

Witness Name: The Rt Hon Lord David Owen CH FRCP

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exhibit list

Dated: 5 February 2020

## **INFECTED BLOOD INQUIRY**

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### **WRITTEN STATEMENT OF THE RT HON LORD DAVID OWEN**

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I, **The Rt Hon Lord David Owen CH FRCP**, will say as follows:-

#### **Background**

1. I was educated as a physician at Sidney Sussex College, Cambridge and St Thomas's Hospital, London where I was a Neurological and Psychiatric Registrar from 1964 to 1966 and Research Fellow in neuroscience in the Medical Unit from 1966 to 1968. I was elected MP for Plymouth in 1966. Under Labour Governments, I served as Navy Minister (1968-70), Health Minister (1974-76) and Minister of State, Europe and then Foreign Secretary (1976-79). I helped to co-found the Social Democratic Party and served as Leader from 1983-87 and 1988-90. In 1992 I retired from the House of Commons and was made a Life Peer in the Dissolution Honours list. I sit as an independent social democrat in the House of Lords. From 1992-95 I was very much out of the British domestic political scene spending the majority of my time overseas in my role as EU Co-Chairman of the International Conference on the Former Yugoslavia.
2. From 1995-2011 I held positions in business as chairman and non-executive director of various companies in the UK, US and Russia, one of which, of some relevance, was Abbott Laboratories based in Chicago from 1996-2015. I served as Chancellor of Liverpool University from 1996-2009. During this time, I involved myself in a number of political issues in

the House of Lords; the one of particular relevance to this Inquiry is campaigning against the increasing marketisation of the NHS.

3. This statement has been prepared without access to all my Private Office Ministerial papers which were destroyed without asking my permission. I have tried to give as much detail as possible. However, as these events took place up to 45 years ago it has not always been possible to give as much detail as I would like or to fully recollect past events.

### **Part 1. Period as Minister of Health in the Department of Health and Social Security 1974-76.**

#### **Decision to Pursue a Policy of Self-Sufficiency**

4. The policy of self-sufficiency was set out in my written answer to Parliament on 22 January 1975:

“...I believe it is vitally important that the National Health Service should become self-sufficient as soon as practicable in the production of Factor VIII, including AHG concentrate. This will stop us being dependent on imports and make the best-known treatment more readily available to people suffering from haemophilia. I have, therefore, authorised the allocation of special finance to boost our own production with the objective of becoming self-sufficient over the next few years.” [LDOW0000032]

5. My views had its roots in a book review of *The Gift Relationship* by Richard M. Titmuss which I wrote in the *New Statesman* on 22 January 1971, a copy of which is attached [LDOW0000343]. I quoted Titmuss's claim that the NHS has:

“allowed and encouraged sentiments of altruism, reciprocity and social duty to express themselves; to be made explicit and identifiable in measurable patterns of behaviour by all social groups and classes.”

6. I went on to write, "This is an ambitious claim, and in this profound case-study of the provision of blood for transfusion he has quantified to an extent that has hitherto seemed impossible the real moral values that underpin the most significant piece of social legislation undertaken in the 20<sup>th</sup> Century." Namely, the NHS.
  
7. I also wrote in that article about the blood transfusion service: "It is clearly shown that the private market in blood is seriously deficient in quality, largely because of the character of the donor population, and entails much greater risk to the health of the unsuspecting recipient. The commercial blood market also fails in terms of economic efficiency, for the cost alone in the US is 5 to 15 times greater than in Britain. In terms of administrative efficiency, failure is revealed by serious shortages and marked wastage. So far from giving greater consumer freedom, the marketplace in blood actually involves considerable consumer exploitation."
  
8. Within my review I also wrote, "No one seeing the recent BBC-2 film *Don't Get Sick in America* can lightly espouse the philosophy of treating medical care as merely one other commodity to be bought and sold in the market place, and when in short supply merely sold to the highest bidder. The inevitable long-term effect of such policies is to turn doctors into profit-orientated businessmen, to build (as has already occurred in America) profit-making hospitals, geared to receiving profitable patients. It leads, as Titmuss spells out, to a complete breakdown in the doctor-patient relationship, so that in 1969 it was estimated that one in five of all physicians in the United States had been or was being sued for malpractice. It will be hard for anyone who reads carefully through this well-documented book to doubt the final sentence; 'Freedom from disability is inseparable from altruism.'"
  
9. In 1975 WHO laid down guidelines saying paid donors should not be used from countries such as the US. This report and its findings were an important part of my continued decision making on the need for self-sufficiency within the UK. Indeed, in April 1976 I addressed the World

Federation of Haemophilia Congress in London supporting the WHO policy, stating:

“Blood voluntarily and freely given by the healthy to those in need is a manifestation of the values which we should all strive to maintain in society. There are dangers of developing a modern society whose values are solely conditioned by the market place, where ‘What is the price’ and ‘What is something worth’ predominate. We should not be afraid, nationally and internationally, to champion the true values of a society: love, altruism, and concern for our neighbours which alone provide essential cohesion and peace which we all seek.” [LDOW0000044]

10. In addition, within the medical profession a paper was published in the *Lancet* in 1975 by Craske entitled ‘An Outbreak of Hepatitis Associated with Intravenous Injection of Factor-VIII Concentrate’ [PRSE0001794] which claimed a rise from 3% to 50% in cases of hepatitis in his UK patients after the introduction of American plasma products. I had the *Lancet* and the *BMJ* on my personal reading list so almost certainly I would have read the Craske article. It may be that my basic medical training and ongoing reading material helped me understand better some of the issues but I believe anyone, even without medical knowledge, would have had no difficulty in making the same decision.

11. Even before 1975 the increased risks were known within the medical field. In the minutes of the Expert Group on the Treatment of Haemophilia (20 March 1973) [PRSE0004706] attended by doctors and DHSS staff, attention is drawn to the increased risk of hepatitis once the number of plasma donors has been increased. The minutes state the importance of “reducing and as soon as possible ending the purchase from foreign sources”. I first read this document, to the best of my knowledge, when reading Carol Grayson’s dissertation which she sent to me in 2007. But that view was expressed to me orally in meetings and in papers by DHSS doctors from 1974-76. Sadly, I am unable to provide any further detailed information given I have no recourse to my personal papers during my

time as a Minister which have been destroyed without any consultation or permission from me.

12. A newly discovered memo from my private office dated 17 December 1974 [LDOW0000344] reveals how keen I was to consider a legislative ban on paid donor panels for blood and semen. No action was taken. I could not legislate for practice in foreign countries. As always in government legislative time is at a premium and the government at that time barely had a majority so legislation like this would have been very difficult to control even in committee.

13. In 1975 a two-part World in Action TV programme was shown "Blood Money" [LDOW000039] in which I was interviewed. The programme had a large audience and rightly brought into the public domain in some detail most of the issues of concern which lay behind my decision to choose the policy of self-sufficiency as quickly as possible (elaborated in the opening comments to the programme quoted below). It also meant that there was a welcome degree of public knowledge and Departmental openness with the public about haemophilia and its treatment as well as the issues causing concern. This was the opening sequence from Part 2 of the World in Action programme:

"...On the skid rows of several cities we talked to men who sell their blood plasma for money. Our investigation took us to 10 of the 24 plasma centres of the Hyland division of Baxter Laboratories, a leading American drug company. We found that Hyland's paid donors included many alcoholics and down and outs. ...Paid donors are from 6 to 13 times more of a health hazard than British volunteer blood donors. Because of their lifestyle many carry a high risk of passing on hepatitis, a serious liver disease. Blood plasma from men like these is being used in Britain – in this Hyland product – Hemofil, a concentrated form of Factor 8. Factor 8 is the clotting agent in the blood."

GRO-A suffers from haemophilia, a rare incurable blood disorder. His blood won't clot naturally because it lacks Factor 8. To stop internal bleeding and crippling, haemophiliacs can be treated with a British Factor 8 product called cryoprecipitate. But this may mean a hospital visit. More conveniently, they can treat themselves at home with a special concentrated Factor 8 product like the American Hemofil. Many prefer this. It's easier and treats bleeding without delay. ...Britain does produce some Factor 8 concentrate but most is imported and comes from paid donors. In the last 18 months imported Hemofil has been linked with an unprecedented outbreak of hepatitis among Britain's 3000 haemophiliacs. Tonight WIA [World in Action] investigates why Britain has had to import high risk concentrates and how much it has cost."<sup>1</sup>

14. We did not seek out this publicity but when the programme makers came to see me from World in Action I had little doubt I should participate and explain some of the issues. I, of course, did not choose what edited segments of a long interview they decided to air. There was a delicate balance to maintain since haemophiliacs were very keen to use the new treatments, in particular, home treatment with Factor VIII. I also had to be careful not to be alarmist and talk about banning the treatment. Also not to withhold information. For me as a physician and the Minister it was important not to encroach on professional advice to patients which was for individual doctors advised by their professional bodies and the Department's Chief Medical Officer.

15. What doctors were advised to say to patients was the responsibility of then Chief Medical Officer of Health, Dr Henry Yellowlees. I had the greatest confidence in his expert knowledge of public health and it was certainly not for me to intervene in that professional relationship from the CMO, having consulted specialists, to the medical profession. At all times, I encouraged the greatest possible transparency between the large haemophilic community, their organisations and the Department.

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<sup>1</sup> World in Action, "Blood Money, Part 2", Extract from Opening Commentary.

## Efforts to Achieve Self-Sufficiency

16. Some of the facts about the resources that were made available to achieve self-sufficiency when I was Minister of Health, and why the Department of Health thought they were adequate, have surfaced despite my own papers having been destroyed. In particular, in 2008, ten documents with a covering 'Inventory and Timeline' relating to my self-sufficiency initiative from 1974-75 were transferred to the National Archives by the Department of Health, without my knowledge at the time, and published under the heading, 'Lord Owen's self-sufficiency initiative' [LDOW0000015-24]. How that could be done without any recourse to me by a Department that had destroyed all my private office papers, about which I had already expressed disbelief, is very hard to understand. These few documents underline the pressure I was applying within the Department and they were applying outside in the NHS as a whole to do everything possible to achieve the target of self-sufficiency. The documents reveal some delay with the delivery of the centrifuges for BPL which were successfully resolved and some initial concerns from the Regional Centres over both resources and physical modifications of the Centres but satisfactory assurances were given that targets could be met [LDOW0000023].

17. In LDOW00000042, I describe the production of domestic AHG concentrate as being dependent on two factors: "The first is the ability of the 14 Regional Transfusion Centres to collect sufficient plasma from blood donations, and the second is the capacity of the Central Laboratories at Elstree and Oxford to manufacture AHG concentrate from the plasma sent by the Centres."

18. The belief in 1975 that self-sufficiency could be achieved within a 2-3 year timescale is mentioned in a document dated 11 July 1975 where in referring to PQ 3474 I state, "Once again we are in a 2-3 year timescale. I have asked if we can improve on this. Can I have a note?" The paper goes on to say, "This is the timescale Dr Owen gave in a reply to a PQ

from Mr John Spence on 22 April 1975" [LDOW0000019]. I reiterated this pledge to the World Federation Haemophilia Congress on 29 April 1976 saying that we hoped to be self-sufficient in blood products by mid-1977 [LDOW0000044].

19. The steps that were put in place within Regional Blood Transfusion Services to increase the volume of blood donations are spelt out in this document of 11 July 1975 [LDOW0000019] and build on the draft letter to Regional Administrators sent to me on 9 December 1974 [LDOW0000015] which details provision made for processing blood donations to produce blood factor products.
20. In a series of Parliamentary Questions and Answers on 19 January 1978 (Hansard Vol 942) my successor released figures which show that during my time as Minister of Health expenditure on the National Blood Transfusion Service in England and Wales rose from £11,757,506 in 1974-75 to £15,806,099 in 1975-76, and to £18,921,856 in 1976-77.
21. On 26 June 1978 (Hansard Vol 952) the then Minister of State in Parliamentary Questions and Answers confirmed that "The production target of Factor VIII set for June 1977 was attained" and that "the whole sum" of £500,000 authorised by me in February 1975 "was used to increase Factor VIII concentrate production within the National Health Service" and that "Production of Factor VIII concentrate at Elstree and Oxford is currently at the rate of approximately 15 million international units per annum. The National Blood Transfusion Service, in addition, produces approximately the same amount of Factor VIII in the form of cryoprecipitate."
22. On 7 December 1978 (Hansard Vol 959) the then Minister of State in a Parliamentary Answer said, "The production of Factor VIII in England and Wales estimated in 1975 to be needed was exceeded by July 1977, and production has risen substantially since then. The two fractionation centres for which my Department is responsible are working at full current capacity."



23. This assessment of what was undertaken during my period in office shows, without any shadow of doubt, that the policy of aiming for self-sufficiency was becoming successful, confirmed on 15 December 1978 (Hansard Vol 960, Col 475-6). "The quantity of Factor VIII estimated in 1975 to be needed annually by the NHS in England and Wales was 375,000 donation equivalents. The current rate of production is estimated to be 630,000 donation equivalents annually, about two-thirds of which is the freeze-dried product. The extension of clinical requirements however means that self-sufficiency has not yet been achieved, and my Department is therefore reviewing production in relation to present demands and resources."

24. As regards what expert committees had oversight of this issue while I was in office and what advice they provided, a good starting point are paragraphs 6 and 7 of the document dated 11 July 1975 [LDOW0000019] which for ease of reference I set out below:

"6. It is difficult to be precise in estimating a date for achieving self-sufficiency, not least because not all are agreed as to what constitutes self-sufficiency; some Haemophilia Centre Directors envisage prophylactic treatment whereas the Department's programme is based upon home treatment of those patients for whom treatment at home can be recommended. It remains to be seen whether RTDs will be successful in persuading clinicians to accept a steadily increasing proportion of blood in the form of concentrated red cells; this may be a possible limiting factor. AHG concentrate has not previously been prepared in the NHS on the scale envisaged and this in itself will almost certainly give rise to some problems.

7. However, accepting these qualifications, the figures in paragraph 3 suggest that we can improve on the previous estimate of achieving self-sufficiency within two to three years. We can now say that we expect to be self-sufficient within two years, or alternatively,

that within about a year we will be able to meet some 2/3rds of present requirements and become self-sufficient in 1977.”

25. On page 5-6 of the transcript of my oral evidence to the Archer Inquiry [LDOW0000345], I refer to my recollection that “there was resistance in the department to going for self-sufficiency.” This is evident in the first paragraph of the memo dated 9 December 1974 [LDOW0000015] which is no more than a statement of the obvious, covered somewhat by “we have been asked to draw attention”. Who asked is not clear but probably stems from that part of the Department which was answerable to the Treasury for keeping within financial limits agreed between the two Departments. These sorts of judgement are made by any Minister of Health frequently. I remain firmly of the view I was deciding on the correct allocation of funds on the balance of spending priorities. Health spending is virtually unlimited, and all priorities for NHS spending will never be met. What the NHS represents is a democratic decision making on the basis of evidence for the rationing of health expenditure. I used the term rationing in public as Minister and I have never ceased to use the same word to help understanding amongst all NHS users and practitioners that resources are not unlimited.

“... We have been asked to draw attention to the fact that a decision to make this special allocation of resources to blood products production inevitably means that less money overall will be available for other high priority Health Authority services e.g. mentally ill, mentally handicapped, family planning, and certain centrally sponsored projects, such as schemes to reduce waiting times. But there is broad agreement that such an allocation would be justifiable.

If the Minister of State confirms his intention to take special measures to increase production of AHG concentrate he could write in the following terms to the several MPs to whom answers are outstanding.”

I did write to several MPs explaining my decision.

26. I refer to another important memorandum dated 20 February 1976 [LDOW000043]. What this demonstrates is that the Oxford part of the Regional Blood Transfusion service was warning that they needed extra money for AHG concentrate. This was addressed in my letter of 23 February 1976 to Andrew Bennett MP [LDOW000042].

27. The Department had been dealing with Oxford, as is made clear, it being one of the two regions referred to in the memo dated 23 October 1975 [LDOW000023] which explains how with minor modifications to the financial terms offered, assurances had been given to meeting the targets:

“5. After a series of written and oral exchanges over the past few months both Regions have now given us reasonably satisfactory assurances that they can and will meet the targets which we originally set them and, with only minor modification, on the financial terms we first offered. We are now therefore in the position that all Regions have agreed to take part in the programme. Satisfactory though this is in itself, it is no guarantee that things will run smoothly, and it will be necessary to monitor developments closely. Arrangements have already been made for this to be done”.

28. I believe an essential element in reaching and surpassing target figures during my period as Minister was my decision to use a small amount of central funds (£500,000) to help achieve self-sufficiency and not to just rely on the much larger regional funds within the National Blood Transfusion Service for England and Wales referred to in paragraph 20.

29. I left my post on 10 September 1976 as Minister of State (Health) to become Minister for Europe and deputy to Anthony Crosland in the Foreign and Commonwealth Office.

## **Part 2. Self Sufficiency and Department of Health Policy after 1976**

30. An increase in donors in the UK was evident as document [LDOW0000042] dated 23 February 1976 shows the expectation that by the summer of 1976 two-thirds of the plasma required would be available from the Regional Transfusion Centres.

31. In 1980, however, an internal DHSS memo from Diana Walford, a medical expert within the DHSS, [LDOW0000346] shows that the risk was increasing because of a much more virulent virus, referred to as “rapidly fatal”.

“I must emphasise that 90% of all post-transfusion (and blood-product infusion) hepatitis in the USA and elsewhere is caused by non-A, non-B hepatitis viruses which (unlike hepatitis B) cannot, at present, be detected by testing donor blood. This form of hepatitis can be rapidly fatal (particularly when acquired by patients with pre-existing liver disease) or can lead to progressive liver damage. It can also result in a chronic carrier state, thus increasing the “pool” of these viruses in the community.”

32. Sir George Young in the Adjournment Debate of 15 December 1980 said “the demand for blood products increased beyond what could reasonably have been predicted.” In that debate he talked of the need for investment in BPL and “as a result of this new investment, by the end of 1982 BPL is expected to double its output of Factor VIII to 30 million international units.” This suggests that in the 1980s there was an opportunity to choose to invest more in advertising the UK-based donor programme and availability of donor centres to meet increased need and if this was insufficient even contemplating donor payments in the UK (to which I had as Minister been opposed) rather than rely on imported blood from paid donors in the US and elsewhere.

33. It is worth noting that Conservative Minister Sir George Young categorically stated, “that there was no place for a commercial company in the management of BPL” and that Dr Vaughan, the Minister of State, in

a Written Answer on 26 November 1980 (Vol. 994) stated, "After exploratory discussions we have concluded that there is no place for a commercial company in the management of a service which depends on volunteer donors. There is, therefore, no question of commercial management of the blood products laboratory." Yet that is exactly what happened later. There had clearly been in 1980 serious consideration of commercial involvement. In an internal memo, already referred to, entitled 'Blood Products Laboratory: Possible Take-over by Industry' dated 15 September 1980 [LDOW0000346] the author, Diana Walford, writes:

"In my view, the Department has a moral obligation to ensure that any collaboration with industry does not increase the health hazards, not only to recipients of blood products, but to the community as a whole."

34. This was after Dr Walford having pointed out that Beechams might take over BPL, had warned they intended to import blood for fractionating.

"If the DHSS did not agree to Beechams fractionating imported plasma other than in a separate plant etc, Beechams would probably feel constrained to obtain the necessary extra volume of plasma by buying it in the UK. That is, it is likely that the company would establish plasmapheresis centres in this country for paid donors and thereby seriously undermine the voluntary donor principle in the UK."

.....

"I should add that the projected requirements for FVIII, which were based on advice given to the Department earlier this year, may have to be revised in the face of very recent evidence which indicates that UK clinicians are coming under pressure from various quarters to step-up the dosage regime for the home treatment of haemophilia."

35. Of course, I was not aware at the time of this internal debate going on as above since I was no longer in the Department nor indeed in the Government in 1980. But over the years I have retained relevant material to this issue given my interest, underlined also by my correspondence with Ministers in subsequent years.
36. Diana Walford also mentioned a better alternative would be to expand PFC Liberton in Scotland and supply the English and Welsh NHS from Scotland.
37. I received a reply to my letter of 17 November 1987 to John Moore [LDOW0000205] from dated 21 January 1988 [LDOW0000086] saying, "The £500,000 helped the output increase from 3.2 million units to 12.8 million between 1975 and 1977. However, the total demand for Factor VIII increased from 8.2 to 27.4 million units in the same period so that the proportion of commercial product needed remained roughly the same." On 17 May 1988 I received Written Answers from Tony Newton [LDOW0000038] to whom I subsequently wrote on 18<sup>th</sup> and 24<sup>th</sup> May [LDOW0000190 and LDOW0000061]. The reply to these letters was sent by John Moore on 16 June 1988 [LDOW0000064]. I also received a letter dated 20 July 1988 from Graham Ross of Keith Park & Co commenting on the Secretary of State's letter [LDOW0000314]. I believe there are important inconsistencies in the figures supplied to Parliament in the past but I have neither the resources nor the ability to examine all the relevant documents including letters and Parliamentary Questions regarding Factor VIII usage and production and whether self-sufficiency was still the Government's objective.
38. Returning to that same Adjournment Debate on the blood transfusion service on 15 December 1980 the Under-Secretary of State, Sir George Young, said "But self-sufficiency must inevitably be a long-term aim." Yet within the same section of his speech he is reported as saying, "Quite apart from the possible risk of hepatitis from imported products, particularly those manufactured from plasma supplied by paid donors, the very fact that products are imported – unless they come from a country

that produces an excess of such products – raises difficult moral issues concerning trade in blood.” Sir George Young also said, somewhat surprisingly, “I am not aware of any deaths directly attributable to blood transfusion or blood products.” Yet heat treatment for blood products was only introduced in the UK in March 1985.

39. Lord Jenkin’s recollection, who was Secretary of State for Social Services from 1979-81, differs. A newspaper report<sup>2</sup> of his evidence to the Archer Inquiry states “he was aware that blood was being brought in from other sources because the Blood Transfusion Service was not self-sufficient but he had assumed the products used were reliable.” In his oral evidence to the Archer Inquiry Lord Jenkin states, “maybe my memory is at fault but I don’t recollect there being at that stage a strong policy imperative that this country should become self-sufficient.” As I queried in my own evidence to the Archer Inquiry, was the delay in attaining self-sufficiency a Ministerial decision, or maladministration taken by default by officials in the Department who knew of the factual situation but did not tell Ministers? Either way it raises important questions in terms of ministerial and/or civil service accountability. The delay put many thousands of people’s lives at risk.

40. While self-sufficiency in principle was not formally abandoned between October 1976 and December 1980 it appears to have slipped as illustrated by exchanges in the House of Commons. Admittedly, other countries were facing similar problems to the UK in respect of increased demand for treatment from haemophiliacs. But self-sufficiency by some other countries was achieved in a much shorter timescale: it took the UK 13 years to become self-sufficient whereas in Ireland it took them five years. I note Lord Archer’s finding that “Had self-sufficiency been achieved earlier the scale of the catastrophe would have been significantly reduced.”<sup>3</sup> It was very disappointing that the then Government Ministers refused to give evidence to the Archer Inquiry and

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<sup>2</sup> *The Guardian*, 15 June, 2007 [LDOW0000347].

<sup>3</sup> Independent Public Inquiry Report on NHS Supplied Contaminated Blood and Blood Products, 23 February 2009, p. 106.

by any standard reading their responses to the Inquiry's Report revealed, in my view at the time, defensive and incomplete comments.

41. The following are Questions in 1984 and 1985 from two SDP MPs which were almost certainly discussed with me, as the then leader of the SDP.

- On 23 November 1984 Charles Kennedy asked the Secretary of State for Social Services whether he will make available the extra £1 million needed to produce raw blood plasma if the United Kingdom is to become self-sufficient in blood products by 1986.

Mr Kenneth Clarke:

“There are a number of methods by which plasma can be collected to achieve the targets set for self-sufficiency. Each regional health authority must decide which methods to adopt and provide the necessary funding. Regional health authorities are being asked to apply to plasma collection all income derived from the handling charges that we introduced recently for blood and blood products supplies to non-NHS hospitals.”

- 19 February 1985 Mr Hancock asked the Secretary of State for Social Services what studies the National Blood Transfusion Service has undertaken into the economics of self-sufficiency in Factor VIII; and if the results are to be published.

Mr Kenneth Clarke:

“We decided in 1982 that this country should become self-sufficient in blood products. This will eliminate the health risks attached to the use of imported commercial products derived from blood provided by paid donors. In order to achieve self-sufficiency in England and Wales it was decided to redevelop the Blood Products Laboratory at Elstree. ....”

42. It was extremely odd for Kenneth Clarke in his reply above to say, “We decided in 1982 that this country should become self-sufficient in blood products” as if it was a new decision by government.



43. Contamination from the HIV virus affecting blood products was first identified in the US in 1982. I became aware of this possibly through my regular reading of the then US newspaper, *The Herald Tribune*, now the *New York Times* international edition which I still read. Something prompted me to write to Norman Fowler on 23 January 1985 expressing concern about contamination particularly for those 'at risk' patients suffering with haemophilia. Again, the reply I received from Baroness Trumpington stated, "It was with the needs of haemophiliacs very much in mind that we decided in 1982 that the UK must become self-sufficient in blood products' [LDOW0000048]. It was again as if the previous Labour Government programme had never existed. This inconsistency in both replies should have been challenged by doctors within the Department and by civil servants. Now it needs clarification at least.

44. It is also not clear from Mr McCrindle's Question to the Secretary of State for Social Services on 12 May 1987 when the Department first became aware that supplies of Factor VIII were contaminated. Mr Newton replied:

"I assume that my hon Friend is concerned with the transmission of the AIDS virus. Evidence emerged from the United States of America in 1982 that haemophiliacs were contracting AIDS and although the mechanism of infection was not known, it was presumed that it had been transmitted through the use of blood products such as Factor VIII."

45. On 2 November 1987 Mr Michael Morris asked the Secretary of State for Social Services what action is being taken to ensure the United Kingdom is self-sufficient in blood products. Mr Newton replied:

"Scotland and Northern Ireland are self-sufficient in all blood products. England and Wales are already self-sufficient in many. To ensure complete self-sufficiency a new blood products laboratory has been built at Elstree at a cost of £60 million. The new factory was officially opened on 29 April 1987. Production is

expected within the next few months leading to a very substantial output in 1988 and self-sufficiency in 1989.”

46. Although I had no direct involvement in the Parliamentary Questions tabled by Mr McCrindle and Mr Michael Morris or other Questions tabled by other MPs I did from time to time discuss these issues with fellow members of the House of Commons and in particular Mr John Morris but I have no record or exact memory of these discussions.

47. John Cash, National Medical Director of the Scottish National Blood Transfusion Centre in his article in the BMJ of 12 September 1987 on ‘The blood transfusion service and the National Health Service’ [LDOW0000046] wrote, “The National Blood Transfusion Service is a fragmented and disorganized shambles” ... “somehow the concept of the “gift relationship” of the voluntary donor and the needs of the patient have been lost.... Perhaps the most striking example of this has been the circumstances surrounding the capital expenditure of over £60m on the building of the new Blood Products Laboratory at Elstree. The need arose because of years of central managerial neglect...”.

48. This article would have had a big impact on me at the time. I already knew, and shared, the view of the Medical Research Council in 1974. An extract of its analysis follows [LDOW0000046]:

- “In 1974 the Medical Research Council’s blood transfusion research committee expressed its concern at the continued inability of the UK transfusion services to meet the blood product needs of patients with haemophilia. This view was reiterated in 1977 by Dr Rosemary Briggs, on behalf of the haemophilia centre directors, and concern was also expressed at the predicted rapid rise in demand, the high cost of commercial products, and their higher risk of transmitting viruses when compared with products derived from voluntary blood donors.”

- "there has been a remarkable failure of senior civil servants and therefore politicians of all political colours to recognize the unique and strategic importance of the nation's blood donors, their donations, and the associated work of the blood transfusion services. It has not been simply a matter of budgetary restrictions but primarily a lack of interest, vision, and commitment."

49. In the debate on the Address on 23 November 1989 in the House of Commons I devoted a major part of my speech as Leader of the SDP to society's responsibility to the people who suffer as a result of treatments undertaken under the National Health Service. [Hansard Vol 162, col 271-8/LDOW0000349] In particular I talked about AIDS:

Dr. Owen: I want to draw attention to another scandal surrounding AIDS. We should be blunt about it—we are not doing what we ought to do to prevent the spread of AIDS, especially among the drug community. The biggest bridge of AIDS into the heterosexual community is among drug addicts. There are focuses of infection among drug addicts which we know about. Edinburgh is by far the largest in Britain, but it is spreading. We are still failing to do what we have done in the past when faced with infectious illness—to conduct routine blood tests without the need to have permission for them.

When asked whether they want HIV tests, many people will be frightened and resist. We have confronted this problem before. I understand the fear. The main focus of AIDS is in the homosexual community and, because that community has been savagely discriminated against over the years, it senses that new discrimination is coming because of HIV testing, which would be conducted mainly among homosexuals.

Fear of testing and of the unknown has also been experienced before. Syphilis was on the point of becoming a pandemic, and doctors were under tremendous pressure to conduct compulsory blood tests, but they refused. They argued that it would be possible

instead to conduct routine testing without permission and for the information to be completely confidential between doctor and patient. That is the public health practice that has been used successfully in the past. Why was it not used for HIV testing? Why were we told that we could not have HIV blood tests without permission and that not to have written permission was an assault on a person? We did not need written permission for a Wassermann test for syphilis. I suspect that most hon. Members have had such a test, unknowingly, 10 or 12 times in their life. In some parts of the United States, it is compulsory to have such a test to get a marriage certificate.

The way to deal with this matter is to identify the focus of infection. We will now have a great fanfare of publicity because of anonymous testing. What will that do? A ludicrous situation will exist where the doctors know that the result of a blood test is positive but will not be able to trace it to the individual or counsel that person who, not knowing that he has HIV, could be infecting his wife, girlfriend or boyfriend. How can that make sense? It is utterly ludicrous.

The medical profession seems to be completely stymied. I receive private, confidential letters from members of that profession asking, "Can you not do something about this?" I write back, saying, "What is the advice of the chief medical officer?" We have persuaded ourselves that a civil liberty is involved. Is it a civil liberty to have people unknowingly infecting some of those closest and dearest to them? It is time that we went back to proper public health prevention practice. The problem exists not only in this country but around the world. I do not know what scientific advice the Government have received or what the chief medical officer has said. I beg the Government to listen to some of the comments of some of the wiser heads in the medical profession who are deeply worried. They believe that we have gone up a blind alley and they are appalled and horrified by what is happening.

## The Dual Hierarchy

50. A general explanation of what progressively may have gone wrong in the Department of Health under the Conservative Government of 1979-1992 may lie in the abolition of the 'dual hierarchy' which was established early on in the NHS which meant that key policy decisions until the 1980s were always taken in 'tandem' between Department of Health medical practitioners, usually trained in public health, and Departmental civil servants. This structure meant that the medical undersecretary and the administrative undersecretary ordinarily had to agree policy before it could go forward to Ministers, and that there was joint responsibility for the formulation of policy. This explanation is sourced from my correspondence with Dr Norman Halliday which I have made available to the Inquiry.

51. The very existence of public health doctors within the Department of Health was challenged by the then Prime Minister, Margaret Thatcher, in 1979 as unnecessary and they should be sent "back to the NHS to do proper medical jobs."<sup>4</sup> This attitude meant that more and more decisions with medical implications have been taken by civil servants with limited detailed medical knowledge during the last 40 years. The Treasury from my experience appeared to want Health to be treated as other Departments, controlled by civil servants who would evaluate specialised input and felt doctors were given too great an influence on policy and its implementation. Above all, the Treasury were not ready to give up annual budget control.

52. I have reappraised myself of the contents of a letter from Lord Hunt of 12 November 2001 to Lord Morris which states, "If the UK had achieved self-sufficiency in the 1970s as Lord Owen intended blood products would still have transmitted hepatitis C, because the virus was in the donor population and as you know the technology to treat pooled plasma was

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<sup>4</sup> Sally Sheard, 'Quacks and Clerks: Historical and Contemporary Perspectives on the Structure and Function of the British Medical Civil Service', *Social Policy and Administration*, Vol 44, No 2, April 2010, pp. 193-207.

not available until 1985” [LDOW0000173]. However, civil servants, doctors and Ministers knew in the 1970s that on public health grounds specific screening questions about jaundice of the donor pool - like “Have you ever been yellow?” to alert for possible jaundice was an important check for in the UK blood transfusion service donor pool. Anyone who has been a blood donor in the UK, as I have, would be aware of the procedure. It could not exclude all risk but it would help to alleviate the risk of a particular blood pool being contaminated. That risk is much greater for imported blood products from donors who have given blood for financial gain and might not admit in a screening question to ever having been ‘yellow’. The risk of contamination of blood pools increases with the number of donors contributing to a particular pool with or without screening questions. This was flagged up by doctors in the Department.

### **Part 3: The Destruction of Documents and Disputes with the Parliamentary Ombudsman**

53. As part of my evidence to the Inquiry I should like to draw the Inquiry’s attention firstly, to an internal DHSS memo [LDOW0000350] dated 15 December 2003 which was attached by mistake to a letter from the Parliamentary Under Secretary of State, Melanie Johnson, to me of 17 March 2004 in reply to my original letter to the Secretary of State John Reid on 7 October 2003 [LDOW0000142]. Paragraph 5 of this internal memo reads:

“Unfortunately, none of the key submissions to Ministers about self sufficiency from the 70s/early 80s appear to have survived. A search of relevant surviving files from the time failed to find any. One explanation for this is that papers marked for public interest immunity during the discovery process on the HIV litigation have since been destroyed in a clear out by SOL. This would have happened at some time in the mid 90s.”

54. These words appear to indicate that the Department were aware that legal action might be coming their way - perhaps Ministers and civil servants -

by patients affected by contaminated blood. It rather corroborates Mr Jenkin's description that files on contaminated blood products were destroyed as a "conscious decision." [see para. 59]

55. The other matter to which I wish to draw your attention is the long-running dispute I had with successive Health, and then Parliamentary, Ombudsmen concerning my request that the Ombudsman's office investigate abundant evidence of gross maladministration by the Department of Health in not implementing self-sufficiency in blood products. It is my claim that it was ever more obvious that maladministration was a central factor which these bodies refused repeatedly to explore.

56. I first wrote on 5 February 1988 [LDOW0000201] taking up the issue of the Department's lack of achieving self-sufficiency and used in confidence, with the person's permission, the name of a haemophiliac constituent infected with HIV as a result of a transfusion. It was necessary to use an individual complaint since hitherto the Ombudsman's terms of reference required any investigation to relate to a specific individual.

57. A letter from the Ombudsman dated 4 September 2002 [LDOW0000119] is, quite frankly, flippant in the extreme. Other exchanges with the Ombudsman's office – particularly my assistant's letter of 30 September 2004 [LDOW0000090] – gives a flavour of the growing frustration which we both felt from the Ombudsman's office and the Department of Health. They gave the appearance of being linked and without the necessary independence from each other.

58. Regarding my Ministerial papers dating back to my decision to achieve self-sufficiency in 1974-76, within my constituency files I have a handwritten note made by one of my secretaries at the time which reads "DHSS Records. Papers have been destroyed. Normal procedure after 10 years" [LDOW0000318]. This was likely to have been written between late 1987 to 1989 and almost certainly was written in January 1988 coinciding with when I first started writing letters about my individual

constituent which instigated my enquiry with the Department of Health. That would mean it was after the Cabinet sub-committee meeting of 4 November 1987 which discussed contaminated blood in depth and from which major decisions may have stemmed. No explanation has ever been given to me as to why my Ministerial papers from my Private Office were destroyed without any reference to me nor why I had not been asked as a still active politician, already heavily involved in the contaminated blood controversy if they could be destroyed. I should have been asked if I wished to be sent my papers for my own records before they were destroyed as was the procedure adopted by the Foreign Office to my papers held there when I was Foreign Secretary, which I have since made available in my personal archive held by the Collections and Archives Department of the University of Liverpool Library.

59. My letter of 15 March 2004 [**LDOW0000011**] to the Ombudsman additionally clarifies that when finding out about the destruction of my papers, it was explained that there was a “Departmental rule that Ministerial papers were pulped after 10 years”. What other Department did this? It surely runs completely counter to what was then still a 30-year rule concerning the release of Ministerial and Departmental documents?

60. I note from Patrick Jenkin’s oral evidence to the Archer Inquiry that many years after he left office when wanting to go back over his papers he went to see the then Permanent Secretary, Sir Nigel Crisp who made it clear that all the files had been destroyed.<sup>5</sup> I also refer to an article in the Birmingham Post of 15 June 2007 reporting on Lord Jenkin’s oral evidence which states it had been made clear to him the destruction of files was a “conscious decision.” [**LDOW0000351**]

61. Also relevant is Patrick Jenkin’s letter of 14 April 2005 which gives details of his meeting with Sir Nigel Crisp and refers to a great many documents held by the Public Record Office [**LDOW0000352**].

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<sup>5</sup> Oral evidence of The Right Honourable Lord Jenkin to the Archer Inquiry, transcript of 14 June 2007



62. On learning of the destruction of my papers, I grew more and more dissatisfied with the explanations and responses I received from both the Ombudsman's office over maladministration and the Department of Health over what exactly had happened inside the UK Government. In April 1991 an article in France sparked that country's own infected blood scandal which led eventually in 1999 to the prosecution on manslaughter charges of the former Prime Minister, Laurent Fabius, and other individuals.<sup>6</sup> It has been asked whether there was a deliberate decision to destroy all papers which could have been relevant were prosecutions to take place in the UK. I do not have the facts to make a considered judgement on this.

63. It has come to my attention that an investigation was undertaken by the Government Internal Audit Agency last year at the start of this Inquiry looking at the record management processes of the Department of Health and Social Security. Following a FOI request I understand it has been established that at least 950 files have in past years been 'checked out' from the archives of both the Department of Health and Department of Education and never returned. The GIAA I gather have been able to identify over 10,000 files that may be of relevance to this Inquiry.

#### **Part 4. Recommendations to the Inquiry**

64. In this part of my statement, I set out below a number of issues which I believe are of wider significance though still relevant to the Inquiry's Terms of Reference and should, in my view, be investigated and pursued by the Inquiry. If requested, I would be content perhaps at a later date to give evidence on these.

65. Can I make a personal request that if any previously undisclosed documents submitted to the Inquiry relate to my own period as Minister of

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<sup>6</sup> Casteret, Anne-Marie (1992). *L'affaire du sang* (in French). Paris: Éditions La Découverte. [ISBN 2707121150](#)

Health, it would be helpful if they could be sent to me and if appropriate I could add an addendum to this written statement?

66. The WHO's resolution promoting voluntary non-remunerated blood donations was an important part of my decision making on the need to achieve self-sufficiency within the UK. In my view the handling and importance given to this resolution should be examined carefully by the Inquiry.
67. I note that from 1978 the administration of BPL had transferred from the Medical Research Council and the Lister Institute of Preventive Medicine on behalf of the DHSS to the North-West Thames regional health authority. I wonder if this was a factor in failing to achieve self-sufficiency and is something that the inquiry should examine or consider.
68. The Inquiry should discover why Elstree, in particular, became unable to fulfil its purpose requiring investment from the Government in 1980-82 to build a new facility which delayed self-sufficiency being reached until 1989. The inquiry should also examine what measures were being taken during these years reduce the contamination of the donor pool of any imported blood products. Specifically, why screening questions were not insisted upon and other measures to remove dubious donors from all pooling arrangements.
69. The Inquiry should establish at what stage were Ministers in the UK specifically made aware of HIV contaminating blood products, first discovered in the US in 1982. This knowledge should have speeded up the case for self-sufficiency and for substantially increasing the blood donor programme within the UK and ensuring less reliance on large donor pools. It should also be established when guidance was given to stop voluntary blood donations from people more exposed to HIV. I understand tests for HIV were not introduced in the Blood Transfusion Service until 1985.

70. The Inquiry should determine at what point was self-sufficiency, in effect, abandoned because of a reluctance to find more capital and instead rely on increased revenue spending for the supplies of Factor VIII concentrate from the US.
71. Blood pooling will need to be subject to the closest scrutiny by the Inquiry both within the UK and in other countries from which we in the UK bought blood products.
72. I recommend the Inquiry should familiarise themselves with the abolition of the 'dual hierarchy' and the progressive attitudinal change towards the NHS of 1948. It is the subject of an excellent piece of research by Sally Sheard.<sup>7</sup> I am personally concerned that Sally Sheard's research points to a basic and growing misunderstanding in the Department of Health and in advice to Ministers of what Public Health is all about in relation to HIV and also in what the public terms "mad cow disease" which manifests itself in humans as variant Creutzfeldt-Jakob disease (nvCJD).
73. The diminution of public health advice to civil servants and Ministers goes far deeper than even this. It is an attitude which lies at the root of a progressive failure to be self-sufficient in the UK on the basic training of nurses, doctors and health related scientific services. It became cheaper for the Department of Education to rely on other countries carrying the training costs while UK students were turned away, despite being well qualified to pursue careers in medicine, nursing or medical science. Why was this? The inquiry should examine whether the Department of Health was not talking about their concerns to the Department of Education and those responsible for higher education. Were both Departments forced to do this by Treasury cuts? Did the Departments of Health and Education at Ministerial level challenge these priorities?

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<sup>7</sup> Sally Sheard, 'Quacks and Clerks: Historical and Contemporary Perspectives on the Structure and Function of the British Medical Civil Service', *Social Policy and Administration*, Vol 44, No 2, April 2010, pp. 193-207.

74. I have been involved in this issue of blood contamination for a long time, at varying levels of intensity, since 1971. I believe the terms of reference of this Inquiry are broad enough to allow it to learn deep lessons from the past and ensure that they are not repeated in the future. I am convinced too that this Inquiry should recognise governmental liability. Historically the government has only paid “ex-gratia” payments without accepting liability. It should now openly refer to them as “Liability Payments” and take the form of generous compensation to both infected and affected victims of the Contaminated Blood scandal. It cannot be right that those infected with Hepatitis C are treated differently to those infected with HIV and into the future by CJD through the nvCJD which has sensibly lead to UK plasma being no longer acceptable for use anywhere. Although recent payments have increased for those infected, at present, as I understand it, if an infected person dies of hepatitis C their partner would receive no ongoing payments unlike bereaved partners of those who died from HIV. This, if accurate, is indefensible.

75. Another issue is the practice of largescale pooling of blood in the manufacturing of blood products. This should have been challenged far more vigorously by the medical profession as a whole and other scientists. Dr Walford’s memo [LDOW0000346] shows it was being challenged in 1980 in the Department but as more blood products were being manufactured abroad due to the progressive loss of manufacturing capacity within or in close association with the NHS, all the Medical and Surgical Royal Colleges should have been raising their voice.

76. Ireland paid out to victims and their families many years ago at compensation levels based on the principle of “loss and need” without accepting legal liability. In the UK hundreds of victims have gone further than Eire in establishing gross safety violations related to imported products and in tracing and proving infected batch numbers through US lawyers accepted by the international plasma companies yet they are still awaiting financial recompense here. Why?

77. Firstly, the government should be persuaded now, in the interim before the Inquiry concludes, to match the Scottish annual payments bringing the rest of the UK (infected and affected) to the level of Scotland and importantly scrap all means testing. Secondly, in 2009 Lord Archer recommended "compensation on a parity with Eire" for haemophiliacs and their families. This was knocked back by the government giving one reason only and that was, I am informed, false information on the Irish settlement as proven in the winning of a 2010 Judicial Review where the government decision was deemed to be "infected with error" and they were ordered to look again at this decision. At that point, I am told, the government moved the goalposts, failed to apologize and made no attempt to rectify the incorrect statements made to Parliament. That situation following the Review needs to be changed before this Inquiry reports and the Government should be asked to do this now by this Inquiry.

78. I believe the Inquiry should consider the many haemophiliacs who were also exposed to hepatitis B during the 1970s and 80s and in the 1990s in worrying numbers) to nvCJD. The Government have all along failed to acknowledge the number of people exposed and there must be people who have unknowingly been affected. Hepatitis C victims received no ex-gratia payments until 2005. Only HIV victims were initially paid small amounts of ex-gratia from 1991, yet some of those haemophilia victims were also Hepatitis C infected. All of these discrepancies are relevant to the waiver many had to sign. When was the Government aware that there was another virus out there in the country? Did they take enough steps to discover the facts?

79. I suggest that the Inquiry team examine correspondence or telegrams that took place around the late 1980s and into the early 1990s between the FCO and the UK Embassy in France or correspondence between the French and UK Departments of Health to see if there is any relevant reference to legal prosecutions related to contaminated blood.

80. I also suggest that the Inquiry examines when files were checked out of the Department of Health and Department of Education Archives and why the Government Internal Audit identified 10,000 relevant documents when the Department of Health had stated that all documents were in the public domain.

81. The French prosecution raises very many issues for this Inquiry.<sup>8</sup> The Canadian experience was written about by Gilles Paquet, a Professor in the Centre on Governance in Ottawa, and Roger A. Perrault, an immunologist who managed the Canadian blood transfusion service between 1974 and 1991. In their book, *The Tainted-Blood Tragedy. A Cascade of Governance Failures*, they refer to “the new rhetoric of the precautionary principle which emerged in the 1970s, and had become part of the *culture governance* - the sort of amalgam of attitudes, beliefs, conversations and propensities in the culture that distils a greater likelihood of being swayed by certain points of view.”<sup>9</sup> The authors go on to write, “The precautionary principle, as a form of prudence that suggests that one should carefully gauge the full range of possible futures before making a final decision, is laudable. However, when such an attitude is not only mandated but judicialised, and when it is open season on experts, who may be faulted for sins of omission (i.e. for having failed to be clairvoyant), it becomes very dangerous.”<sup>10</sup>

82. The precautionary principle is used by policy makers to justify discretionary decisions in situations where there is the possibility of harm where extensive scientific knowledge is lacking.<sup>11</sup> The principle was first used in the World Charter for Nature in 1982. The Inquiry may wish to explore this principle in the light of it being invoked by others in the context

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<sup>8</sup> Jean-Pierre Allain, *Le Sida des Hémophile. Mon témoignage entretiens avec Fabienne Prat*. (Éditions Frison-Roche, 1993). Professor Allain is a French haematologist who was sent to prison in France but continued to be a Professor at Cambridge University during and after his sentence, a decision upheld when independently assessed by Baroness Warnock.

<sup>9</sup> Gilles Paquet and Roger A. Perrault, *The Tainted-Blood Tragedy in Canada. A Cascade of Governance Failures* (Invenire, 2016), p. 48.

<sup>10</sup> Francois Ewald, et al, *Le principe de précaution*. (Paris, FR: Presses Universitaires de France, 2009).

<sup>11</sup> [https://en.wikipedia.org/wiki/Precautionary\\_principle](https://en.wikipedia.org/wiki/Precautionary_principle)

of blood contamination and whether experts were too slow to adapt to changing information on harms to patients, in effect a professional adaptability problem.

83. Another different issue, but I think highly relevant to this Inquiry looking forward into the future, is informed consent. Informed consent has become much more influential in medicine since 1975 and rightly so. It is the big lens through which the blood scandal should be viewed and how we can learn from it. Informed consent has evolved to mean that it is a duty of doctors to disclose to patients information on, for example the transfusion of blood products, (including information on potential harms) which they reasonably believe to be relevant to the patient as a person. And then, once the patient and their relatives, in the case of children, have taken that in and considered it, seek their permission to proceed.

84. What is clear to me is that there are few, if any, solutions to the issues of blood contamination to be found in the courts or in the language of victims or criminals. These are hugely difficult issues of medical care concerning blood transfusions and products and their provision. It is also intimately involved in the rapidly evolving scientific knowledge of the whole subject of blood contamination. In addition, there are deep-seated questions about the size of the financial underpinning for these services.

85. I believe that the cumulative evidence of how we have handled blood contamination so far points to the conclusion that medical negligence and legal action in the courts accompanied by 'ad hoc' compensation is not the right way to continue if the UK overall is to maintain the 1948 basic design of our NHS. The 1975-76 Labour government, under Prime Minister Harold Wilson, considered legislating for a scheme similar to that which exists in New Zealand. The Cabinet Office Ministerial discussion then, in which I participated, would, I believe, be worth examining. Also, the Cabinet Office, under Prime Minister David Cameron, studied in some depth the New Zealand system with a view to introducing something similar and their papers will, I suggest, be even more relevant and up to date to consider.

86. In 2010 the Scottish Government Social Research published a fascinating in-depth review of this whole issue drawing on New Zealand's experience entitled 'No-fault Compensation Schemes for Medical Injury' and surveys of public opinion showed considerable public interest and support.

87. In the days when I was Minister of Health the nature of Treasury control of the Department of Health was that it was easier to get the same amount of extra money for increased revenue spending than for capital spending. I do not know whether the same mechanisms exist for the NHS England now under the legal framework of the Health and Social Care Act 2012. There is growing evidence that that legislation is only being selectively applied by NHS England and it is my profound belief that they are acting *ultra vires* in many areas of their activities. For example, the relationship between the Chief Executive of NHS England and the Secretary of State for Health is not in accord with the separation of powers in that legislation. I opposed this separation in the House of Lords consideration of the Act. It is not legal for this to be changed by administrative procedures. Some of these issues have been highlighted in a recent report from CHPI.<sup>12</sup>

88. It is not for NHS England any more than for me to pick and choose what parts of the Act are implemented. It is high time that this Act was replaced. But until it is repealed it is the law of the land. The relevance of all this to the blood contamination question is how much has changed in the management of the NHS from 1979 and how much has changed in legislation affected the blood transfusion services and the use of contaminated blood from a donor pool overseas. I hope the Inquiry will examine how NHS England should be dealing with these issues in the future. NHS England operates in many different ways to the NHS in Scotland and Wales. It must be part of this Inquiry's task to make comparisons between England and the NHS in Scotland, Wales and Northern Ireland.

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<sup>12</sup> <https://chpi.org.uk/blog/unconstitutional-governance-of-the-nhs-in-england-a-symptom-of-the-uks-political-malaise/>



89. Attitudes that believe health care is a commodity to be bought and sold in a world market has resulted in Conservative politicians like Jeremy Hunt, when Secretary of State for Health, selling off NHS assets important for UK self-sufficiency, as evidenced in 2012 by the sale of PRUK Ltd to the US private equity company, Bain & Co. PRUK Ltd was previously a Department of Health-owned company that held two separate but related subsidiary companies Bio Products Laboratory (BPL) and an American company DCI Biologicals Inc which together formed a supply chain for the production and supply of plasma-based medical treatments. The privatisation went ahead despite vigorous protests – including my own to the then Prime Minister, David Cameron. A fuller account is given in my book on the NHS. This privatisation, I believe, ran counter to the best interests of the NHS. Bain has now sold its asset at a considerable profit from which the UK had a 25% share. But there is even less accountability through the new company based overseas. Many aspects of the health service are being increasingly treated as a commodity rather than a service. In respect of blood this was highlighted as far back as 1987 in the BMJ article of 12 September 1987 already previously cited. Within that article in relation to Elstree it reads:

“There is also evidence that the DHSS has developed policies which will ensure that over the next 20 years the Blood Products Laboratory will move its operational centre of gravity away from servicing the NHS’s needs to making money in the international market place for plasma products.”

90. This way of thinking in the Conservative/Liberal Democrat coalition in 2012 was a far cry from two Conservative politicians in Mrs Thatcher’s government. I have in mind Sir George Young’s categorical statement of 1980 which I have already quoted and those of Dr Gerald Vaughan against such privatisation. In addition, politicians with cross-party support in successive Labour and Conservative governments have legislated in 2001, 2006 and 2012 for a progressive marketisation of the NHS itself. This has contributed to the destruction of the ethical, moral and vocational

character of the original NHS and is highly relevant to many of the mistaken decisions on blood contamination.

91. I believe the Inquiry should investigate if the Parliamentary Ombudsman's terms of reference are as restricted as the Ombudsman has claimed (see paragraph 56 above). If so, should this be changed to allow, in exceptional circumstances, cases of maladministration to go wider than an individual case?

92. Finally, I would like to pay a huge tribute to the sufferers from contaminated blood; their affected families, campaigners, societies and individual parliamentarians, most notably the late Lord Morris, who have sought answers and redress over many decades.

Statement of Truth

I believe that the facts stated in this written statement are true.

Signed: .....

GRO-C

Dated: .....

5. 2. 20