New Minister brief – Lord Archer's report

Policy Issue

Lord Archer of Sandwell set up an independent inquiry in spring 2007 into the contamination of NHS blood and blood products with HIV and hepatitis C in the 1970s and 1980s, which resulted in the infection of many patients.

Lord Archer was encouraged to set up his inquiry by Lord Morris of Manchester, who has campaigned on this issue for many years, and is president of the Haemophilia Society. There had been repeated calls for a public inquiry, but this was not taken up by successive Governments as they considered there was little more to be learned and the important thing now was how to best care for those infected.

The report of the inquiry was published on 23 February 2009. Lord Archer does not find successive Governments to have been at fault, and does not apportion blame. However, he expressed 'dismay' at the speed with which the NHS reacted to events.

The Government's response was published on 20 May 2009 together with a written ministerial statement. The general reaction from interested stakeholders is that the Government's response does not go far enough in addressing the recommendations of Lord Archer's report. Most of the concerns centre around the amount of financial relief being given to those infected (and/or their dependents).

A summary of Lord Archer's recommendations are as follows:

- establishment of a statutory committee to advise Government on the management of haemophilia in the UK;
- free prescription drugs and free access to other NHS and support services;
- secured funding by Government for the Haemophilia Society (a third sector organisation);
- review of the current ex-gratia payments system, including bringing payments in line with those in Ireland (very much higher than in the UK), and incorporating them within the DWP benefits system;
- enabling haemophilia patients to have access to insurance; and
- establishing a 'look back' exercise to identify any remaining patients who may have been infected, and may not be aware of this.

The Scottish Executive announced on 23 April 2008 that it intended to set up an inquiry, under the Inquiries Act 2005, into the contamination of blood and blood products. This followed a judicial review under Scottish law of an earlier decision of the Lord Advocate and Scottish Ministers not to convene Fatal Accident

Inquiries or public inquiries into two deaths from contamination by hepatitis C. The judge ruled that both had acted unlawfully, on the basis that the refusal was incompatible with Article 2 of the European Convention on Human Rights. The Scottish Executive decided not to appeal and the inquiry started in January 2009. It is headed by Lord Penrose.

The Department has said it will aim to be helpful to the Scottish inquiry, e.g. by making relevant documentation available, where this is not already in the public domain.

Efforts to make properly-informed assessments of the relevant events and decisions taken throughout the period in question, that is the fifteen year period 1970 to 1985, are constrained by the incompleteness of the documentary record, for which this and former governments have apologised. We acknowledge that the loss or misplacement of some official documents has led to suspicion that we have 'something to hide'. We have been very open about these mistakes, and have made every effort to collect and release the relevant papers. Over 5,500 documents have already been placed on the Department of Health website, and we have said that where we identify any further relevant documents, they will also be released, subject to safeguards such as not releasing personal data. We are committed to release, in line with the freedom of information act, all relevant documents that we hold on the safety of NHS blood and blood products from 1970 to 1985. We are pleased to see that Lord Archer discovered no evidence of malicious destruction of relevant records.

Background

Most patients with haemophilia in the 1970s and 1980s became infected with HIV or hepatitis from contaminated blood and blood products. Many patients died and survivors have led seriously impaired lives.

The Government set up payment schemes to offer financial help to those who were infected. The MacFarlane Trust (1989) and Eileen Trust (1993) provide lump sum and discretionary payments to, respectively, haemophiliacs and others, who contracted HIV. Over £45m has been paid out to date and there are around 600 current beneficiaries.

The Skipton Fund (2004) provides lump sum payments to people infected with hepatitis C. This includes NHS patients infected from transfusions prior to 1991 as well as those infected from blood products. £97m has been paid out to date to over 4000 beneficiaries.

SofS and MS(PH) met with Lord Archer on 11 March 2009 to discuss the findings and recommendations contained in his report. Following this, careful consideration was given to each of the recommendations contained in the report.

The summary of the Government's response is as follows:

- Increasing the funding available to the Macfarlane and Eileen Trusts to allow them to move to a system of annual payments of £12,800 for infected individuals (the current average annual payment is around £6,400)
- Commitment to review the Skipton Fund in 2014 when it will have been in existence for ten years
- Not establishing a new statutory committee by legislation, but instead building on existing arrangements and expertise by way of the Haemophilia Alliance, which comprises patients, haemophilia doctors, and others involved in their care
- The issue of prescription charging for long term conditions is being considered by Prof. Gillmore's review into prescription charging in England (due to report in the summer)
- We have committed to provide funding of £100,000 per annum to the Haemophilia Society for the next five years
- We have committed to fund a 'look back' exercise

There are already measures in place to help to prevent similar events happening in the future. The Government receives expert advice on safety measures from the independent Advisory Committee on the Safety of Blood Tissues and Organs (SaBTO), and NHS Blood and Transplant is responsible for ensuring a safe and sufficient supply of blood to England and Wales.

Lord Archer's recommendation to mirror the payments to those made by Ireland is a little misleading as the circumstances there were different, but campaigners have nevertheless latched onto these significantly larger sums.

The Government here has never accepted any liability. We believe that people were offered the best treatment available at the time and that as soon as blood screening tests were available they were implemented. There were attempts to bring litigation against the Government by those infected with HIV in the early 1990s but these were withdrawn following legal advice to the plaintiffs that they were unlikely to win their case. However as a gesture of goodwill, the Government established the Macfarlane and Eileen Trusts at that time for those infected with HIV – and the Skipton Fund in 2004 for hepatitis C. Payments from all these funds are ex gratia goodwill payments only.

In Ireland also, the State did not explicitly admit liability. However, contrary to the position in the UK, the Irish Blood Transfusion Service (IBTS) was found, by a judicial inquiry, to have been responsible on two occasions (1977 and again in 1991) for failures which resulted in the large-scale contamination with hepatitis C of a blood product used to treat pregnant women. This finding resulted from the IBTS's failure on both occasions to follow its own guidelines that blood from previously-transfused individuals should not be used for the preparation of blood products because of the increased risk of infection. The report of this Finlay

inquiry concluded that "wrongful acts were committed". The Irish Government therefore set up a hepatitis C compensation scheme in 1997 for the infected women following this conclusion, and because of the threat of litigation (which the Irish Government believed it would lose). The compensation scheme was later extended to all people infected with hepatitis C through blood products and blood transfusion, as some infected women had donated blood and thereby infected others.

Current State of Play and Issues

Early Decisions or Immediate Actions

Interested stakeholders do not feel the Government's response sufficiently addresses Lord Archer's recommendations. Their key concerns are:

- The increase in funding for the Macfarlane and Eileen Trust is too little
- No review of the Skipton Fund until 2014
- Still no support to those who died before 29 August 2003 who currently cannot claim (an anomaly the widows were campaigning to be rectified)

MS(PH) has asked for, and been given, advice on options in relation to financial relief for hepatitis C sufferers.

Strategic Forward look

- We are now starting to implement the Government's response
- We will support Scotland's Penrose Inquiry
- We will review the Skipton Fund in 2014