue self-sufficiency in blood products in England and Wales is explored in the Department of Health report, Self-Sufficiency in Blood Products in England and Wales: A Chronology from 1973 to 1991, which was published in February 2006 **[DB/6a]**.

10. In 2006 the Department commissioned a further review of all the documents held between 1970 and 1985 relating to non-A, non-B hepatitis (later described as hepatitis C). These mainly refer to the UK's drive to achieve self-sufficiency in blood products, to the reorganization of the Blood Products Laboratory, and to measures taken to safeguard the blood supply and blood products from contamination by HIV/AIDS and viral hepatitis. The review report was published in May 2007, together with all the references (Review of Documentation Relating to the Safety of Blood Products 1970-1985 (Non A Non B Hepatitis) **[DB/6b]**).

EX GRATIA PAYMENT SCHEMES

11. I set out below my understanding of the payment schemes.

12. Three ex-gratia schemes in the UK make payments to those infected with either HIV or hepatitis C via NHS supplied contaminated blood and blood products. These schemes were established purely in recognition of the unfortunate position of those who were infected. The UK Government, through successive administrations to date, has acknowledged the tragedy which befell those who were infected and their families, and has sought to give some financial support to those families, recognizing that these are special cases deserving of special measures (see for example the DH Press Release dated 17th February 1992 at **[DB/3d]).** The UK Government does not accept any suggestion that it was at fault in the circumstances leading to the infection of so many from contaminated blood and blood products.

The Macfarlane and Eileen Trusts

13. The Macfarlane Trust was established in 1987 to assist people with haemophilia who had contracted HIV infection through NHS treatment of their haemophilia with contaminated blood products. It also makes discretionary payments to dependents of qualifying persons and is a Charitable Trust funded by the Department of Health.

14. In addition to the £10 million made available to the Trust in 1987, a further £19 million was made available in November 1989 (the Press Release to that effect is dated 23rd November 1989 and appears at **[DB/3a]**)

15. Litigation was commenced against the UK government in the 1980s by haemophiliacs infected with HIV alleging fault on the part of the UK government. That litigation was compromised in 1990, in the context of advice having been given to those claimants that their prospects of succeeding in that litigation GRO-D GRO-D **[DB/1]**. Although the Macfarlane Trust had by that date already been established, it was a term of the compromise of that litigation that the UK Government would make a further payment to that Trust of £42 million (see the Press Release dated 3rd May 1991 at **[DB/3c]**; see also the Written Answer dated 10th June 1991 at **[DB/5c]**).

16. The Eileen Trust was set up in 1993 to assist people, other than those with haemophilia, who had contracted HIV through NHS treatment with contaminated blood products. It also makes discretionary payments to dependents of qualifying persons and is a Charitable Trust funded by the Department of Health.

17. The Eileen Trust was established on the basis of extending the existing provision for those with haemophilia and HIV (under the Macfarlane Trust) to others who were infected with HIV as a result of blood transfusion or tissue transfer in the UK (see the Press Release dated 17th February 1992 at **[DB/3d]**).

18. There are currently around 600 beneficiaries of the Macfarlane and Eileen Trusts, of whom 401 are living infected registrants. Prior to the Government's Response to the Archer Report, the current average amount paid by the Macfarlane and Eileen Trusts was around £6,400 per annum (this is an average of all payments – not just to those infected).

19. Following the Archer Report, the Government announced it would move to a flat rate payment of £12,800 per infected registrant of the Macfarlane and Eileen Trusts per annum. This was in part to meet Lord Archer's recommendation 6 (c) that infected individuals' entitlement should not be means tested, but should be by prescribed periodical payments. However, as the Macfarlane and Eileen Trusts are registered charities and this sort of flat rate payment is not compatible with payments by a registered charity, it has been necessary to set up new vehicles for the delivery of these payments and to ensure that they are disregarded for income tax and benefit purposes. The existing special payment vehicle (the MSPT2 fund) was modified to permit payments to be made in the financial year 2009/10 and a new company has been set up to make such payments in 2010/11 and later years. The new payment has been backdated to 20th May 2009 (when the Government response was published).

20. The total paid out by the Macfarlane and Eileen Trusts is approximately £52 million to the end of March 2009.

The Skipton Fund

21. The Skipton Fund was announced on 29 August 2003 and became operational on 5th July 2004. It was set up as a company limited by guarantee. The principal activity of the company is to implement and manage the UK-wide ex gratia payments scheme for people infected with Hepatitis C from NHS treatment with blood, blood products or tissue. This was decided on compassionate grounds (see the Press Releases dated 29th August 2003, 23rd January 2004 and 3rd June 2004) **[DB/3e-g]**.

22. The company acts as agent for the Department of Health, which in turn acts for the health departments of the devolved administrations.

23. Unlike the Macfarlane and Eileen Trusts, the Skipton Fund only makes payments to those infected – it does not make payments to dependents. It also makes one-off payments, as opposed to the on-going per-annum payments for those with HIV (via Macfarlane and Eileen Trusts). The scheme is set up on two levels: a stage one payment is made (£20,000) on successful application to the Fund, and a stage two payment (£25,000) is made to those stage one beneficiaries who go on to develop severe liver disease. To the end of March 2009, 4046 people had received stage one payments and of these, 760 subsequently received a stage two payment as well. At the time of the Government response, nearly £100m had been paid out via the Skipton Fund since it was set up, shared amongst 4046 registrants.

24. The payments from both Trusts and the Skipton Fund are free from income tax and are ignored by the Department for Work and Pensions for the purpose of assessing state benefits.

IRELAND

25. I set out below my understanding of the Irish response to contaminated blood and blood products in its supply. Where possible I have exhibited a document, but some of my understanding is based on conversations with colleagues (both in the UK and Ireland). My understanding is common to all of us working within the Blood Policy branch of the Department and has been confirmed by Irish colleagues.

26. 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 national Blood Transfusion Service Board (BTSB). Infection with hepatitis C in this way is unique to the Irish Republic.

27. Faced with a similar debate as was at the time underway in the UK, in 1989 the Irish Government established a trust which was similar to the Macfarlane Trust in structure. In 1991 the Irish government set out a scale of lump sum payments to persons infected with HIV from the use of contaminated blood products.

Expert Group

28. When the problem about contaminated Anti-D immunoglobulin came to light in Ireland, the Irish Minister for Health established an Expert Group on 4 March 1994 with the following terms of reference:

> *"I To examine and report to the Minister for Health on the following matters:*
>
> *(a) All the circumstances surrounding the infection of the Anti-D Immunoglobulin product manufactured by the Blood Transfusion Service Board;*
>
> *(b) The systems and standards in place for donor selection, the manufacturing process and use of the anti-D Immunoglobulin produced by the Blood Transfusion Service Board.*
>
> *II To make recommendations to the Minister for Health on the above matters and on any other matters relating to the Blood Transfusion Service Board which the Group consider necessary."*

29. The Irish Government by a declaration of policy issued in December 1994 committed itself to fair compensation for women infected by Hepatitis C virus from Anti-D (Finlay Report, **[CB/8]**, p 117).

30. The Expert Group published its report in January 1995 (Report of the Expert Group on the Blood Transfusion Service Board) **[DB/7]**. The Group identified many failures by the BTSB, including a failure to adhere to its own clear standards in 1976/77, in relation to the acceptance of particular plasma which was used in the production of Anti-D, serious delays and a failure to act with sufficient urgency. Further failings in 1991-4 in the failure to withdraw the Anti-D product were identified. The BTSB was

also criticised at an organisational and managerial level, as was the system of licensing of blood products. The Report adopted explicit language of criticism.

Hepatitis C Compensation Tribunal

31. The Hepatitis C Compensation Tribunal was set up to operate on a non-statutory basis. I understand that it was established against the background of a number of civil actions pending in the courts for compensation as a result of infections through contaminated Anti-D. Before it started operating, it was extended to include persons who had contracted Hepatitis C from a blood transfusion or other blood products (Finlay Report **[CB/8]**, p.117).

32. The Hepatitis C Compensation Tribunal operated on a non-statutory basis from 16th December 1995 to 31st October 1997 (see **[DB/9]**). The Hepatitis C Compensation Tribunal Act 1997, which came into effect on 1st November 1997, placed the Compensation Tribunal on a statutory basis **[CB/6]**.

Finlay Tribunal

33. On 17th October 1996, the Irish Parliament passed resolutions establishing a Tribunal of Inquiry into the circumstances surrounding the contamination of blood and blood products due to contaminated Anti-D **[CB/8]**, p.5.

34. The inquiry published its report on 6th March 1997: Report of the Finlay Tribunal of Inquiry into the Blood Transfusion Service Board **[CB/8]**. The Report found various failures on the part of the BTSB and the Department of Health. The Report found that "*wrongful acts were committed*" by the Irish authorities and that the Department of Health was "*at fault*", with responsibility for that failure resting between the medical and administrative sections of the Department.

35. It was established that around 100 of the women infected with contaminated Anti-D were also blood donors, so that hepatitis C had contaminated the whole Irish blood supply until screening was introduced in Ireland in 1991 (**[CB/8]**, Appendix G of the Finlay Report, p. 177, para (C) (1)).

36. Following the findings of the Finlay Tribunal in March 1997, the Irish Government decided to place the Tribunal on a statutory footing and the Hepatitis C Compensation Tribunal Act 1997, published on 21 May 1997, came into effect on 1 November 1997 **[CB/6]**.

Lindsay Tribunal

37. On 2nd June 1999, both Houses of the Oireachtas passed a Resolution that a further Tribunal of Inquiry should be established to examine and report on matters of urgent public importance relating to the infection with Hepatitis C and HIV of persons with haemophilia. The Report of the Tribunal of Inquiry into the Infection with HIV and Hepatitis C of Persons with Haemophilia and Related Matters **[CB/9]** was published on 5th September 2002 by Her Honour Judge Alison Lindsay.

38. Although one of the criticisms of that report was that the Irish Blood Transfusion Service Board should have commenced heat treating its blood product sooner, and once heat treated products became available should have immediately recalled any unheated product from the treating centres, these products only constituted a very small proportion of the products used by treating physicians – the Lindsay report concluded that only eight haemophiliacs were likely to have been infected as a result.

39. Following the Lindsay Report, the Irish Blood Service issued an apology acknowledging failures in the past **[DB/10]**.

40. In 2002 the remit of the Tribunal was extended to include compensation for HIV infection through blood products, and certain additional heads of claim. The decision

to extent the compensation scheme to haemophiliacs with HIV predated the Lindsay Report, although delays in the negotiation process meant that the legislation was enacted after the Lindsay hearings were concluded (but some months before the Report was received).

41. The total cost to December 2008, excluding legal costs, was €767m (approximately £670m on current exchange rates). This is shown at Appendix IV to the 2008 Annual Report of the Hepatitis C and HIV Compensation Tribunal at **[DB/8]**, pp 95-96. The number of awards paid and appeals was 3,155 – which is believed to be the approximate number of claimants under the Irish system.

DIFFERENCES BETWEEN UK AND IRELAND

42. I set out below my understanding of the differences between the UK and Ireland. The compensation scheme in the Republic of Ireland was set up in the light of evidence of mistakes by the Irish BTSB and the Irish Department of Health.

43. The UK Department of Health works in close liaison with its Irish counterparts to agree what is said in relation to their circumstances. The foregoing paragraph has been expressly approved for inclusion within this witness statement by the Irish Department of Health. The UK Government does not refer to the particular difficulties which have occurred in Ireland in the past unless it is necessary to do so, for example in the context of explaining the UK Government's own (and different) response to the problem of contaminated blood and blood products.

44. The evidence to which I refer in paragraph 42 has emerged over time in Ireland, including from the Expert Group and two Tribunals of Inquiry, and relates to contamination of Anti-D, whole blood, or other blood products with Hepatitis C and HIV.

45. The level of payments in Ireland is substantially higher than has ever been the case in the UK. The Irish model provides compensation for all losses which can be proved to the Tribunal which results in very much higher individual awards being made. The Irish model also allows claimants to claim exemplary and aggravated damages (or to pay a 20% uplift on the basic compensatory award where there has been a settlement), and to claim legal costs.

46. I understand that this model was devised as a political response to the unique circumstances which gave rise to contamination in blood and blood products in Ireland. Those circumstances are very different from those which pertain in the UK.

ARCHER INQUIRY

47. I set out below my understanding of the Archer Inquiry. Lord Archer of Sandwell QC wrote to the then Secretary of State for Health on 16th February 2007 informing her that he had agreed to chair an independent inquiry into the circumstances surrounding the supply to patients of contaminated NHS blood and blood products, its consequences for the haemophilia community and others afflicted, and further steps to address both their problems and needs and those of bereaved families **[DB/4a]**.

48. The Defendant had already embarked on a review of all the documents held relating to the safety of blood products between 1970 and 1985. This review was commissioned in 2006 and was completed in May 2007 **[DB/6b]**. The Defendant offered to share the results of this review with the Archer Inquiry team.

49. The then Secretary of State further indicated that the Department was willing to assist Lord Archer "*as far as we can*" and offered an early meeting with Department officials **[DB/4b]**.

50. Thereafter three meetings and various telephone conversations took place between the Department and the Archer team.

51. The Report of the Archer Inquiry was published on 23 February 2009. The Report expressed the terms of reference of the Inquiry as follows:

> *"To investigate the circumstances surrounding the supply to patients of contaminated NHS blood and blood products; its consequences for the haemophilia community and others afflicted; and suggest further steps to address both their problems and needs and those of bereaved families".*

GOVERNMENT'S RESPONSE

52. I set out below my understanding of the Government's response. The UK Government carefully considered the content and recommendations of Lord Archer's report. The then Secretary of State and the then Minister for Public Health met with Lord Archer on 11th March 2009 to discuss the report and its recommendations. A number of internal meetings took place between officials and Ministers, and between the then Minister and then Secretary of State.

53. In the Response, a range of measures were announced which dealt with the various recommendations made by Lord Archer. Those measures can be seen from the Response itself. However, it would not be correct to view the Archer recommendations as relating solely to the funding available to those affected. The recommendations went wider than that – as did the UK Government's response, which met the various recommendations in large part, where it was able to do so.

54. In response to the recommendation that there should be increased financial assistance, the UK Government recognized that Lord Archer's Recommendations 4 and 6 were in essence a package of measures to improve the financial situation of those affected. Aspects of that package were based on the Irish model, especially Recommendation 4. The package related to the method of payment as well as the level of payment.

55. Recommendation 4 was to a great extent already in existence (free GP visits, physiotherapy, and home nursing already being available under the NHS); some

aspects were already subject to review (the level of charging for prescriptions being the subject of a then ongoing review by Professor Ian Gilmore); and Department of Health statutory guidance to local authorities on charging for non-residential social care services already made it clear that they that they should assess and take into account service users' specific needs and costs associated with their condition or disability. This would include any additional costs related to living with HIV or Hepatitis C.

56. In response to Recommendation 6, the UK Government undertook to implement a range of measures. Funding to the Macfarlane and Eileen Trusts was increased, so that each infected registrant would receive £12,800. Further, that payment would be made each year (ie as a periodical payment as recommended) and was no longer on application and subject to discretion. The funding to allow for discretionary payments to dependents was also increased. The Skipton Fund was to be reviewed in 2014, when it had been in existence for 10 years.

57. Thereby, the UK Government went a considerable way towards accepting the recommendations for a different system of payments, and increased levels of payment to those affected by HIV. The position of those suffering from Hepatitis C will be reconsidered when the Skipton Fund comes up for review.

RECOMMENDATION 6(h)

58. I set out below my understanding of how Recommendation 6(h) was considered. The then Minister was briefed by officials within the Department very soon after the Archer Report was released, in relation to the content of the Report and its recommendations.

59. Officials produced an early briefing for Ministers dealing with the Archer recommendations. That note referred to the recommendation that a system similar to that in Ireland should be adopted. A rough costing was given of £3-3.5 billion.

60. A subsequent briefing noted that Ireland operated a more generous compensation scheme which was thought to provide an average payment of around £750,000 per patient affected. Ministers were advised that the situation in the UK was different from that in Ireland. In Ireland, it was acknowledged that action to reduce the risk could have been taken earlier, the Irish Blood Service had issued an apology acknowledging "failures" in the past and the payment regime reflected this admission of mistakes. In view of the very different situation in Ireland, it was not necessary to give Ministers a detailed history of the findings of failings in Ireland beyond this general account.

61. The recommendation that a system similar to the Irish system should be adopted was not considered in detail and was not fully costed or investigated. Officials had limited details of the Irish compensation scheme and would not, in any event, have been able to match it to the corresponding UK population.

62. The Department subsequently worked on a range of options covering eligibility criteria, options to rationalize the schemes and options for increased funding, none of which matched recommendation 6(h). Various options for increased funding of the Macfarlane and Eileen Trusts were subsequently costed and put before the Minister. Ministers focused on options for removing the discretionary element of the Trusts and increasing their recurrent level of funding for infected registrants.

63. In the event the Minister decided to double the annual payments under the Macfarlane and Eileen Trusts to £12,800 pa per infected individual and increased overall funding to enable the Trusts to make higher payments to dependents. Taken together, this is an additional annual cost this year to the Department of approximately £3.8 million. This additional funding was to be found by reprioritization of expenditure within the existing Department budget. The then Secretary of State agreed this proposal. The Minister also decided to move to a system of prescribed periodical payments, as described in paragraph 19 above.

64. I was asked to draft part of the Government's response, reflecting the then Minister's decisions in relation to Lord Archer's recommendations about financial relief, as well as his other recommendations. The Minister cleared the final response and the written Ministerial Statement on 19 May 2009. (The written Ministerial statement appears at **[DB/5d]**).

65. The Response states *"We have carefully considered Lord Archer's recommendations, and are responding in as positive a way as possible at the current time, bearing in mind the constraints on public funds"* (p 8). That statement reflects the process by which I understand the Ministerial decisions relating to financial relief, as set out in the Response, were arrived at.

66. The then Minister had asked for a response which demonstrated that the UK Government had reacted positively to Lord Archer's recommendations, and had done what was possible while taking financial considerations into account. The Response does not refer to paragraph 6(h) and the Irish system in terms. The recommendation in paragraph 6(h) was one part of a package of measures recommended, some of which had been accepted while some of which had not. It was obvious from reading the Response what had been decided (and which recommendations were accepted and which were not). The Response made clear that the Minister wanted to respond as positively as possible, bearing in mind financial constraints.

SUBSEQUENT DEBATE ABOUT ARCHER REPORT

67. Following publication of the Archer Report, and the Government Response, there has been considerable Parliamentary debate on the issue, including the question of financial relief for those affected. Lord Morris of Manchester has introduced a Private Member's Bill, the Contaminated Blood (Support for Infected and Bereaved Persons) Bill, which has been debated in the House of Lords and introduced to the

House of Commons **[DB/5g]**. It seeks to embody the recommendations of the Archer Report in legislative form.

68. In the course of these debates, MPs and Peers have referred to the situation in Ireland. In response, Ministers have explained that the background in Ireland differs from that in the UK. That has long been the Government's view. I have outlined the different situation in Ireland, as it is understood by me and my colleagues, above.

69. I do not believe there to be any inconsistency between the answers in Parliament and what was stated in the Response. Details given about the Irish situation have been confirmed by Irish colleagues. The point about Ireland is that it has a different, and much more costly system of ex gratia payments in place. The Irish Government made different political choices about the nature and level of payments to those affected because of the evidence, accrued over a number of years and by one Expert Group and two Tribunals of Inquiry, that there had been fault on the part of the Irish authorities. That was a particular situation, not replicated in the UK.

CONCLUSION

70. I believe the facts stated in this witness statement are true.

GRO-C

Name: Deborah Webb

Position: PRINCIPAL CIVIL SERVANT

Date: 16. FEBRUARY 2010.

Deponent: Deborah Webb
On Behalf of: Defendant
Date:
Statement: First

IN THE HIGH COURT OF JUSTICE
CLAIM NO: CO/9344/09

QUEEN'S BENCH DIVISION

ADMINISTRATIVE COURT

BETWEEN

THE QUEEN
(ON THE APPLICATION OF
ANDREW MICHAEL MARCH)

v

THE SECRETARY OF STATE FOR HEALTH

WITNESS STATEMENT
OF DEBORAH WEBB

Department of Health
Wellington House
133-155 Waterloo Road
London SE1 6UG