Chronology relating to Variant Creutzfeldt-Jakob Disease

This chronology is intended to assist in understanding the development of events relating to vCJD and transmission by blood or blood products. It is not intended to be exhaustive and its content should not be taken as a finding or statement of fact by the Inquiry.

Date	Event	Reference
1920s	CJD first described by the German neurologists Hans Gerhard Creutzfeldt and Alfons Maria Jakob.	
25 July 1966	'Pathogenesis of scrapie virus infection in the mouse' Eklund et al. (1964) They found involvement of lymphoreticular tissues in scrapie. This study suggested that the infectious agent responsible for scrapie was transported in the blood by infected lymphocytes.	RLIT0000726
19 February 1966	'Experimental Transmission of a Kuru-like syndrome to Chimpanzees' Gajdusek et al. Nature 19 February 1966 794. Brain tissues of kuru patients were inoculated into three chimpanzees to study the transmissibility of kuru. The results showed remarkable similarity in the clinical presentations and neuropathological findings between humans and chimpanzees leading the authors to believe that kuru could be transmitted to chimpanzees intracranially.	RLIT0000724
26 July 1968	'Creutzfeldt-Jakob Disease (Spongiform Encephalopathy): Transmission to the Chimpanzee'. Gibbs et al. (1968) Brain tissues of a CJD patient were inoculated into a chimpanzee to study the transmissibility of CJD. The results showed remarkably similar clinical signs and pathological findings between the chimpanzee and the human patient. This indicated that CJD was caused by a transmissible agent.	RLIT0001073
1980 - 1984	Creutzfeldt-Jakob disease in England and Wales, 1980 – 1984: a case-control study of potential risk factors' Journal of Neurology, Neurosurgery and Psychiatry. 1985; 51: 1113-1119. Knight, Will et al	DHSC0004379_076

	This was a prospective study of the epidemiology of CJD in England and Wales.	
1985	'Retrospective study of CJD in England and Wales 1970 – 1979 II: epidemiology' carried out, published in the Journal of Neurology, Neurosurgery and Psychiatry 1986; 749 – 755. Will et al.	DHSC0032252_110
31 October 1987	Wells et al 'A novel progressive spongiform encephalopathy in cattle' The Veterinary Record, 31 October 1987, 419. This noted the similarity between the viral agent encephalopathies recorded in several species such as scrapie in sheep. The article noted that the aetiological basis of bovine spongiform encephalopathy remained unknown.	RLIT0000712
4 April 1989	Advisory Committee on the Virological Safety of Blood (ACVSB) determined that their advice to the Chief Medical Officer (CMO) should be that human growth hormone recipients were not acceptable as blood donors due to the theoretical risk of transfer of CJD, and that the blood services should attempt to exclude them as donors. They also agreed that transplant groups should be reminded about excluding people at risk of CJD from being potential donors.	NHBT0000041_003
13 November 1989	Use of specified bovine offal (SBO) banned in human food by the Bovine Offal (Prohibition) Regulations 1989.	RLIT0001111
1990	National Creutzfeldt-Jakob Disease Unit (later renamed the National Creutzfeldt-Jakob Disease Research and Surveillance Unit (NCJDRSU)) set up by the Department of Health and the Home and Health Department of the Scottish Office to monitor the incidence of CJD in the UK population.	
3 April 1990	Announcement of the formation of the Spongiform Encephalopathy Advisory Committee (SEAC) to advise the Department of Department of Agriculture, Fisheries and Food and the Department of Health on matters related to spongiform encephalopathies on an ad hoc basis.	CABO0000383_026
May 1990	UK national surveillance prospective program for CJD initiated. A retrospective study of CJD between 1985 – April 1990 undertaken by death certificates. Established a total of 260 suspect cases of CJD	This is the first CJDSU annual report RLIT0001109

23 January 1993	Esmonde, Will et al 'Creutzfeldt-Jakob disease and blood transfusion' Lancet 1993; 341; 205 – 07. This study identified 21 patients who had received a blood transfusion and 29 who had donated blood, out of a total of 202 definite and probable cases from the NCJDRSU database. This frequency of blood transfusion or donation did not differ from that in the age and sex matched controls, and the clinical features in patients with a history of blood transfusion were similar to those of classical CJD and clearly distinct from CJD in recipients of hGH. These data did not suggest that blood transfusion was a major risk factor for CJD.	LOTH0000015_003
1994	'Transmission of Creutzfeldt-Jakob disease via a Corneal Transplant' Heckmann et al; Journal of Neurology, Neurosurgery and Psychiatry 1997; 63; 388 – 390. A woman who died of CJD had been the recipient of a corneal transplant thirty years earlier, from a donor who had had a diagnosis on necropsy of subacute spongiform encephalopathy. In view of two previous case reports in the literature, it was presumed that the cornea was the source of the transmission of CJD.	NCRU0000154_006
1 May 1995	GRO-A died in GRO-A 1995 at 18 years old of vCJD. First known death from vCJD (although not at this stage known to be vCJD). Initially diagnosed as sCJD by Collinge et al in a letter to the Lancet on 28 October 1995 'Sporadic Creutzfeldt-Jakob disease in 16 year old in the UK'. This case was only subsequently diagnosed as vCJD.	CABO0000367_009
15 December 1995	Mechanically recovered meat (meat dislodged from vertebral columns of cattle) banned from human food by the coming into force of the Specified Bovine Offal (Amendment) Order 1995.	RLIT0001110

8 March 1996	Professor Will and Professor Ironside presented their work on the new variant of CJD to the SEAC (initially referred to as nvCJD, and then subsequently vCJD).	DHSC0004445_043
20 March 1996	Secretary of State for Health announced in the House of Commons, that there was a probable link between BSE in cows and vCJD in humans on the advice of the Spongiform Encephalopathy Advisory Committee (SEAC).	CABO0000383_036
6 April 1996	Wills, Ironside et al 'A new variant of Creutzfeldt-Jakob disease in the UK' Lancet vol 347. They reported ten cases of a previously unrecognised variant of CJD. They concluded that exposure to the BSE agent was the most plausible interpretation of their findings.	HSOC0010099
9 April 1996	Ad hoc meeting held at the Royal College of Physicians in Edinburgh to review the implications of the newly reported variant of CJD to the blood transfusion services. It was agreed that the possibility that CJD could be transmitted by transfusion of blood could not be excluded and so steps to minimise the impact on the safety of blood were agreed, including UK blood services instituting direct questioning of donors in relation to a family history of CJD, and investigating whether reported cases of those with CJD had ever received transfusions or given blood.	NHBT0115407
16 April 1996	SACTTI meeting at which it was agreed that: • Dr Robinson would ask MSBT for approval to do a look back on recipients of blood donations from donors who had subsequently developed CJD. • Dr Gillon would prepare a paper on leucodepletion and its potential role in providing protection from the putative CJD agent.	NHBT0000088_013
May 1996	Dr Hewitt consulted Professor Kennedy for ethical advice about the proposed look back (subsequently named the Transfusion Medicine Epidemiology Review (TMER)), and in particular about whether those who had received blood originating from a donor who later developed CJD, should be notified.	Referred to in NHBT0017407

Summer 1996	Irwin Mitchell solicitors were instructed by families whose members had developed CJD, with a view to bringing a claim against the Government.	RLIT0001072
1 July 1996	The Chief Medical Officer (Dr Kenneth Calman) issued PL CMO (96)5 - a Dear Doctor letter providing information about vCJD, following the announcements made by the Secretary of State on 20 and 25 March 1996 (the latter being an announcement about beef)	BART0000554
1 August 1996	Blood Transfusion Services in the UK began asking all blood donors whether they had a family history of CJD. Where a close family member had CJD the donor would be advised not to give blood. This change in practice was reflected in the declaration by donors, together with questions about whether the donor had had brain surgery spinal surgery or injections of human pituitary extracts.	JPAC0000177_008 JPAC0000004_134
24 October 1996	Collinge, Ironside et al 'Molecular analysis of prion strain variation and the aetiology of 'new variant' CJD in Nature, volume 383; 685 – 690. The paper reported on the molecular analysis of vCJD, which showed it had strain characteristics distinct from other types of CJD and resembled those of BSE transmitted to mice, domestic cat and macaque, consistent with BSE being the source of new variant CJD.	MHRA0021347
6 January 1997	Ethical approval from Mid Lothian Research Ethics Committee was granted for 'A retrospective Study to examine a possible link between Creutzfeldt-Jakob Disease (CJD) and blood transfusion' (the TMER).	NHBT0008885
11 January 1997	Hill, Zeidler, Collinge and Ironside 'Diagnosis of new variant Crutzfeldt-Jakob disease by tonsil biopsy' In this paper they concluded that it might be possible to make a specific diagnosis of nvCJD by tonsil biopsy.	DHSC0004747_040

6 June 1997	The nvCJD Families Association formed. Its aim was to call for a public judicial inquiry into vCJD, to make vCJD a notifiable disease, to obtain financial assistance for those who had suffered hardship due to a relative's illness and to ensure proper care packages for vCJD patients.	MHRA0011469
1 July 1997	The Department of Health published the SEAC statement 'Research into link between new variant CJD and BSE' in answer to a parliamentary question. The statement concluded that evidence had accumulated that was consistent with the hypothesis that nvCJD was caused by exposure to the BSE agent.	DHSC0006880_072
23 September 1997	Letter from BPL to the English and Welsh Blood Services to request that they should inform BPL if they learn of information indicating that a blood donor whose plasma had been sent to BPL had been identified as suffering from or having died when suffering from, vCJD. Where centres received information as a result of the TMER that one of their donors had suffered or is suffering from vCJD, they were to undertake a review of plasma previously supplied to BPL from such donors and advise BPL accordingly.	NHBT0005418_006
29 September 1997	Chief Medical Officer issued a letter to the Directors of Public Health regarding the publication of the research into the link between BSE and vCJD. The letter concluded by stating that SEAC had concluded at its last meeting that the necessary measures were in place to protect public health.	DHSC0006535_172
2 October 1997	Bruce, Will Ironside et al 'Transmission to mice indicate that 'new variant' CJD was caused by the BSE agent'' Nature.	DHSC0004125_011
6 October 1997	The CMO issued a statement on CJD, publishing the latest figures from the NCJDRSU and stating that one of the vCJD patients identified was suspected of being a blood donor while the other three had been confirmed as blood donors.	DHSC0041442_171

23 October 1997	At a meeting of the Biotechnology Working Party of the Committee on Proprietary Medicinal Products (CPMP) it was agreed that there should be a recall of batches of blood products if a blood donation to a plasma pool was subsequently found to have been made from a person who developed vCJD. The working party deferred making a recommendation on possible recall where plasma derived products were used as excipients in vaccines, cytokines and other medicinal products.	DHSC0041442_050
24 and 31 October1997	In a report entitled 'vCJD, Blood components and plasma products' (undated) and authored by Dr Shepherd and Dr Snape, it was noted (at page 8 of that report) that BPL were notified on three separate occasions that they had received seven donations of plasma, donated by three donors who had been confirmed as having died from vCJD. Six of the seven donations had been included in fractionation pools. Recipients of the plasma were not notified.	NHBT0001722 Page 8 of the report
24 October 1997	SEAC meeting at which it was agreed that it was sensible to advocate a policy of reducing exposure to vCJD as far as possible, by leucodepletion	NCRU0000174_001
27 October 1997	MSBT meeting at which it was agreed that when the blood services were informed of suspected cases of vCJD from any source, which were then confirmed by the NCJDRSU, they would have to trace the recipients. It was also agreed that it was important to continue the vCJD lookbook (the TMER) without informing the recipients that they had received implicated product.	SBTS0000522
30 October 1997 and 4 November 1997	BPL recalled Factor VIII and albumin from a pool to which a vCJD diagnosed donor(s) contributed.	NHBT0001722 page 39 – 40 of the report NTHT0000006_007

30 October 1997	The National Blood Authority (NBA) released a media statement that it had recalled albumin and Factor VIII from 26 sites within England on the basis that a blood donor who developed vCJD had contributed to that batch of blood products.	DHSC0042286_068
5 November 1997	Dr Metters, DCMO, wrote to Professor Will to ask NCJDRSU to notify the 'relevant' blood services of anyone suspected of having vCJD so that they could investigate whether any donations were made by that person.	NHBT0009036
6 November 1997	The Secretary of State for Health, Frank Dobson, announced that he had accepted the SEAC advice to extend leucodepletion to blood and blood products as a precautionary measure to protect the public from any risk of contracting vCJD.	BART0002084_002
10 November 1997	The DH gave instructions to the NBA to draw up a leucodepletion strategy in light of the SEAC advice.	NHBT0009276
20 November 1997	In a press release the CPMP announced its view that it would be prudent, as a precautionary measure with respect to vCJD, to withdraw batches of plasma derived medicinal products from the market in the event that a donor to a plasma pool subsequently had a confirmed diagnosis of vCJD. '*However, consequences for essential medicinal products where alternatives may be unavailable will need careful consideration*'	BPLL0000167
27 November 1997	The UKHCDO issued a press release recommending recombinant Factor VIII as the first choice of treatment for people with haemophilia. Where this was not available, the risk of transmission of vCJD would be reduced by using concentrates prepared from donor plasma collected in countries other than the UK where there were no recorded cases of vCJD or BSE e.g. the USA.	HSOC0015139

16 December 1997	NBA/BPL position statement entitled 'The nature of advice to be given to patients who have been treated with plasma products manufactured from a plasma pool which includes plasma from a donor suffering from nvCJD'. This provided that while products should be withdrawn in accordance with the current BPL procedures, no attempt should be made to advise individual recipients that they might have been treated with an affected batch.	NHBT0001722 page 41
End of 1997	Some Haemophilia Centres provided information to their patients about vCJD arising from the withdrawal by BPL of some of their products. Some Haemophilia Centres informed individual patients that they had received implicated batches.	Some examples are: WITN3063002 and HSOC0015148 NHBT0004053_004 WITN0282027
22 December 1997	Inquiry announced by Minister of Agriculture Jack Cunningham to establish and review the history of the emergence and identification of BSE and nvCJD in the UK.	
19 January 1998	Meeting of the Committee on Safety of Medicines (CSM) Working Group on TSE and variant CJD. Agreed to make a recommendation to the CSM, to extend the withdrawal policy to excipients and blood products used in the manufacturing process if donors who had contributed to the plasma pool had proven vCJD.	MHRA0009455
6 February 1998	NBA executive letter PL(CO)98 from the NHS Executive to NHS Medical Directors entitled 'New Variant CJD – Patients who have received implicated blood products'. As a consequence of the CMO announcement in September 1997, there had been a number of recall exercises. Clinicians had contacted DH to ask what those patients who had received recalled product should be told. The advice DH had received from ethical experts and advisory bodies was there was no need to inform patients of their exposure because: • It was thought unlikely that vCJD will be transmitted in this way • There was no diagnostic test for vCJD • There was no preventative treatment for vCJD. It was for individual clinicians to decide whether to follow the ethical advice.	BART0002418
25 February 1998	Committee on Proprietary Medicinal Products (CPMP) position statement CPMP 201/98 'Position Statement on New Variant CJD and Plasma Derived Medicinal Products'. This largely replicated its position statement of 20 November 1997, but also advised that manufacturers should avoid using	MHRA0009439

	as an excipient, albumin derived from countries where a number of cases of vCJD had occurred.	
26 February 1998	Frank Dobson, Secretary of State for Health, announced that: • The CSM would review the use of UK sourced plasma, - they would be looking at all products individually to ensure a safe and sufficient supply of blood products. • Blood product recalls would be extended to include donors subsequently identified as being strongly suspected of having vCJD. • Recombinant Factor VIII must be available for children under the age of 16 not yet receiving it, and to new patients. • BPL would be able to import plasma so that blood products might now be manufactured from imported plasma. This was promulgated to the Directors of Public Health by Dr Metters (Deputy CMO).	BART0002231 BWCT0000029
1 April 1998	At a meeting of the CSM Working Group on TSE and Variant CJD it was decided that BPL and PFC must move away from UK sourced plasma for manufacturing blood products, by a date to be agreed with CSM.	MHRA0009404
23 April 1998	Scottish Office Department of Health wrote a letter to NHS Trust Medical Directors entitled 'nvCJD – Patients who have received implicated blood products' This referred to the UK policy of withdrawing any unused blood components or products from blood donated by those who had developed vCJD as a precautionary measure. It pointed out that as a consequence of this there had been a number of recall exercises. Clinicians had contacted DH to ask what those patients who had received recalled product should be told. DH had taken expert ethical advice. The advice from ethical experts and advisory bodies was there was no need to inform patients because: • It was thought unlikely that vCJD would be transmitted in this way • There was no diagnostic test for vCJD • There was no preventative treatment for vCJD. It was for individual clinicians to decide whether to follow the ethical advice.	GGCL0000111_001

30 April 1998	CSM meeting at which it accepted the recommendation of the CSM Working Group on TSE and Variant CJD and advised that all manufactured blood products should be sourced from non UK plasma and that BPL and PFC must move away from UK sourced plasma for manufacturing blood products, by a date to be agreed with CSM.	DHSC0038638_079
5 May 1998	Meeting between DH, Scottish Office, NCJDRSU, NBA, SNBTS and BPL to review when and how NCJDRSU should notify the blood services of a donor who was a confirmed or strongly suspected case of vCJD. Later SOP devised for NBA once such information received.	DHSC0032368_003 NHBT0008720_002
13 May 1998	The Committee on the Safety of Medicines, having reviewed each individual blood product licence, advised that all products should be manufactured from plasma sourced from abroad. The Secretary of State accepted the advice.	DHSC0004790_065 and press release MHRA0034749_015
May – June 1998	UK fractionators shut down manufacture from UK plasma.	
15 June 1998	SEAC recommend that the Government should extend the use of leucodepletion for all blood destined for transfusion as soon as practicably possible. Care should be taken that this did not impact adversely on the donation and supply of blood.	DHSC0041249_091
17 July 1998	Government announced £70 million programme to leucodeplete blood donations on the advice of SEAC. Press release 'Government Accepts Advice on Leucodepletion From SEAC'	DHSC0004790_066
27 August 1998	DH press release reported the finding of vCJD prion in the appendix of a patient who went on to develop the disease. Testing the appendix was heralded as a way of carrying out 'a preliminary study of the disease'.	DHSC0038575_075

November 1998	Draft final report for SEAC and DH by Det Norske Veritas Ltd (DNV) 'Assessment of the risk of exposure to vCJD infectivity in blood and blood products'	DHSC0041249_004
1999	According to a CJDIP subgroup meeting, in 1999 SNBTS were advised of a donor with possible vCJD who had provided two donations. The products were traced and all had expired several years previously. Information on clotting factor batches was passed to Haemophilia Centre Directors and patients offered the choice as to whether to be informed of their potential exposure.	DHSC0004206_072
18 February 1999	Final report for DH and SEAC by (DNV) entitled 'Assessment of the Risk of Exposure to vCJD Infectivity in Blood and Blood Products'. Recommendations included: o Discontinue use of UK plasma for fractionation o Establish leucodepletion.	NHBT0008380
13 August 1999	Health Circular HSC1999/178. Addressed to all Health Authorities and NHS Trusts, entitled 'Variant Creutzfeldt-Jakob Disease: Minimising the Risk of Transmission' It set out what action should already be being taken by health organisations and clinicians and some further precautionary measures that should be implemented. In particular it stated that all cases of CJD of any type should be reported to the NCJDRSU.	NHBT0001719
15 April 1999	In a letter to Professor Kennedy, Dr Hewitt sought further advice about the ethics of not notifying those who had been identified as having received blood from a donor who later developed CJD in light of the steps now being taken by the blood services to prevent such recipients from giving blood.	NHBT0017407
17 August 1999	Canada and the USA excluded anyone who had spent time in England, Scotland, Wales, Northern Ireland, Isle of Man and the Channel Islands amounting to (cumulatively) 6 months or more between 1980 and 1996, inclusive, from donating blood.	WITN6933015 page 3
6 October 1999	MSBT advised the DH that blood from individuals who had themselves received blood from donors who had developed vCJD should not be allowed to enter the blood stream. This advice was accepted by DH and NBA instructed accordingly.	SBTS0000293_007

1 November 1999	All blood and blood components in the UK blood transfusion service has been subject to leucodepletion since 1 November 1999	NHBT0046300
20 December 1999	Professor Doyal's letter to Dr Hewitt expressed his view that (i) it would be illegal and immoral to allow someone to give blood and then simply destroy it; (ii) recipients or donors who were told that their blood could be used must be informed why and (iii) it would be wrong to deny individuals at risk of vCJD from knowing their status.	NHBT0004392_002
2000	DH commissioned and funded a UKHCDO 5 year prevalence study of vCJD in people with haemophilia.	HCDO0000109_013
12 January 2000	Letter from Senior Medical Officer at DH (Dr McGovern) to Dr Robinson regarding management of potential donors known to have received blood from a person who had developed vCJD. This letter gives consideration to the NBA policy of flagging potential donors on databases who had been identified as having received blood from a person who had subsequently developed vCJD. It had been agreed that information regarding flagged persons was to be shared amongst the four nations as they could present as donors anywhere in the country. As a donation from a flagged person should not enter the system, it was agreed that in the spirit of openness, the blood services would need to consider telling, or offering to tell the donor why their blood could not be accepted. It was agreed that in any such case, the appropriate Health Department should be contacted in the first instance and it would be discussed and managed on a case by case basis. NBA agreed to develop a protocol for dealing with these cases.	NHBT0004310
30 January 2000	Mid Lothian Medicine/Clinical Oncology Research Ethics sub-committee refused NCJDRSU's application for renewed ethical approval of the TMER in light of the difference of opinion as to whether to notify those who had either donated to someone who had subsequently developed vCJD, or someone who had received blood or blood products from a person who had subsequently developed vCJD.	NHBT0004364_004

23 May 2000	Application from Professor Will of NCJDRSU to the Mid Lothian Medicine/Clinical Oncology Research Ethics sub-committee to re-consider ethical approval for the TMER on the basis that; • It was unethical not to do the study as it might be the only mechanism by which transmission of vCJD through blood or blood products could be identified. • An expert group had been set up to consider each incident as it occured.	NCRU0000112_068
30 May 2000	Mid Lothian Medicine/Clinical Oncology Research Ethics sub-committee re-instated ethical approval for the TMER on the basis that the decision as to whether to inform a person identified by the TMER was left to the local Health Authority	NCRU0000112_069
1 April 2000	Only leucodepleted blood products transfused to patients within the NHS after 1 April 2000	NHBT0046300
16 June 2000	Meeting to discuss the management of patients who receive blood from donors who later develop vCJD Agreed that prior to donating, a donor would be (i) asked whether they had received a transfusion (ii) asked whether they wished to be informed of a risk to their health and (iii) told that their blood could be rejected for a range of reasons from the very minor to something that posed a major health implication.	NHBT0009063_002
26 October 2000	BSE Inquiry report published	Available at https://webarchive.nationalarchives.gov.uk/ukgwa/20060525120000/http://www.bseinquiry.gov.uk/report/index.htm
26 October 2000	Govt announced it would set up (i) a fund for the care of victims of vCJD to ensure a speedy response to diagnosis and improvement in the quality of care for such patients, to be co-ordinated through the NCJDSU; and (ii) a compensation scheme operated through a special trust fund.	MHRA0021231
10 November 2000	First meeting of the CJD Incidents panel.	DHSC0020839_067
8 December 2000	BPL notified that a donor who had made two donations had been diagnosed with vCJD. All products made from these donations had expired.	MHRA0020990 BPLL0016009_085

14 December 2000	BPL notified consignees of the (expired) product they had been provided, made from the donations of the donor diagnosed with vCJD.	For example BHCT0002598 and BPLL0000184_003
14 December 2000	The Treasury agreed to fund from the Reserve, the cost of establishing a UK wide compensation fund for up to 250 cases of vCJD.	DHSC0004451_072
4 January 2001	DH press release announcing an investment in 2001 of £200 million into NHS decontamination and sterilisation facilities to protect patients against possible vCJD.	NHBT0001720
18 January 2001	Haemophilia Society posted a letter dated January 2001 to all members notifying them of the fact that some (expired) BPL products had used plasma obtained from a donor who had now been diagnosed with vCJD.	GGCL0000150_001
19 January 2001	Letter from UKHCDO to Haemophilia Centre Directors regarding the BPL notification in respect of products made of plasma from a donor who had developed vCJD. The letter suggested the way to approach patients was to give them the choice as to whether they wished to be informed that they had received an implicated batch. This approach had been agreed with DH. The letter enclosed draft letters to patients and a fact sheet.	BART0000916
29 January 2001	Lord Hunt in a written answer to parliament stated that the UKHCDO in consultation with DH had agreed a policy of giving all haemophilia patients information about the December 2000 vCJD incident and offering them the choice as to whether they wished to know whether they or their children had received the implicated clotting factor.	HSOC0002201
February 2001	Interim guidance on vCJD in the form of a letter from Dr Troop, DCMO, drafted, but not at this stage issued. The guidance addressed how hospitals should manage requests for information from patients who feared that they had been given products made from someone who later went on to develop vCJD. In short, it was up to the patient whether or not they wanted to be informed that they had received such a product. It is unclear whether this was ever issued.	NIBS0000538

14 February 2001	Alan Milburn announced interim payments of £25,000 for families of victims of vCJD, once regulations were in place to ensure that the payments were not taken into account in the calculation of income-related social security benefits.	DHSC5277545
16 March 2001	DH press release regarding the risk assessment published on updating decontamination facilities to deal with the theoretical risk of transmission from patient to patient via surgical instrument.	DHSC0014461
May 2001	Draft letter from DCMO Dr Troop to all NHS Trust Medical Directors and others entitled 'Patients who have received implicated blood products – interim guidance' This was a further draft of the guidance to hospitals on how to respond to patients who wished to know whether they or their children might have been given vCJD implicated blood products. Pending completion of the CJD Incidents Panel more detailed framework, the guidance proposed that hospitals did not contact patients pro-actively about the products that had been the subject of notifications to clinicians, but if a patient wished to know whether they or their children had received vCJD-implicated batches, hospitals should ensure that the patient fully understood the facts about vCJD and the implications of being given the information. If on receipt of this information the person still wished to know whether they had received such products, they should be told. It is unclear if this guidance was ever issued.	NHBT0001123_002
28 September 2001	Alan Milburn, Secretary of State for Health announced the development of a compensation scheme for vCJD victims.	DHSC0046974_007
1 October 2001	Health Secretary Alan Milburn announced further details of the compensation scheme for people diagnosed with vCJD and their families. The scheme, to be administered by the vCJD Trust, would provide payments of up to a maximum of £55 million for the first 250 cases with a discretionary fund capped at £5 million.	NHBT0008988
10 October 2001	CJDIP launched its consultation on 'Management of possible exposure of CJD through medical procedure'. This included a consultation on informing people about their exposure to CJD.	NHBT0096710_001

22 November 2001	Letter from Professor Franklin of SNBTS to Professor Ludlam as chair of the Coagulation Factor Working Party about two episodes of plasma production batches which included a donation from a person subsequently diagnosed as having strongly suspected vCJD. He wished to wait for the CJDIP to publish its final guidance on notification to patients, before making the specific batch numbers available.	GRAM0000127_002
24 November 2001	Alan Milburn invited Sir Robert Owen to become the chairman of the vCJD Trust.	DHSC0004297_002
3 December 2001	First meeting of the CMO's National Blood Transfusion Committee.	DHSC0038528_050
22 February 2002	First meeting of the vCJD Trust.	DHSC0030993
11 March 2002	Second meeting of the CMO's National Blood Transfusion Committee took place.	DHSC0006566_029
19 June 2002	Professor Ludlam wrote to the Scottish CMO Dr Armstrong regarding the episode of plasma production batches which included a donation from a person diagnosed as having strongly suspected vCJD. Haemophilia Centre Directors in Scotland and Northern Ireland considered a letter should be sent to patients who received SNBTS concentrate in the period 1987 – 1989. The CJDIP had expressed concerns about the draft letter. The CJDIP had not responded further, it being Professor Ludlam's understanding that they were seeking a review of the risk assessment of blood products carried out 3 – 4 years ago, but that report was not available.	DHNI0000049_017
25 June 2002	Economics and Operational Research Division of the DH presented their report 'On vCJD Transmission Through Blood Components: Reconciling Modelled Risks With Case Evidence' to the MSBT at the meeting on 25 June 2002. This concluded that the DNV inputs on infectivity (based on the current draft of their second study (ultimately produced in February 2003) produced implausibly pessimistic scenarios.	PHEN0001791 (report)

15 August 2002	Hazel Blears announced that the NBA had been instructed to import FFP from the USA for neonates and children born after 1.1.96, and that this would be virally inactivated using Methylene Blue treatment.	DHSC0004403_165
26 September 2002	CSM made a series of recommendations about the sourcing of plasma for fractionated products including that plasma should be sourced where possible from countries with no or low risk of BSE.	MHRA0009022
30 September 2002	CMO's third meeting of the National Blood Transfusion Committee.	NHBT0009155_001
4 October 2002	The CJDIP Chairman sent the CJDIP framework document to the CMO and set out the responses it had had to the consultation exercise.	DHSC0004806_026
25 October 2002	Professor Lowe as co-director of the Scotland and Northern Ireland Haemophilia Directors Group wrote to Dr Armstrong, Scottish CMO, stating that in light of the fact that it had now been 8 months since Haemophilia Directors in Scotland and Northern Ireland had been informed that some batches of SNBTS factor concentrates were made with plasma from a donor who subsequently died from vCJD, they had agreed at a meeting on 10 October 2002 to proceed to circulate information sheets to their patients. The template letter to be sent to patients was enclosed and a potential press statement.	GGCL0000152_001 GGCL0000152_003 HCDO0000266_075
1 November 2002	Letter sent from Northern Ireland Haemophilia Centre to patients informing them that they may have received treatment from an implicated batch and asking them whether they wished to make an appointment to discuss the matter	SCGV0001012_024 DHNI0000021_048 DHNI0000021_049
26 November 2002	A number of letters were sent to both patients and to clinicians notifying them that they might have received a batch of concentrate from a donor who had subsequently been diagnosed with vCJD, and offering the patient an opportunity to discuss this at an appropriate appointment.	For example LOTH0000630_211 GGCL0000151
29 November 2002	Dr Keel, DCMO, wrote to Professor Lowe as co-director of the Scotland and Northern Ireland Haemophilia Directors Group, stating that (i) the DCMO was awaiting a response on the question of notification of patients from the CJDIP; but that (ii) if the Haemophilia Directors felt that from a clinical and professional point of view patients should be told about SNBTS concentrate used for treatment between 1987 – 1989 then they should do so, with the appropriate counselling.	GGCL0000152_004

17 December 2002	DH purchased an independent US plasma collector Life Resources Incorporated. The plasma from Life Resources would be manufactured into plasma products by the NHS at BPL.	HCDO0000266_021
February 2003	Risk Assessment of Exposure to vCJD Infectivity in Blood and Blood Products by DNV for DH. This was an update of the 1999 report.	MHRA0007248
10 April 2003	CJDIP sub-committee on the management of risks from blood products and plasma derivatives potentially contaminated with vCJD. The sub-committee recommended that the best approach would be to set a threshold of a risk estimated at 1% (0.02 ID50 units). Individuals who were above the threshold would be notified of their at risk of vCJD status. This recommendation was accepted by the full CJDIP at the meeting on 12 June 2003.	HCDO0000254_930 DHSC0020839_082
9 June 2003	Response from the CMO to CJDIP on behalf of all four CMOs regarding the Framework document. The CMOs were content with the majority of the proposals, including the proposal to contact patients potentially exposed to CJD to inform them of their exposure, and the plans to inform the blood services of the identity of the potentially exposed patients in order to ensure the safety of the blood supply.	HCDO0000108_106
22 October 2003	Expert Committee on the Microbiological Safety of Blood and Tissues for Transplantation concluded that further action such as stopping those who had received blood transfusion from giving blood was not necessary at present, but that this would need to be reviewed should a transmission by donation be discovered. The Committee also recommended that the NBA pursue a phased increase in platelet apheresis as soon as practicable, recognising that 100% target was not likely to be achievable.	NHBT0034823
December 2003	DH accepted the CJDIP proposals that all identified recipients of blood donated from donors who then went on to develop vCJD, be notified.	DHSC0020839_020

December 2003	Notification of 15 recipients of blood donated from a donor who went on to develop vCJD organised by HPA. Notification took place by the GP.	PRIU0000145
17 December 2003	Announcement in Parliament by the Secretary of State for Health, John Reid, that a patient who had received blood from a donor in 1996 who subsequently went on to develop and die from vCJD, had themselves died and was diagnosed with vCJD post-mortem. Mr Reid stated that 'it is therefore possible that the disease was transmitted from donor to recipient by blood transfusion'. This is the first report from anywhere in the world of possible transmission of vCJD from person to person via blood. A copy of this statement was sent by CMO Liam Donaldson and CMO (Wales) Dr Hall to a wide variety of medical clinicians including Medical Directors of NHS Trusts. The CMO for Scotland also wrote to clinicians informing them of this statement	HCDO0000108_005 HSSG0000014_001 LOTH0000788_110
December 2003	CJDIP Framework Document entitled 'Management of Possible exposure to CJD through medical procedures'. This document was amended from time to time, and published on the CJDIP website and the HPA website	DHSC0020839_003
2004	National Referral System instituted. This is the system that allows clinicians when reporting cases of suspect cases of vCJD to the NCJDSU and the NPC to do so simultaneously using a standard form.	Paragraph 26(d) statement of Professor Knight on behalf of NCDJSU WITN5592001
22 January 2004	Extraordinary meeting of the MSBT convened to discuss the implications for the UK Blood Services of a case of possible transmission of vCJD by blood transfusion. It was agreed that previously transfused donors (transfused after 1 January 1980) should be excluded from donating. The date was chosen on the basis that there would have been no dietary exposure to BSE in the UK before then. It was agreed that the exclusion should relate to UK transfusions only. This advice was subsequently accepted by all four devolved administrations.	NHBT0035101

7 February 2004	Hewitt, Knight, Will et al report the first presumed case of transmission of vCJD by blood transfusion in a paper published in the Lancet 'Possible transmission of variant Creutzfeldt-Jakob disease by blood transfusion'. Vol 363; 417 – 421.	NHBT0008743_013
16 March 2004	Dr Reid, Secretary of State for Health made a ministerial statement in which he accepted the recommendations of the MSBT that anyone who had received a blood transfusion of whole blood since January 1980 should be deferred from donating. This was reflected in the NBA leaflet.	DHSC0020695_173 DHSC0004555_008
17 March 2004	Letter from Dr Hall, CMO for Wales, to NHS Trust Chief Executives entitled 'Protecting the Blood Supply from variant CJD: Deferral of donors who have received a blood transfusion', This stated that any donor who had received a blood transfusion since 1980 would not be able to donate from 5 April 2004.	HSSG0000007
22 March 2004	Hilton, Ironside et al 'Prevalence of lymphoreticular prion protein accumulation in UK tissue samples'. Journal of Pathology: J Pathol 2004; 202 They found abnormal prion in 3 out of 12,674 appendix/tonsil samples, giving a prevalence of 237 per million in the study cohort. This has subsequently been referred to as the first appendix study.	NHBT0063957_002
21 April 2004	Meeting of the CJDIP Technical Sub-group to discuss notification and plasma products. Decided to adopt an 'umbrella' approach to people with haemophilia who had received British products since 1980 (the earlies date at which the British population was exposed to BSE), informing them public health measures were being taken and asking them whether they wished to know whether they had received an 'at risk' batch. Whether or not they chose to know, the need for special public health measures would be recorded in their medical notes. This advice was accepted by the CJDIP at the meeting on 10 May 2004	DHSC0004206_072 PHEN0000502
28 June 2004	Sir Robert Owen in a letter to Dr Reid, Secretary of State for Health, requested that £3m be transferred from the main vCJD Trust fund to the discretionary fund.	DHSC0004513_087

22 July 2004	Dr John Reid, Secretary of State for Health, in a written Ministerial statement announced a second probable case of vCJD transmission through a blood transfusion. He also announced an extension to the criterion for exclusion of blood donors to include previously transfused apheresis donors and donors who were unsure if they had previously had a blood transfusion since January 1980, to take effect from 2 August 2004.	DHSC0004570_019
23 July 2004	Report published by CJD Incidents Panel titled: 'vCJD and Implicated Plasma Products Notification Road Map' providing recommendations for those who should be notified of their increased risk of vCJD for public health purposes as well as notification timelines.	LOTH0000082_007
7 August 2004	Peden, Ironside et al 'Preclinical vCJD after blood transfusion in PRNP Condon 129 heterozygous patient'. Lancet vol 364. This concerned a patient who had died of a non-neurological disorder five years after receiving a blood transfusion from a donor who subsequently developed vCJD. Protein-resistant prion protein had been detected in the spleen but not in the brain.	DHSC0004215_039
11 August 2004	Letter from Dr Martian Donaghy, Clinical Director, of Scottish Centre for Infection and Environmental Health to Medical Directors, re: vCJD, Plasma Products and implicated batches, background information, actions to take and local preparations. The letter enclosed various documents including • Clinical information • Recommendations of the CJD Incidents Panel	NCRU0000206_016 NCRU0000117_016 (NHBT0031747)
7 September 2004	Letter from CJDIP to whom it may concern, setting out the recommendations of the CJDIP for the tracing and assessment of patients exposed to plasma products manufactured in the UK using donations from individuals who subsequently developed vCJD. This was accompanied by: (i) A table of all the implicated batch numbers categorised as either high, medium or low risk for vCJD public health purposes; and (ii) Clinical information.	HCDO0000647 HCDO0000649 WITN3289114
9 September 2004	Letter from UKHCDO to Haemophilia Doctors regarding the patient notification exercise, which required them to send the relevant information to their patients by 20 September 2004.	HCDO0000658

9 September 2004	Ministerial Statement by Secretary of State for Health, Dr Reid, announcing that the HPA was sending information to clinicians to enable them to trace particular plasma products. The clinicians would notify the patients identified as 'at risk' as a precaution. Contact should be made later in the month.	HCDO0000660
20 September 2004	Health Protection Agency, Scottish Centre for Infection and Environmental Health, National Public Health Service for Wales, and the Department of Social Services and Public Safety (Northern Ireland) provided a letter and information leaflet to clinicians to be sent to patients with haemophilia and other bleeding disorders informing them that all patients with bleeding disorders who had received clotting factors derived from UK-sourced plasma between 1980 – 2001 were considered 'at-risk' of vCJD for public health purposes.	NTHT0000012
September to end of Dec 2004	The HPA CJD section had carried out 1,800 risk assessments of patients who had received implicated plasma products for conditions other than PIDS or bleeding disorders. 12 patients received sufficient doses to be considered to be 'at risk for public health purposes'.	NCRU0000175_005
2 October 2004	Frosh, Collinge et al 'Analysis of 2000 consecutive UK tonsillectomy specimens for disease-related prion protein'. Lancet vol 364; 1260 – 1262.	RLIT0000727
January 2005	Publication of a report by Health Protection Agency "Notification of potential exposure to vCJD through plasma products". This provided a narrative explanation of the notification process and the various stages.	ICHT0000049
7 January 2005	Dr Reid, Secretary of State for Health, wrote to Sir Robert Owen and agreed a transfer of £3m from the main vCJD Trust fund to the discretionary fund.	DHSC0038543_118
17 June 2005	SACTTI working group on vCJD agreed that all donors who had received transfusions, irrespective of where those transfusions were received, should be deferred from giving blood.	JPAC0000061_022
20 July 2005	Written Ministerial statement by Caroline Flint, Parliamentary Under Secretary of State for DH: 110 donors whose blood was given to three patients who went on to develop vCJD (and whose donation may be the	NCRU0000117_011

	possible source of infection) were being notified of their at risk of vCJD for wider public health purposes and advised not to donate blood or tissues or organs. This notification exercise was written up by Dr Hewitt et al and published in Clinical Ethics in 2006 'vCJD Donor Notification Exercise: 2005'.	RLIT0000156
17 November 2005	Public announcement of CJDIP advice to trace the recipients of the donations from the 110 donors whose donations had been given to patients who then went on to develop vCJD.	NHBT0031729_002
2006	Primary Immunodeficiency Surveillance Study established to investigate whether those who received UK sourced immunoglobulin products between 1996 – 2000 might have been exposed to vCJD.	WITN7034001 paragraph 4(d)(ii) page 13
31 June 2006	Guidance first published "Assessment to be carried out before surgery and/or endoscopy to identify patients with, or at increased risk of, CJD or vCJD – Annexe J". Updated from time to time.	WITN3093024
21 August 2006	Hewitt et al 'Creutzfeldt-Jakob disease and blood transfusion: results of UK Transfusion Medicine Epidemiological Review Study' Vox Sanguis 2006, reporting the results of the study to 1 March 2006. As of 1 March 2006, it identified three instances of probable transfusion transmission of vCJD infection and found no evidence of transmission of other forms of CJD by blood transfusion.	NCRU0000109_092
6 September 2006	NHSBT, in liaison with the HPA, wrote to consultant haematologists in charge of hospital blood transfusion laboratories, asking them to trace individual recipients of four batches of plasma products issues by BPL in the late 1980s. These had not been included in the 2004 notification exercise as the fate of these batches could not be identified at that time.	PHEN0002376_002
November 2006	HPA and UKHCDO notified Haemophilia Directors (for the first time) and medical directors of trusts of the same four batches that were the subject of the 6 September 2006 notification exercise by NHSBT.	ABMU0000053

9 December 2006	Wroe, Hewitt, Collinge et al 'Clinical presentation and pre-mortem diagnosis of variant Creutzfeldt-Jakob disease associated with blood transfusion: a case report'. Lancet vol 368. A third patient from the group of known recipients of transfusion from donors who subsequently developed vCJD, was diagnosed with vCJD.	RLIT0000157
18 January 2007	Health Protection Agency issued a press release reporting the fourth case of vCJD transmission associated with blood transfusion.	HCDO0000131_006
28 March 2007	Report of the vCJD Clinical Governance Advisory Group chaired by Sir William Stewart whose terms of reference were to advise the CMOs of the appropriate clinical governance arrangements, including follow-up care and support, for individuals identified as 'at risk' from developing vCJD, and to advise on the appropriate monitoring of such individuals. The report made a number of recommendations with a review in a year's time.	HCDO0000902
2007	A committee was set up, independent from NCJDRSU and NPC/MRC Prion Unit, to determine access to scarce vCJD samples, Now called the 'CJD Resources Centres Oversight Committee.	WITN3733002 paragraph 55
June 2008	Closure of the Protein Fractionation Centre, Scotland.	
15 December 2008	Clewley, Ironside et al 'Prevalence of disease related prion protein in anonymous tonsil specimens in Britain: cross sectional opportunistic survey'. BMJ online. Overall 63,007 samples were screened including 32,661 obtained from people in the age range most exposed to BSE contaminated meat. The results gave a prevalence of zero per million with an upper 95% confidence limit of 289 per million among the exposed cohort and 122 per million among the unexposed cohorts.	RLIT0000715

February 2009	HPA wrote to all UK Haemophilia Centre Directors notifying them of the post mortem finding of asymptomatic vCJD in a person with haemophilia and informing them that it did not change the public health 'at risk' status of any patients. The directors were asked to write to all their patients with bleeding disorders providing information to them drafted by the HPA, and make appointments to see any concerned patients. The letter enclosed a number of documents including: • A template letter to bleeding disorder patient groups • A template letter to bleeding disorder patients • A leaflet entitled 'Patients at increased risk of variant Creutzfeldt-Jakob disease. Actions for healthcare staff'. •	WITN3289130 WITN3289131 GRAM0000124 ABMU0000040
5 February 2009	CJDIP meeting at which it was noted the CMO had accepted the panel's recommendation for a two- pronged strategy for highly transfused individuals: • Identifying highly transfused patients with 80 or more donor exposures through pre-assessment for surgery and neuro-endoscopy on high risk tissue. To start in April 2009 • Prospective notification of very highly transfused patients with more than 800 donor exposures. To start in July 2009. This had been approved by CMOs for all four nations.	NCRU0000152_060
16 February 2009	All haemophilia doctors informed of the plasma notification exercise being carried out by HPA in a letter from the UKHCDO. This letter enclosed: • A letter from HPA to all UK Haemophilia Centre Directors notifying them of the post mortem finding of asymptomatic vCJD in a person with haemophilia, informing them that it did not change the public health 'at risk' status of any patients. • A template letter for the Haemophilia Centre Directors to send to their bleeding disorder patients • A leaflet entitled 'Patients at increased risk of Creutzfeldt-Jakob disease. Actions for healthcare staff' prepared by the HPA and Health Protection Scotland • A leaflet entitled 'Patients at risk of Creutzfeldt-Jakob disease: Background Information' prepared by the HPA and Health Protection Scotland • A leaflet entitled 'Information for people who have an increased risk of CJD' prepared by the HPA and Health Protection Scotland • A leaflet entitled 'Who has an increased risk of CJD?' prepared by the HPA and Health Protection Scotland.	CVHB0000011_015

17 February 2009	HPA press release 'vCJD abnormal prion protein found in a patient with haemophilia at post mortem'.	ABHB0000189
18 February 2009	BMJ reported that a post mortem carried out on a person with haemophilia who had been treated with plasma products, found the abnormal prion protein for Creutzfeldt-Jakob disease in his spleen. This was the first time the vCJD agent had been found in a person with haemophilia or anyone treated with a plasma product. This was later reported in an article written by Peden et al entitled 'Variant CJD infection in the spleen of a neurologically asymptomatic UK adult patient with haemophilia' in Haemophilia' in 2010.	RLIT0000731 HCDO0000799
28 April 2009	SaBTO advised that the UK Blood services should provide a double dose of red cell for children and/or multi-transfused patients on the basis that it reduced the risk of transmission of vCJD by 50%.	RLIT0000733
14 July 2009	SaBTO recommended that the UK Blood services should move as far as possible towards 100% apheresis platelets, but that as a minimum 80% of platelets should be collected by apheresis.	RLIT0000734
July 2009	Health Protection Scotland and NHS Services Scotland wrote to the Chief Executives of NHS Boards of the change to Annexe J, which now required patients due to have 'high risk surgery' or neuro-endoscopy to be asked if they had received transfusions of blood or blood components from 80 or more donors since 1980. This was because these highly transfused patients were at an increased risk for vCJD and special infection control precautions should be followed. The information should be marked on the patient's records and the patient would need to be told via HPS or their GP. The pre-surgical highly transfused vCJD risk assessment form Information for healthcare staff carrying out this assessment	RLIT0001222 LOTH0000563 LOTH0000564
2010	Modelling performed by Garske & Ghani in a paper entitled 'Uncertainty in the tail of the variant Creutzfeldt-Jakob disease epidemic' in which they estimated the future numbers of vCJD cases from 2010 – 2179 (table 3)	WITN7034008

	Total vCJD cases: 390 [95% Credibility Interval: 84-3000] Total MM: 200 [20-2200] Total MV: 160 [4-980] Total VV: 13 [0-85] Identifiable blood cases: Total:17 [1-220] MM:12 [0-160] MV: 4 [0-57] VV: 0 [0-5]	
3 February 2011	Collinge, Mead et al 'Detection of prion infection in variant Creutzfeldt-Jakob disease: a blood-based assay'. Lancet 377; 487-93 Their initial findings provided a prototype blood-based test for diagnosis of vCJD in symptomatic individuals which could allow development of large-scale screening tests for asymptomatic vCJD prion infection. This blood test is known as the Direct Detection Assay or DDA.	NHBT0033626
31 March 2011	SEAC abolished.	
14 July 2011	ACDP TSE risk assessment sub group meeting at which the group considered how best to assess the number of vCJD cases that might be transmitted by blood. The group agreed to calibrate the transmission models against up to 10 blood borne vCJD cases. One of the actions from the meeting was for the DH analysts to produce a short self-contained note setting out the arguments and calculations of the estimation of risks of vCJD infection. This was produced on 31 August 2011 by Peter Burnett.	DHSC5235271 PHEN0000600
2011	Zaman et al 'The risk of variant Creutzfeldt-Jakob disease among UK patients with bleeding disorders, known to have received potentially contaminated plasma products' Haemophilia.	WITN0644101
24 January 2013	Letter from the HPA to UKHCDO informing them of the re-assessment of vCJD risk from UK produced plasma products, which had led to the recommendation that individuals who had received Factor VIII and Factor IX between 1990 and 2001 should remain notified as 'at increased risk of vCJD for public	WITN3775004

	health purposes' but those who only received plasma products between 1980 and 1989 should now have their treatment history re-assessed to confirm this fact and if confirmed, should be de-notified.	
14 February 2013	vCJD and transfusion of blood components: An updated risk assessment by Peter Burnett and Maren Daraktchiev of DH. This estimated the number of infections in the coming decades based on a variety of scenarios. The central estimate for the number of future transmissions: • by red cell transfusion was roughly 160 with a range of 30 – 460. • By FFP was roughly 40 – 50 with a range running up to 120.	NCRU0000197_038
31 March 2013	Dissolution of CJD Incident Panel.	
25 April 2013	UKHCDO provided guidelines and a draft letter to Haemophilia clinicians to provide to their patients about the de-notification process.	LGFT0000020
15 October 2013	Gill, Ironside, Mead et al 'Prevalent abnormal prion protein in human appendixes after bovine spongiform encephalopathy epizootic: large scale survey'. BMJ 2013; 347. Of the 32,441 appendix samples in the study, 16 were positive for abnormal PrP, indicating an overall prevalence of 493 per million population (95% confidence interval 282 to 801 per million). This is the second appendix study.	PRIU0000069
2013	In 2013 the pre-surgical CJD risk assessment was revised so that it only patients who had more than 300 donor exposures were to be considered at risk for public health purposes. As a result of this some patients who had been notified pursuant to the 2009 risk assessment (which applied to patients who had had more than 80 donor exposures), were de-notified	WITN7091001 paragraph104 WITN7091009
24 July 2014	The House of Commons Science and Technology Committee published its report 'After the Storm? UK blood safety and the risk of variant Creutzfeldt-Jakob Disease'. This concluded by recommending that the Government take a more precautionary approach to both vCJD risk mitigation and blood safety more generally, and that it should begin by commissioning a full assessment of the key risks, known and	WITN3733002

	unknown, that the UK blood supply currently faces and might face in the future so that it could identify and fill relevant knowledge gaps and support the development of appropriate risk reduction measures and technologies.	
28 December 2015	Will, Hewitt et al 'Creutzfeldt-Jakob disease and blood transfusion: Updated results of the Transfusion Medicine Epidemiology Review Study'. Vox Sanguis (2016) 100, 310 – 316. The vCJD arm of the study found 18 vCJD blood donors who had donated blood which was issued for clinical use. To date 3 cases of vCJD had occurred in 67 recipients identified in the recipient group, with one recipient being identified post mortem. The data also showed no new cases of transfusion associated vCJD since 2007.	NCRU0000109_082
2016	The last known UK case of vCJD was reported	WITN7034001 para 4(a)(ii))page 6)
21 December 2016	Bougard D et al, in an article published in Science Translational Medicine (3701a 182) entitled 'Detection of prions in the plasma of pre-symptomatic and symptomatic patients with variant Creutzfeldt-Jakob disease' reported that a diagnostic assay allowed the detection of silent carriage of prions a few years before clinical onset in two samples.	WITN5592004
30 March 2020	Gill, Sinka, Mead, Ironside et al 'Prevalence in Britain of abnormal prion protein in human appendices before and after exposure to the cattle BSE epizootic' (the third appendix study). Acta Neuropathologica (2020) 139: 965-976 Seven appendices were positive for abnormal PrP out of 29,516 samples. None of the seven positive samples were from appendices removed before 1977, or in patients born after 2000 and none came from individuals diagnosed with vCJD.	WITN7034009 Or RLIT0000725

8 October 2020	Commission on Human Medicines (CHM) concluded that the risk of vCJD cases arising from the use of UK plasma for the manufacture of immunoglobulin medicinal products would be negligible as reflected in the report produced by the MHRA and Medicines & Healthcare products Regulatory Agency 'Use of UK Plasma for the manufacture of immunoglobulins and vCJD risk: Critical Risk Assessment Report'.	WITN7034044