Witness Name: Alice Mackie

Statement No.: WITN2189005

Exhibits: WITN2189006 – WITN2189065

Dated: 30th April 2021

INFECTED BLOOD INQUIRY

EXHIBIT WITN2189032

Mr Arthur
I have had to extend again. See p 17 WITN2189032 Mr Arthur
confidential GRO -C 4/5.

NOT FOR PUBLICATION

PRODUCTION AND SUPPLY OF COAGULATION FACTOR CONCENTRATES BY BPL ELSTREE

NOTE OF MEETING OF 15 SEPTEMBER 1986

Present	In attendance
Dr A Smithies (Chair)	Dr R Moore)
Prof A L Bloom	Mr M H Arthur) DHSS
Dr I W Delamore	
Dr C Forbes	
Dr H H Gunson (NBTS)	
Dr F G H Hill	
Dr P Jones	
Dr P B A Kernoff	
Dr R S Lane (CBLA/BPL)	
Prof F E Preston	
Dr C R Rizza	
Dr G Savidge	
Dr J Smith (CBLA/BPL)	
Dr T Snape (CBLA/BPL)	
Dr J Craske (~~NIBSC~~)(PHLS)	

Introduction

1. The Chairman welcomed Haemophilia Centre Directors (hereafter 'Directors') and all other representatives. Against a background of the withdrawal of Armour's heat treated Factor VIII (F8) and Parliamentary Questions about the use of plasma which had not been screened for HIV antibody she hoped for a prospective discussion. The unscreened stockpile held at BPL was not being used, and would not be used, pending separate consideration of its disposal. Representatives of Directors would be consulted about its disposal. NIBSC would now extend their (these products including) ~~expand their~~ HIV testing to include all BPL production. This would be the first of a number of meetings to discuss supply problems with Haemophilia Directors.

Factor 8Y and Factor 9A

2. Dr J Smith of the CBLA/BPL reported on the development, clinical trial and viral inactivation of these two products. Previous experience with Hepatitis B had guided the direction of research and development. With the emergence of HIV, chemical and small pool methods were considered but heat treatment was thought the best prospect. In early 1984 an heat treated intermediate concentrate [60°C for 3 days] was introduced. Only two Centres ~~were willing to~~ used it; ~~and a breakthrough of non A non B hepatitis was occurring~~. The PFL at Oxford was scaled up for a trial of F8Y in March 1985. [High purity concentrate - 70°C for 24 hours]. F9D was added to this trial but there was concern about its thrombogenic capacity.

3. The F8Y product went straight to clinical trial; CDC data on inactivation suggested overkill for HIV but ~~CBLA~~ BPL believed only a non A non B clinical trial would present conclusive evidence. A protocol for trial of F8Y to test for ~~on~~ virus transmission (~~through heated and unheated~~) was agreed with three Centres in the Spring of 1985.

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4. Dr Smith displayed slides showing the results of testing 11 batches of F8Y and 7 of F9A given to patients previously untreated with large pool concentrates but who had received some cryoprecipitate. Those showing raised ALT levels were repeated and shown negative. BPL believed their concentrates were not transmitting non A non B hepatitis. In terms of HIV the results had been even more negative. About 50 cases were being followed up, but no sero conversion had been seen.

5. In response to doubts expressed by Directors, Dr Smith confirmed that in 5 of 42 patients there was only a 50/50 chance of detecting hepatitis infection; the undetected percentage could not be shown from the data they held. Directors thought at least one patient with a raised ALT should have been included; BPL thought it possible that some would have had slightly raised ALTs at the beginning of the trial.

6. Directors wished to know the extent of the manufacturers liability. For the DHSS, Dr Moore said that the Crown bears its own liability and that the Government would back any claim against BPL.

7. Dr Craske advised that with a 1:52,000 incidence of HIV infection in blood donations the chance of an undetected positive in a batch of F8 was not high; heat treatment would inactivate those which were not detected.

8. Although Directors were encouraged by CBLAs report, they thought the results should be scrutinised by a statistician after those patients with raised ALTs had been removed from the sample. Other studies in France and Italy had shown higher levels of ALT; this could have been the result of the use of cryoprecipitate. A national effort was required to find 50 more naive patients for further study. It was agreed that MRCs statistical department should be approached to provide the validation of results Directors sought.

9. Dr Lane reported that CBLA had applied for a manufacturers licence for the new building; until they knew their position under clinical trial conditions it was difficult to proceed to a product licence application.

10. Directors sought BPL's assurance that they had equal access to CBLA and commercial data. Dr Lane confirmed that Crown product information was fully available; indeed the information BPL gave exceeded CTX requirements. Directors sought official endorsement of the proposed further study.

11. Dr Smithies asked BPL if the Committee on Safety of Medicines was to scrutinise their protocols. CBLA confirmed this and added that they could also apply to CSM for exemption from clinical trials.

12. Directors asked if any participants in CBLA's previous immunoglobulin trials or any participants in commercial trials had sued or claimed compensation.

13. Dr Smithies said that there was an analogy in the whooping cough vaccine trials. Directors asked for further advice on this and on the possibility of statistical examination for the October meeting.

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21. Dr. Gunson advised that there was no decision to begin ALT testing in the BTS. Such testing may eliminate 2-3% of donors without necessarily excluding carriers of non A non B hepatitis. If the results of the present F8/ trial held up then ALT testing would only benefit recipients of blood and FFP Directors etc

14. Directors said that ~~the~~ a clinical co-ordinator for the trial should be recruited from their ranks; goodwill and a team effort would be required to achieve ultimate success. Dr Smithies supported this and said that the idea could be discussed further at the October meeting of Haemophilia Centre Directors.

15. Directors considered full ~~patient~~ co-operation could be achieved only when ~~there was a standard 'consent form'~~ the protocol with an extended trial had been re-circulated and previously agreed protocol was suggested.

Blood Products Laboratory

16. Dr Lane reported progress on the building and on the commissioning of BPL. He gave estimates of projected growth. There had been a slippage of one year due to the uniqueness and complexity of the concept; he expected handover around March 1987.

17. He reported present production of 120 tonnes of FFP per year. This was down from 150 tonnes as F8Y was a more complex product; he expected new building output to be ~~in-line during commissioning~~ at that level during commissioning

18. In October/December '87 quarter he anticipated 58 tonnes a quarter, or 60 tonnes fast-track. In April/June '88 he expected 80 or 115 tonnes per quarter. There would be a 12 month work-up to full rate which he anticiapted would be reached during '88.

19. During October/December quarter '87 production of 22,500 vials (of 250 mls) would allow accumulation of an end stock. In April/June '88 he anticipated 33,000 vials production and an end stock of 26,000 vials. In October/December '88 he expected to issue 63,000 vials and have an end stock of 55,000; a 3 month stock was sought. 82,000 vials per quarter would represent 450 tonnes per annum which was the target; however he said BPL had the capacity to go on to 100 million units.

20. At the end of 1986 he expected to hold 51 tonnes of FFP not tested for HIV and 211 tonnes which had been tested. There would be no shortage for commissioning the building (up to 370 tonnes) provided ALT testing was not introduced.

21. Dr Gunson advised that ~~this had not been decided; testing would have to be done at RTC's rather than centrally and whole blood would benefit more than large pool concentrates. He thought~~ Such testing may eliminate 2-3% of donors that necessarily excluding carriers of non A non B hepatitis. If the results of the present FBY trial held up then ALT testing would only benefit recipients of blood or FFP.

22. Directors thought this a problem which needed to be addressed since in the USA the AABB had already adopted ALT and Hepatitis core antibody testing. Dr Craske thought such testing would only reduce the chance of a donation with a high level of virus in it.

Regulatory aspects

23. Dr Snape reported the affect upon the supplies situation of testing source plasma for HIV antibody. From 1 June 1986 all plasma committed to fractionation was from screened plasma. Region batching had had to be abandoned and BPL were now on a "first in first out" basis.

24. He reported that in August '86 the production of F8 at BPL had been 50/50 from screened and unscreened plasma; September '86 production would be entirely from screened bar 4 batches; thereafter all would be from screened.

being made plasma.

24. All F9 was from unscreened. He estimated this would continue until December '86. All stocks of F7, F13 and other minor products were also from untested plasma. Even 'focussing' could not guarantee their products from screened plasma before December '86. However the rationale for continued use was that all products undergo viral inactivation steps and clinicians were appraised of the risks. A product licence application for F8 and F9 was being made and a licence for anti-thrombin 3 would be sought in the future.

25. Directors believed that haemophilia care might increase at the rate of 14% per annum and conjectured that the level of consumption by April/June 1988 might exceed 100 million units.

26. Dr Smithies suggested another meeting in about six months for a progress report; Dr Lane offered Elstree as a venue if the date coincided with the official opening of the new facility.

Any other business

27. There was no other business.

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