Wednesday, 21 September 2022

(10.00 am)

SIR BRIAN LANGSTAFF: Yes, Mr Boukraa.

Presentation by Counsel to the Inquiry about government decision-making and the response of government in Scotland

MR BOUKRAA: Sir, we are turning today to Scottish Government decision making focusing on the period from the 1970s to about the early 1990s. I am going to start with a handful of introductory points, most of which will be familiar to those who have followed previous Inquiry presentations, this oral presentation accompanies a written note which has now been disclosed on the Inquiry website. The written note, as will be obvious to those who have seen it, is lengthy and it covers a large number of documents which were available on Relativity. I certainly won't be covering every document or issue that are contained in the written note today.

I should also say, as I have said before in presentations, that whilst the written note is lengthy, it doesn't purport to address every relevant document. No doubt there will be further documents and points brought to your attention by core participants and legal representatives in due course.

The Inquiry team also intends to disclose a much

shorter addendum note on a particular issue that I'll touch on later today. It relates to the hepatitis waiver or the waiver that applied in Scotland in the context of the HIV Haemophilia Litigation and, in particular, whether that waiver covered only hepatitis -- sorry, only HIV or both HIV and hepatitis. I'll come back to that later on today, sir, but we also intend to disclose a short addendum note addressing it.

In terms of witness evidence on Scottish Government decision making, the Inquiry has already heard from Duncan Macniven and Lord Forsyth, but the Inquiry is also obtaining a further witness statement from a further Scottish Government official, Mr John Davies, who was a senior official in the Scottish Home and Health Department between 1983 and 1985. We will see his name appear on a number of documents relating to AIDS in particular during the course of today. The Inquiry is in the process of obtaining that statement and it should be available shortly, both a written note and what I say orally will fall to be considered alongside that statement and Mr Davies's evidence.

Now, the structure of the rest of today will broadly follow the structure of the written note for those who are following it. I should flag that one

topic I intend to miss out more or less completely today is self-sufficiency and supply of blood products.

Now, that topic was of course considered in some detail in the March hearings. The written note adds some further detail on the involvement of Scottish Government decision-makers. They looked at very similar issues and a similar chronology to the material considered in March. The evidence that's available is in the written notes and I'll be focusing on other topics today.

Finally, on terminology, much of the material that we're going to be looking at today concerns the Scottish Home and Health Department, the SHHD, which is a bit of a mouthful sometimes. I'll occasionally refer to it as the HHD, occasionally as "the Department". I will try to make it clear when I'm contrasting it with the equivalent department in England and Wales, the DHSS or the Department of Health.

I'm going to move now, sir, to the structure and organisation of the HHD and the Scottish Office relatively briefly and its relationship with other bodies.

It will be apparent from the written note that the sources we rely on to outline the structure and organisation of the HHD and its position within the

Scottish Office mainly involved witness evidence. That includes witnesses who gave evidence to the Penrose Inquiry and witnesses to this Inquiry, such as Duncan Macniven. The note also makes reference to a document created during the course of the Penrose Inquiry which summarises the structure of the HHD in the 1980s, lists the names and titles of number of officials and ministers, and that's a document which is set out in the written note.

Now, that and a significant part of the available witness evidence focuses on the 1980s but many of the key features of the way in which the Department was structured also apply to the 1970s.

Now, as the witnesses we have heard from in this Inquiry have noted, during the 1970s and 1980s, the Scottish Office was of course part of the wider UK Government. It was headed by a Secretary of State for Scotland, beneath whom were a number of more junior ministers.

Now, that Secretary of State for Scotland was a member of Cabinet, but there were a number of areas in which decision making, policy and decision making, was devolved and fell to Scottish Office ministers and officials. Health, including blood services, was one of them. One of the issues we'll look at further during

the course of today is the relationship between those decisions taken in Scotland and the wider UK Government.

Now, the Scottish Office itself was divided into a number of departments, one of which was the HHD. Each department reported to one or more junior ministers and through the junior minister to the Secretary of State. The junior minister with responsibility for Health could be a parliamentary under-secretary of state or a Minister of State. The ministerial responsibilities were allocated by the Secretary of State for Scotland.

As with the DHSS, the HHD had a dual hierarchy of officials, on one side were administrative officials, on the other were medical officials. Both contributed to advice to ministers.

A very brief summary of the administrative structure: the hierarchy of administrative officials in the HHD was headed by the HHD secretary, who reported to the Scottish Office Permanent Secretary. Beneath the HHD Secretary were under-secretaries, then an assistant secretary, occasionally called the senior principal, underneath the assistant secretary, senior executive officers, sometimes referred to as principals.

Departments in the Scottish Office were divided into groups, each one was headed by an under-secretary. Each group was divided into several divisions. At the

head of the division was an assistant secretary and, generally speaking, groups were referred to by a Roman numeral, followed by a letter, sometimes the particular Roman numeral and the particular letter changed over the course of years. Divisions were then generally divided into branches and at the head of a branch was a Senior Executive Officer.

On the medical side, the hierarchy of medical officials was headed by the Chief Medical Officer for Scotland, the CMO, beneath whom were deputy chief medical officers, DCMOs, principal medical officers, senior medical officers and medical officers.

Until 1974 the HHD had one DCMO to whom principal medical officer reported. In 1974 a second DCMO post was created and the two individuals who were in post from the mid-1970s in that period were Dr Iain Macdonald, Dr Graham Scott. We'll see their names appear in a number of documents we look at today. In 1985, Dr Macdonald was appointed CMO and the hierarchy beneath him reverted to just one DCMO.

Now, the principal medical officer from 1977 to the early 1990s was Dr Archibald McIntyre. That's a name that will appear a number of times today. The senior medical officer with responsibility for blood services from around 1973 to 1985 was Dr Albert Bell.

We'll see him appear a number of times today, as we will with Dr John Forrester who replaced Dr Bell in 1985 until 1988.

Now, the CMO in Scotland and DCMOs had a wide range of responsibilities. Dr Macdonald, in giving evidence to the Penrose Inquiry, described two practices which he said were intended to keep the CMO and the DCMO aware of the work of the medical staff beneath them. The first one was a meeting every Monday morning, which was chaired by the CMO or a DCMO, attended by PMOs heading each of the groups, principal medical officers. He said these were quite informal meetings. No notes were taken.

The second mechanism was a monthly report written by senior medical officers and medical officers which were generally known I think as PMO reports, principal medical officer reports, which set out the issues and the activities medical officials had been involved in during that month. Dr Macdonald's evidence by the time of the Penrose Inquiry is unfortunately those reports were no longer available. That remains the case today, although we will occasionally see documents which seem to have been intended to contribute to PMO reports.

One of the issues that was explored in witness evidence we've heard previously in this Inquiry with

Mr Macniven and Lord Forsyth was the relationship between ministers and officials in the HHD and the wider Scottish Office, in particular how it was decided whether or not an issue should be put to a minister for a decision or to inform them about an issue.

I'm not going to repeat that evidence that's already been given. The thrust of it was there were no set criteria and it was a matter of judgment for the officials to decide when to put the issue to ministers.

I am going to highlight a paragraph in written evidence to the Penrose Inquiry which casts some further light on this evidence, it comes from the statement of Alexander Murray and, Lawrence, if we could please have PRSE0002440.

This is the statement of Alexander Murray for the Penrose Inquiry. It was on the topic of HIV testing. Mr Murray was a senior executive officer in the HHD between 1983 and 1987. This statement was considering in particular the introduction of HIV testing but there's a section that's of more general relevance for our purposes.

So if we could go to page 4, please. Then the third paragraph. That's great, thank you.

So the first sentence refers to the evaluation programme relating to the introduction of HIV testing,

but Mr Murray goes on to describe --
SIR BRIAN LANGSTAFF: Well, can you help with that, because much depends on timing in respect of this, what is meant by "at this stage"? Can you link that back for us, please, to what he says earlier.
MR BOUKRAA: I believe he's referring to the timing of the decision to put this issue to Scottish Office ministers in the first few months of 1985, and how officials went about deciding --
SIR BRIAN LANGSTAFF: Well, can you be any more precise about that?
MR BOUKRAA: That's -- sir, I will -- if I may, I might come back to being a bit more precise about that.
SIR BRIAN LANGSTAFF: The reason for my asking is this: the idea of evaluating appears to have arisen initially in January 1985 with the DHSS. It is not entirely clear when it was taken forward, but it would have been some time between mid-January and early February, in the DHSS.

It would appear from what is said in this statement that the Scottish ministers were not notified in advance that there would be an evaluation programme and therefore weren't in a position, if they had wished to do so, to challenge it and say, "Well, why are we evaluating? Why don't we get on with it?" Or whatever

might have crossed their minds. And that's why I'm so interested in the precise date.
MR BOUKRAA: Sir, I can quite see why you're interested in the precise date. I'm going to come back to the introduction of HIV screening --
SIR BRIAN LANGSTAFF: It's not -- if you can't answer it off the top then better a considered answer in due course.
MR BOUKRAA: Thank you, sir. I could try to give you an answer off the top but it would be a bit too rough and ready and I will make sure that I have a more precise date to give you linking to this paragraph when we get to the introduction of HIV screening later on today.
SIR BRIAN LANGSTAFF: Thank you.
MR BOUKRAA: Sir, we can see, in this paragraph that's highlighted here, Mr Murray describing the sorts of factors which might lead to a minister being involved directly in an issue, and he says:

"An issue like this would normally be brought to Ministers' attention in the following circumstances: to keep Ministers aware of important current developments; if something was going to appear in the media; if a decision had to be made which officials considered only Ministers can make; if an interdepartmental dispute needed to be resolved; to bring together, in an overview submission, a number of issues affecting multiple

divisions within a Department, or multiple Departments; or where developments in Scotland affected UK Departments and vice versa. When a Department considered an issue was of such importance that the final decision required to be made by the Secretary of State, the submission would be in the form of going first to the junior Minister concerned and then to the Secretary of State."

As we go during the course of today to submissions which were put to ministers in the HHD, we will come across some of those circumstances.
SIR BRIAN LANGSTAFF: There's an element of circularity, is there, about those reasons. As you say, it's a matter of judgment, but keeping ministers aware of important current developments demands someone considering that there is, first of all, a development. Secondly, it's a current development. But, thirdly, it's important. Those are all matters which each of them in turn, to a greater or lesser extent, involve a judgment. Then if something is going to appear in the media, that speaks for itself.

But a decision had to -- the next one:

"... if a decision had to be made which officials considered only Ministers could make ..."

It's exactly the same, isn't it? You are sending

something to a minister which a minister should decide. Well, that's a question of judgment again, isn't it?
MR BOUKRAA: That's exactly right, sir, yes. Yes.

A number of these factors come back, as you just said, to a question of judgment. They're consistent with what, for example, Mr Macniven said. They don't give us a precise answer. They don't give us a set of criteria by which that judgment was evaluated. Some of them are perhaps a bit more hard edged, like something appearing in the media, but you're absolutely right, sir, that many of them come back to the matter of the official's judgement.
SIR BRIAN LANGSTAFF: I mean, I suspect that, as with most matters of judgment, generally most people would agree, but it doesn't answer the point, really, it doesn't provide a specific objective criterion beyond what is set out.
MR BOUKRAA: That's absolutely right, sir, yes.
SIR BRIAN LANGSTAFF: Thank you.
MR BOUKRAA: We can take that down now. Thanks, Lawrence.

Now, the nature of the relationship between the Scottish Office and the wider UK Government, more particularly between the HHD and the DHSS, or later the Department of Health, is an important aspect of our understanding of HHD decision making in this period.

The written note records at a more general level some of the different ways in which that relationship has been described by witnesses both to this Inquiry and to the Penrose Inquiry. There might be said to be contrasts that can be drawn between those descriptions or at least differences in emphasis between them. For example, the note records Dr Macdonald's evidence to the Penrose Inquiry, when Dr Macdonald said that on major policy matters the DHSS will have been expected to take the lead, and other departments, such as the HHD, will have been expected to fit their policy around the lead of the DHSS.

He put it another way when he said that the DHSS would be expected to take the lead and then other departments would implement a common policy, subject to a modest degree of adaptation informed by local circumstances.

Now, those comments should be considered alongside other evidence, such as that of Mr Macniven. Mr Macniven commented that, as a matter of good administration, the HHD and the DHSS will have kept each other in touch with developments in one country that might affect the other, but he described the Health Service in Scotland as being entirely devolved to the Secretary of State for Scotland and through him to

the HHD, emphasised that the DHSS had no oversight role.

Similarly, Lord Forsyth, whilst stating that there were occasions on which he felt that the DHSS or the wider UK Government hadn't consulted sufficiently with the Scottish Office, said that, broadly speaking, every Secretary of State for Scotland used to say that they were Scotland's person in the Cabinet, not the Cabinet's person in Scotland.

Now, that is really just a broad brush overview picture of this issue. Sir, you may wish to consider it and may well hear submissions on how that relationship operated in the context of particular issues, for example the introduction of hepatitis C screening.

Now, the written note also seeks to summarise evidence relating to the HHD's relationships with other bodies such as the Common Services Agency and the SNBTS. I'm not going to go very much further into that now. One of the issues that arises in that context is the extent to which there were difficulties or tension in the relationship between the HHD and the SNBTS, particularly Professor Cash, the extent to which such difficulties may have affected decision making. It was explored in witness evidence to some extent, for example, with Mr Macniven. The written note contains some documents, some of which suggest strains in the

relationship at points but there is more detail, as I say, in the written note.

I'm going to turn now, sir, to a different topic, which is Home and Health Department knowledge and decision making in relation to hepatitis B and, in particular, issues relating to the screening of blood donations for the virus.

Most of the available documents on this issue relate to the position in the 1970s. There was some evidence available of the HHD's understanding of hepatitis B in the 1960s. I'm going to highlight one of those documents now.

Lawrence, could we please have SCGV0000279_165.

Now, this is a letter that we can see, from the date in the top right-hand corner, that was sent on 27 September 1968. The letter heading at the top is the Scottish Home and Health Department.

If we could just go through, please, Lawrence, to the second page for a moment, we can see the signature at the bottom of the page. It comes from the Chief Medical Officer in Scotland at that time, Dr Brotherston.

If we go back, please, to the top of the letter, it's addressed to "Dear Doctor".

If we go, please, Lawrence to the bottom of this

page, we can see who Dr Brotherston meant, "Medical Officers of Health, General Medical Practitioners".

Back up, please, again to the first paragraph. We can see the reason why this letter was being sent. Dr Brotherston says that:

"From 1st October, 1968 effective jaundice and measles will be generally notifiable the Public Health (Infectious Diseases)(Scotland) Amendment Regulations 1968".

The third paragraph makes it a little bit clearer why this letter is being sent:

"The principal object of making all forms of infective jaundice generally notifiable is to enable Medical Officers of Health to enquire into the epidemiological background."

SIR BRIAN LANGSTAFF: Infective jaundice was not serum -- necessarily serum hepatitis.

MR BOUKRAA: What we see in the next two paragraphs I'm going to take you to, sir, is Dr Brotherston seems to use the term "infective jaundice" to cover both what we understand becomes hepatitis A and also serum hepatitis, hepatitis B.

So in the fourth paragraph that begins "The majority", it says:

"The majority of cases of infective jaundice

notified under the new Regulations are likely to be due to infective hepatitis, which is a common condition believed to be of increasing" --

SIR BRIAN LANGSTAFF: That's what he deals with above. That's not serum hepatitis.

MR BOUKRAA: It's not, sir, no.

SIR BRIAN LANGSTAFF: Then if we go to -- what is of interest to us is the last paragraph, is it?

MR BOUKRAA: It's the next paragraph, yes. It's not quite the last one because there are more below that. So he starts with what becomes hepatitis A. He then moves to serum hepatitis, which is what is of interest to us, and he says this -- I just wanted to highlight the first few sentences in this:

"Serum hepatitis occurs less frequently than infective hepatitis. It's potentially a more serious condition with a longer incubation period of usually, 60-160 days. Transmission is almost invariably by a parenteral route and a history of a blood transfusion, or of an injection by any parenteral route, within the incubation period may suggest this diagnosis."

Then in the last sentence of this paragraph he refers to:

"Outbreaks both of infective hepatitis and serum hepatitis have been reported from a number of units

undertaking intermittent haemodialysis for the treatment of chronic renal failure."

We'll come back to points at which that sort of issue comes up in the early 1970s.

So that's a document -- relatively brief but at least makes some reference to the HHD's understanding of serum hepatitis in the late 1960s.

We move forward to the early 1970s, and what we see in the available documents is the HHD becoming involved in debates amongst regional transfusion directors in Scotland over the introduction of screening of blood donations for Australia antigen, for serum hepatitis, what becomes known as hepatitis B screening.

We can see evidence of the debate that takes place around this time. In June 1970 a meeting takes place on that date to discuss a policy which might be recommended on the use of Australia antigen screening of blood donations. The detail is in the written note.

That meeting took place at around the same time as an outbreak of hepatitis in Edinburgh, which was in a renal unit, a haemodialysis unit.

That meeting at which this issue was discussed was attended by transfusion directors and the HHD, including Dr Macdonald.

The note of the meeting which we have records that

prior to the Edinburgh outbreak, Scottish transfusion directors had felt that the time was not yet right for the screening of blood. Their position begins to change around this time, and there seems to be a view that screening should be introduced, at least for high risk patients, such as those undergoing dialysis, but they say it wouldn't yet be feasible to screen larger quantities of blood for other emergency use.

We do see in the documents around this time, mid-1970, certain Regional Transfusion Directors in Scotland emphasising the risk posed by serum hepatitis and pressing the HHD to support a more general introduction of screening at an earlier date. We see that in particular in correspondence from the director of the Glasgow and West of Scotland RTC, Dr Wallace, and we're going to come back at various points to correspondence involving Dr Wallace.

One of those, which is just summarised in the written note, which I won't go to now, but is of interest, is a 16 July 1970 letter written by Dr Wallace to Dr Macdonald at the HHD, which attached a paper on serum hepatitis and the Blood Transfusion Service.

Now, it was directed in particular at issues relating to renal dialysis and it contains some material that is of wider relevance for our purposes.

A couple of points to highlight in particular from that document -- and we can take that down now, please, Lawrence -- that paper provided by Dr Wallace said that for the past 30 years, so this is 1970, for the past 30 years, homologous serum jaundice, serum hepatitis, has been recognised as a delayed complication of the transfusion of blood and blood products.

Dr Wallace also recorded that the highest incidence of serum hepatitis had been observed in recipients of plasma prepared during World War II. He said that was not surprising because it was not uncommon to prepare a plasma pool from 500 donations of blood.

So we see there Dr Wallace making a link between hepatitis risks and pool sizes and providing that information to the HHD.

There was a further letter from Dr Wallace to the HHD in August of 1970 in which he begins to press more strongly for the screening of all donations for Australia antigen. One of the comments he makes is that even if this mass screening only reduces the incidence of serum hepatitis by 25%, it would still be a significant reduction in the incidence of what can be a serious illness:

"In the present climate, I think the SNBTS must be seen to be doing everything possible to reduce this

serious transfusion risk."

Now, by this time, which is around mid-1970, the introduction of Australia antigen was also being considered by the DHSS.

In September 1970, a new group was set up, the advisory group on testing for the presence of Australia hepatitis associated antigen and its antibody, chaired by Dr Maycock, becomes known as the Maycock Advisory Group. It was appointed jointly by the DHSS, the HHD, and the Welsh Office. Dr Wallace was one of its members.

Now, the work of that group has been considered by the Inquiry on previous occasions. I'm not going to go in detail into its development and what it found, but its work relates to the HHD's understanding and response to hepatitis risks during this period.

It seems that the HHD was aware in the early 1970s, so around 1970, 1971, that Scottish RTCs, Regional Transfusion Centres, were taking different approaches to screening, both in the extent of screening they were undertaking and in the technique they were using for screening.

If we move forward to May 1972, the Maycock Group publishes, issues a report, which recommends the introduction of routine testing of all blood donations

for Australia antigen and its antibody, recommends a number of different testing methods.

I'm going to keep moving forward to 1973, when the HHD becomes more closely involved in discussions about the appropriateness of different screening techniques for serum hepatitis. So rather than the principle of whether or not to screen or have mass screening, the appropriateness of different techniques.

Now, this was an issue being considered by the Maycock Group --

SIR BRIAN LANGSTAFF: By now, by 1973, there was general screening.

MR BOUKRAA: Yes.

SIR BRIAN LANGSTAFF: So the question then is: what form of screening are you having?

MR BOUKRAA: Exactly, sir, yes. When I refer to screening techniques, what I mean is the debates about exactly that, sir, the form of screening technique which is --

SIR BRIAN LANGSTAFF: Yes.

MR BOUKRAA: -- appropriate.

Now this issue which is being considered by the Maycock Group, the form of screening which is appropriate, is also being raised in correspondence again between Dr Wallace and the HHD, which provides us some insight into what the HHD -- what information it

had and what its thinking was at the time.

There's a series of documents, which I'm not going to go into the detail of now, which is summarised in the written note, which begin in February 1973. They are about a trial that Dr Wallace began of a newer technique, radioimmunoassay, sometimes referred to as RIA, which was more sensitive and more expensive than the method then being used by his RTC, the electrophoretic method.

We can see that Dr Wallace writes to the HHD effectively to say that in order to be able to undertake this trial, he would get some equipment loaned free of charge from Abbott Laboratories. He would need to purchase some reagents in order to undertake the trial. He asks for the HHD's agreement, the additional funding that would be necessary for that trial to take place. The HHD agrees.

I mention that correspondence, which is from February 1973, because it forms the background to some later developments and, in particular, to disagreements which emerge later on between the HHD and Dr Wallace about the appropriateness of different screening methods.

Now we're moving closer to that by going forward to the mid-1970s, the period from 1975. The HHD's

involvement in debates over screening techniques intensifies. That debate is taking place in the context of the Maycock Group preparing a further report. The documents show that the HHD received a draft version of the Maycock Group's updated report in around February 1975. It discussed that draft report internally, discussed it with the SNBTS over subsequent months, and provided comments to the Maycock Group.

I want to highlight two internal HHD documents from around this time which touch briefly on the Department's understanding of its role in this issue, and also its views on screening.

The first, please, Lawrence, is SCGV0000205_085.

Now, if we can -- if you could zoom out slightly so we can see the whole document, we can see that this is an internal minute which is from Dr Scott. It's dated 1 May 1975. It's addressed to Mr Roberts and Dr McIntyre in the HHD. The subject is "Hepatitis B surface antigen testing".

Now if you could please zoom in on the top half of the page, thank you.

Dr Scott says this, he refers to the NMD, the National Medical Director, which at the time was Major General Jeffrey, has asked if Dr Wallace and presumably the other RTDs who wish to use RPH, reverse

passive haemagglutination, one of the screening methods for screening hepatitis, can go ahead now in anticipation of Maycock to introduce the test in place a CIEOP which was the technique then generally in use, counterimmunoelectrophoresis.

SIR BRIAN LANGSTAFF: Osmophoresis.

MR BOUKRAA: Osmophoresis, thank you, sir.

If we move down to the paragraph that begins "I have no qualms" Dr Scott says:

"I have no qualms about anticipating the Maycock report as I wonder if we could in any case stop a [Regional Transfusion Director] who 50 to do RPH now or indeed RIA. It is to a great extent a clinical matter; similarly, we cannot force Dr Cash and the others to adopt RPH in place of PH."

PH is passive haemagglutination. Dr Cash, in the Edinburgh Regional Transfusion Centre, was using a version of passive haemagglutination at the time.

He then goes on to say:

"There is a question of money but that would be up top the NMD. However this is a matter of such importance I should have thought that the money must be found."

Now that's one perspective from Dr Scott at the time on what the Department's role was in decisions

around the introduction of different screening techniques in RTCs in Scotland.

If we go next, please, to PRSE0000704.

This is Dr McIntyre in the same series of minutes providing his perspective.

So we can see it is dated 13 May 1975. It's from Dr McIntyre to Dr Scott on the same issue.

I'll just read out the first sentence.

Dr McIntyre says:

"There is no doubt that the Advisory Group will recommend reverse passive haemagglutination (RPH) for routine screening of blood for HBsAg. It is also likely that following representation from this Department the passive inhibition agglutination test will be accepted as being perfectly satisfactory for the detection of the antigen."

What that sentence provides us some insight into is the Department's role in commenting on the draft Maycock report before it was circulated more widely.

Dr McIntyre says:

"From the draft text of the report it would appear that they are approximately equally sensitive. There would seem, therefore, to be no reason why a gradual change should not be made at an early date to one or other of the more sensitive methods."

Now on to the next paragraph, Dr McIntyre says that:

"This subject will be sure to come up at the Scottish Transfusion Directors' meeting on 11 June and if the NMD [National Medical Director] knew in advance that we were agreeable in principle to the introduction of a more sensitive test he could perhaps ask the Directors to come prepared to discuss at that meeting the test they were likely to adopt and the financial implications thereof. I agree that the question of money will be up to the NMD but I feel sure that he will eventually come to us for additional money for this purpose."

So we can see there officials discussing the different screening tests they consider to be acceptable, also linking decisions around the introduction of those tests to the question of funding which ultimately comes from the Department.

Now, the updated Maycock report which is discussed in these minutes is eventually finalised in September 1975. That report says that the CIEOP method is no longer recommended. It recommends replacing it with RPH or PH. It also discusses the RIA method, which it says has some extra sensitivity, but that advantage is outweighed by disadvantages, in particular that it is

more expensive and more difficult to perform.

Now, those recommendations come to be discussed at a December 1975 meeting of SNBTS directors. Important to note when looking at the minutes of that meeting that Dr Wallace who is there emphasises that the recommendations in the Maycock updated report were drafted in early 1975. In other words, suggesting that there was a possibility that they were becoming out of date by the time we get to directors considering and accepting them.

Now, by the time we get to March 1976 it seems that recommendations in the Maycock updated report had been implemented in Scottish RTCs and that the HHD was aware of that. Then we get to the summer of 1976 and by this time differences have begun to emerge between Dr Wallace and the HHD about the appropriateness of the different techniques which had been covered by the Maycock report.

Those differences related in particular to whether funding should be provided for RIA screening, which is a more sensitive method. I'm going to quickly go to a document in which Dr Wallace set out his position in this issue to the Department.

It's PRSE0000964.

That's a 22 June 1976 letter to Dr McIntyre at the

Home and Health Department. We can see at the top of this document it comes from the Glasgow and the West of Scotland Blood Transfusion Service. On the left-hand side at the top, the regional director is Dr Wallace. And if we go just very briefly to the end of the document, we'll see that it's signed by the Regional Director, in other words Dr Wallace.

If we could go back, please, Lawrence, to the first page. This letter is headed "Total Screening of Donations for HBsAg".

I'm not going to read them out, but in the first paragraph Dr Wallace describes some of the work undertaken by the Maycock Group. In the second paragraph he says to Dr McIntyre:

"You attended meetings of the Central Advisory Group under the chairmanship of Dr Maycock on the testing of donations for HBsAg. The views of the members of the Advisory Group were similar to those reported by the special WHO group on the same subject. It was acknowledged that radioimmunoassay (RIA) was the most sensitive method available for the detection of HBsAg but in practical terms both expert groups recommended the reverse passive haemagglutination (RPHA) should be introduced as the method of total screening because RPHA could be introduced much more rapidly than

the more sophisticated RIA technique."

So that's Dr Wallace describing the reasons as he understood them for the Maycock Group's recommendations.

He then goes on at the bottom of this page to describe some of his own involvement. He says:

"As a member of the Advisory Group I was aware of the views of the members and I decided to continue my original work within the limits of the finance available."

So that's the work he's undertaking to test different screening methods and to compare their sensitivity. He says:

"I discussed the possibility of a further evaluation of RIA with Abbott Laboratories which is the only firm currently producing reliable reagents for the performance of RIA testing for HBsAg. I had sufficient money available to produce reagents for RPHA testing and Abbott Laboratories agreed to provide me with all the facilities for RIA testing for a period of one year at the same cost as would have been incurred by producing reagents for the RPHA."

If we go over the page, to the top couple of paragraphs. Thank you.

Dr Wallace describes the trials that he has been undertaking and their results. He says:

"This proposal was discussed with General Jeffrey and he agreed that it would be a valuable exercise in respect of (a) the feasibility of total available screening by RIA and (b) the comparative sensitivity of RIA and of RPHA. The exercise was started in the middle of August, 1975 and is due to end in the middle of August, 1976."

He then summarises some of the key findings of his trial to date. He says:

"During the first nine months of the exercise a total of 99,911 donations were tested and 36 examples of confirmed HBsAg positive donors were found."

If we then go down into the paragraph that begins "Of these 36 examples". Thank you.

Dr Wallace says:

"Of these 36 examples of HBsAg, only 13 were detectable by IBOP and only 24 were easily detectable by RPHA. Another 5 specimens gave doubtful positive reactions by RPHA. This means that if we had been relying on RPHA for total screening we would have missed, in the period of 9 months, at least 7 examples of HBsAg positive donations and perhaps as many as 12."

If we go down, please, Lawrence to the final paragraph on this page, Dr Wallace says:

"There is, in my opinion, substantial evidence in

favour of total screening by RIA rather than by RPHA."

In the remainder of the letter he sets out the additional money that would be needed in order for that to be able to take place and we can just go to the last paragraph of this letter. We have what would appear to be Dr Wallace referring to the possibility of litigation if his proposal, which is to continue with RIA testing, is not accepted. He says:

"I have not, at this stage, informed either the Scottish Legal Office or my own Defence Society of the position because I am hoping that something can still be done to maintain a sensitive method of testing donations. If by the middle of August we are obliged for financial reasons to adopt a less sensitive method of testing then clearly I will have to inform these bodies ..."

Now, this letter from Dr Wallace was considered in a number of internal Home and Health Department minutes, which provide some insight into the Department's thinking. They are summarised in the written note.

We can take that away now, thank you, Lawrence, and go instead to one of the internal HHD minutes which discusses this letter from Dr Wallace.

It is SCGV0000205_037.

If we could go to the second page, please, of this

document. Thank you.

So this is a minute dated 25 June 1976 from Dr McCreadie in the Department to Dr Scott and Dr McIntyre. In the first sentence he refers to Dr Wallace's letter. He summarises in that first paragraph Dr Wallace's view. He then says this in the second paragraph:

"This brings us back to the old question of what can we afford to achieve, a marginal improvement in the goal of perfection? According to Dr Wallace the cost of RIA screening is 100% more than the cost of RPHA screening test. We have at least the backing of the Maycock Committee and WHO for the utilisation of the RPHA test.

"It is my view that in the present financial climate it would not be justified to increase our testing costs by 100% to obtain marginally improved sensitivity. Your comments would be welcomed."

If we could go back, please, to the first page, we can see Dr McIntyre picking up Dr McCreadie's comments and providing his own to Dr Scott's. I'm going to look at the third paragraph that begins "Dr Wallace".

Dr McIntyre says:

"Dr Wallace has been involved in the problems of hepatitis right from the beginning and knows that the

problem is complex and that hepatitis B is only the tip of the ice-berg. If we accede to his request for additional money so that he can continue RIA then we are saying that this is such a preferable method that we considered the additional expenditure is justified. This leaves us in a difficult situation as regards the other centres. It may be that we could argue that they do not have the equipment necessary and therefore further additional costs over and above the reagent should be involved. Should a case of hepatitis B arise in any of these other regions however it could be construed that by implication we were adopting in these regions a less sensitive testing method."

Just the paragraph above that, I just draw your attention to, sir, what Dr McIntyre says in the middle of that paragraph:

"I do not like what I consider to be the professional blackmail in the last paragraph of Dr Wallace's letter."

Which is presumably a reference to Dr Wallace considering whether or not he needed to be in touch with the Scottish Legal Office about potential changes to screening methods in his region.

What's not clear, at least from the face of this document, is what Dr McIntyre means when he says that

Dr Wallace knows that hepatitis B is only the tip of the iceberg. That may be a reference to non-A, non-B hepatitis. It may be that other readings and inferences are possible.

So what we have here is a discussion by these officials of the position the Department should adopt in a situation in which a more sensitive method of screening might be available, but it is more expensive than the method which has, the previous year, been recommended by an expert advisory group.

We can take that down now. Thanks, Lawrence.

I'm not going to go to it but Dr McIntyre responds directly to Dr Wallace on 30 June 1976 setting out the Department's position. He described the Maycock Advisory Group as having favoured RPH after weighing up factors such as sensitivity and cost. He noted that the estimated cost of RIA testing on a commercial basis was likely to be twice that of RPH, and he concluded that in light of what was said in the Maycock report, the method of testing recommended by that Advisory Group should be employed in the West of Scotland as in other Transfusion Centres in Scotland.

Now, that response from the Department seems to have led Dr Wallace to write a letter to chief administrative medical officers and others in his

region, including haematologists. That letter comes on 26 July 1976.

In summary, what Dr Wallace says in the letter is that RPHA would replace RIA testing in the Region as a result of the Home and Health Department's position, and he says it was estimated that annually this would lead to 96 chronic carriers of hepatitis B surface antigen not being detected. So linking the change that would need to be introduced in the West of Scotland from RIA to a less sensitive testing method to the Department's position.

Now, that letter from Dr Wallace leads to more internal discussion between officials in the Home and Health Department and we can see that, for example, in a 29 July 1976 minute from Dr McIntyre to his colleagues. I won't bring it up, but I'll just highlight that Dr McIntyre says the point at issue is not the sensitivity of the test, this test RIA -- of that there's never been any doubt -- but the policy to be adopted after consideration of the other factors such as capital and recurrent costs.

"In my view Dr Wallace has not shown any reason why the present policy should be changed at this time."

The correspondence between the officials and Dr Wallace continued over subsequent months. I'm going

to bring up just one further letter from Dr Wallace which helps to explain the reasons for his position and shows the information that he provided to the HHD to try to justify it. It is SCGV0000205_027.

This is a 6 August 1976 letter from Dr Wallace to Dr Macdonald, who was at the time was DCMO in the Department. We can see the subject of the letter from its title. Dr Wallace goes on in this letter to provide a number of comments to help to explain the position that he'd adopted both in correspondence with the Department and directly to clinicians in his region.

He says this:

"1. Neither the Maycock report nor the WHO Report to which you refer is recent. Each report really states views held by experts in the second half of 1974.

"2. The two Maycock Reports (1972 and 1975) and the two WHO Reports (1973 and 1975) all make it abundantly clear that the situation is dynamic and that recommendations must, of necessity, be interim. Expert opinion today recommends either RIA or EIA as the technique of choice."

In the next paragraph he picks up that HHD officials were involved in the discussions of the Maycock Group or he's received evidence of those discussions and he says:

"It is clear from these discussions, notes and papers that the members of the Group [the Maycock Group] were in a quandary by the middle of 1974 as to whether to recommend RPHA or RIA. There was a definite polarisation of members between finance and sensitivity."

If we go in the middle of the page to a paragraph starting "I have told", we have here Dr Wallace trying to explain the reason for his letter to CAMOs and others in his region.

"I have told Dr McIntyre repeatedly that I accept the sad fact that there is no more money available for developments, but I reserve the right to inform medical colleagues in the region for which I am responsible, that I am discontinuing the use of RIA, and as a consequence I anticipate a definite number of false negative donations. What I cannot quantify is the number of cases of type B hepatitis which will result or the amount of cross contamination of products and fractions which will occur."

Finally, the last paragraph in this letter, and it's to pick up what Dr Wallace says here. He refers to recent cases of hepatitis B transmission in the West of Scotland, and then says:

"I cannot believe that these cases of donations

with extremely weak examples of HBsAg transmitting severe viral hepatitis type B are unique to the West of Scotland. What is much more worrying and potentially more serious is the dissemination of these infective agents in multiple blood products. I know that this possibility is causing concern to Maycock and to Watt."

That's John Watt, who is at this time scientific director of the Protein Fractionation Centre in Scotland.

Dr Wallace continued to make these points including at meetings with other RTDs in Scotland and to the Department. We can see that in a 9 March 1977 meeting which was summarised in the written note. The minutes of that meeting as well as recording this point from Dr Wallace include some more general comments about delays in the advice that's provided by expert groups such as the Maycock Group. I'm just going to read out one of the entries from those minutes which records the comments of directors, it says:

"Rapid progress was being made in the use of various blood products with a consequent increase in the risk of the spread of hepatitis. Regional Directors were concerned at this increasing risk and would be considering the entire question in the near future. The situation whereby Reports of this kind had to be widely

circulated for approval prior to publication invariably resulted in the document being somewhat dated, particularly in the developing situation."

And there's a suggestion --

SIR BRIAN LANGSTAFF: Do you have a copy of the document to put up on display?

MR BOUKRAA: This one? Of course, sir, yes. It's SCGV0000079_013.

Sir, we can see at the top of this document that it's a meeting of the Scottish Health Service Planning Council Blood Transfusion Advisory Group. In attendance at the meeting is Dr McIntyre from the HHD as well as number of transfusion directors, and we can see Dr Wallace is one of the individuals present at that meeting.

We can see the discussion which I was just referring to over the page.

SIR BRIAN LANGSTAFF: Lawrence, could you just go back to the top of the page.

MR BOUKRAA: Of course.

SIR BRIAN LANGSTAFF: Thank you. 9 November -- sorry, 9 March 1977.

MR BOUKRAA: 9 March 1977.

SIR BRIAN LANGSTAFF: Thank you.

MR BOUKRAA: While we've got that date, sir, 9 March 1977,

earlier on I described the Maycock Advisory Group draft report being circulated to the HHD in around February 1975. The report seems to be finalised September 1975, discussed by directors in Scotland towards the end of that year.

Then there seems to be a period over about the following year until around this time, in March 1977, before the Department circulates it more widely in Scotland, with a covering circular, so it's that timing which seems to prompt some of the discussions we see in these minutes.

If we go over the page, please, Lawrence. Thank you.

It's the top half of this page, the entry paragraph that begins "Report of the Advisory Group on the Testing for HBsAg and its Antibody".

We can see in the second sentence Dr Wallace emphasising the point he'd made in the previous meeting, that the information in the report was based on 1974 data and was now substantially out of date.

He says:

"In view of the considerable advances which had been made in the meantime he and most members of the Maycock Group would no longer agree with the main recommendations of the Report."

Refers to a further report that's been prepared by the WHO, and then the entry which I had started to read out earlier:

"Rapid progress was being made in the use of various blood products with a consequent increase in the risk of the spread of hepatitis."

SIR BRIAN LANGSTAFF: Yes, he introduces it by saying:

"In view of the considerable advances which had been made in the meantime [ie since the drafting of the report] he and most members of the Maycock Group would no longer agree with the main recommendations of the Report."

MR BOUKRAA: That's exactly right, sir, yes, that's Dr Wallace's contribution at this time, March 1977.

SIR BRIAN LANGSTAFF: Then he goes on to the bit you're now quoting. Let's have a look at that.

MR BOUKRAA: Yes, that's right sir, yes.

"Regional Directors were concerned at this increasing risk and would be considering the entire question in the near future. The situation whereby Reports of this kind had to be widely circulated for approval prior to publication invariably resulted in the document being somewhat dated, particularly in the developing situation."

There's then a suggestion about how to deal with

this issue:

"However, a suggestion that this situation could be overcome by the issue of updating information sheets was thought to have considerable merit. It would also avoid having to go over old ground again."

It was intimated that the report was initially a report to the Health Department for consideration of any financial implications, although tests recommended in the report had been in use for some considerable time, and there's a reference at the end there to apprehension amongst staff working in the centres.

While we've still got this paragraph up, sir, the first sentence at the beginning:

"The second report of the Advisory Group had now been circulated under cover of NHS Circular 1977(GEN)2."

It was that recent development that I was describing earlier, which is wide circulation of this Maycock September 1975 report, not taking place until 1977, though regional directors were aware of its recommendations earlier.

SIR BRIAN LANGSTAFF: So the concern which he is expressing, and begins "Rapid progress" is the use of blood products, which would include presumably clotting factors, would lead to a consequent risk -- increase in the risk of the spread of hepatitis, and it's that risk

which they think is now more concerning and therefore there's a greater case for effective screening. That's what he's saying, is it?

MR BOUKRAA: That's exactly right, sir, yes. And that would be consistent with a document that we looked at earlier from Dr Wallace to the Department and Dr Wallace linked some of his concerns about the sensitivity of the test to developments in the use of blood products to Mr Watt at the PFC, and the use of fractions.

SIR BRIAN LANGSTAFF: Yes. Thank you.

MR BOUKRAA: We're finished with that now, thanks, Lawrence.

Now, in the remainder of the 1970s and early 1980s we can see in the documents further consideration of screening methods, that includes developments of, for example, a lower cost RIA, and other methods, trials of different techniques were being undertaken at RTCs. I'm not going to go into the details of those developments now. The Maycock Advisory Group has reconvened under a different chair. The written note summarises the HHD's involvement in those developments.

I'm going to move forward, finally on this topic, sir, to a last couple of documents in 1981, which is relevant to how the HHD understood its role in relation to screening and also what transfusion directors' responsibilities were.

So in May 1981 a further report from the advisory group on hepatitis B testing, by this point under a different chair, had become available. That report was discussed at a meeting which was attended by the HHD. It considered the merits of different screening methods which had developed by this point beyond those that we've been looking at, RIA, ELISA tests, and RPHA tests. That updated report recommended minimum sensitivity levels for tests used by RTCs.

We can also see from that report a conclusion that it was only possible to lay down approximate guidelines for the sensitivity testing.

If we could go to PRSE0003920, we can see a meeting of SNBTS directors, 22 September 1981, chaired by Professor Cash, attended by Dr Bell and also Mr Finnie for the Department, in which there's discussion of this report. Can we go to page 5, please.

Thank you.

Down little bit further so we can see the whole of section 5. Thank you. "Testing for hepatitis".

Professor Cash introduces the report that I was just seeking to summarise, and there's a discussion of that report's recommendations, and I just wanted to pick up Dr Bell's comments here.

Dr Bell is recorded as having advised:

"... that the document was not intended to provide a legal safety net but to provide guidelines on the best procedures to be adopted, and that Directors' clinical judgment and adherence to the recommendations, within the finance available, was all that could be expected of them."

So we see here Dr Bell emphasising that the use of particular screening tests that were available by this point was a matter of clinical judgment, also recognising that those choices had to be made within the finance that was available. The finance that was available ultimately being a matter for the Department.

Sir, that was all I intended to say about hepatitis B screening and hepatitis B for today. I'm going to move on now to another topic. I note the time, 11.10. I wonder if this would be a convenient moment for a break. Alternatively, I can start on our next topic, which is going to be HIV and AIDS.

SIR BRIAN LANGSTAFF: Yes, well, let's do that, then, and come back to HIV and AIDS at 11.40.

(11.10 am)

(A short break)

(11.40 am)

SIR BRIAN LANGSTAFF: Yes.

MR BOUKRAA: Sir, I'll be moving now to issues relating to

which HIV and AIDS, the Department's knowledge of matters relating to HIV and AIDS, and their responses.

Now, the earliest reference to AIDS in documents involving the Home and Health Department, at least in the material available to the Inquiry, would appear to be a 21 January 1983 meeting of SNBTS and Haemophilia Centre Directors. It was chaired by Dr Bell and attended by Dr McIntyre and Mr McBryde. I'm not going to the minutes of that meeting, which have been considered before, but during the course of it Professor Cash draws the meeting's attention to recent articles in the United States and some other documents including an MMWR extract relating to AIDS.

If we move forward to May 1983, by this stage the SHHD was receiving information relating to AIDS from other sources, in particular the DHSS.

Now, the Inquiry has previously considered a 3 May 1983 DHSS minute on this subject which enclosed a line to take and a background note which had been prepared for the Prime Minister.

Now, those documents were copied to John Davies, who was Assistant Secretary at the time at the Home and Health Department. The Inquiry has looked at those documents previously. They included a line to take that there was as yet no conclusive proof that AIDS had been

transmitted through American blood products.

I'll come back to that line later.

There was also a briefing note which described the risk to haemophilia patients treated with Factor VIII, said they were at increased risk of AIDS, and described the risk as follows:

"As yet there is no conclusive proof that AIDS is transmitted by blood as well as by homosexual contact but the evidence is suggestive that this is likely to be the case."

Sir, those are DHSS documents but they are copied to officials in the Home and Health Department. What we see in the documents is, in the days that follow those documents being provided, both administrative and medical officials work on a submission to the Junior Minister who had responsibility for Health in the Department at this time, and that was John MacKay, and I'm going to go to the submission in which these issues are brought to the Minister's attention.

Lawrence, it's PRSE0004037.

It's a one-page document. We can see at the bottom it's from JG Davies, John Davies, dated 6 May 1983.

At the top it is addressed to PS, that's a private secretary, to Mr MacKay, and copied to some another --

to a number of individuals within the Department.

In the introduction Mr Davies says that:

"Mr MacKay may have seen comment recently in the media about AIDS. He might find it helpful to see some briefing material on the matter prepared earlier in the week by DHSS for the Prime Minister."

Those are the documents which I've just described.

Mr Davies said:

"We agree with the general line in the briefing. There are, however, a few Scottish points to be made ..."

The first is about imported Factor VIII.

"Scotland is virtually self-sufficient in Factor VIII. Occasional purchases of imported concentrate are made for clinical reasons: only a very few patients are involved."

On Scottish cases Mr Davies said that:

"No confirmed case of AIDS has yet been reported in Scotland. Any suspected for diagnosed case will be reported to the Communicable Diseases Unit at Ruchill ..."

SIR BRIAN LANGSTAFF: As a matter of interest, the wording there is "No confirmed case of AIDS". That leaves open that there may have been a suspected case.

MR BOUKRAA: That wording, you're absolutely right, sir,

does leave that open. I'm not aware from the documents that I've seen, and I believe are available to the Inquiry at the moment, that there were any suspected cases of AIDS in Scotland at the time of this note -- of this minute. It's an issue we might want to investigate further, but I'm at least not aware of any suspected cases that had been brought to Mr Davies's attention or the attention of Home and Health Department officials which might lend particular significance to the use of the word "confirmed" in the submission but, as I say, it's something we can look in further to confirm the position.

SIR BRIAN LANGSTAFF: Thank you.

MR BOUKRAA: On "Donation Policy", Mr Davies wrote:

"The Blood Transfusion Directors in Scotland are very aware of the problem and have it under constant consideration." They are currently considering ..."

Then he sets out four measures, first:

"(a) Briefing all frontline blood bank staff to handle questions from donors.

"(b) Preparing a neutral factual leaflet about AIDS and making this available at donor sessions - perhaps drawing attention to it as a follow-up to recent press and television publicity;

"(c) Informal contact with representatives of the

relevant gay associations.

"(d) Avoiding collection in high risk locations such as prisons or where there is known to be a high proportion of homosexuals or drug abusers in the population."

Now, that final sentence there brings with it the suggestion that collection in certain high risk locations such as prisons was still taking place in Scotland at this time. There's a later section in the written note which deals briefly with prisons and what the Home and Health Department understood to be the position at this time, in May 1983.

SIR BRIAN LANGSTAFF: Just as a matter of interest, is there any -- or what are your submissions as to the force of the word "neutral" under (iii)(b), "Preparing a neutral factual leaflet"? It's a word which is often used where there are two rival views. What do you submit the force of that is? Or is it simply saying what we're trying to be and give the objective facts without sensationalism?

MR BOUKRAA: I think's more likely to tend towards that second characterisation, sir. It's perhaps a slightly unusual word to use in this context. I think it is likely to reflect officials' understanding that already at this time, in May 1983, there was what they considered to be a great deal of sensationalism in the

press in particular around any issues relating to AIDS, that they were keen to avoid adding to that sensationalism.

It might also relate to a desire to avoid causing any offence amongst blood donors, a neutral leaflet which tries to present facts about AIDS which doesn't go beyond presenting matters as neutrally as they could be at the time, so as to avoid causing offence. Those are two suggestions that come to mind immediately, sir, but it's a word that might be worth keeping in mind as we look through the remainder of the documents and when we consider documents in the written note relating to the preparation of the AIDS leaflet.

What we'll see in my summary of those documents, sir, and also in the written note, is perhaps less direct involvement by Scottish officials and certainly by Scottish ministers in the wording of leaflets relating to AIDS than might have been seen in England and Wales when officials and ministers were more directly involved in the wording.

So we see, sir, from this document a number of matters which will repeat and will form a part of the pattern of officials' response to the risk of AIDS. One of them in particular is an emphasis on Scotland being, as they describe it, virtually self-sufficient in

Factor VIII.

We know that Mr MacKay, the Minister, saw this document because we have a response from his Private Secretary, which I won't go to, essentially just expresses the Minister's gratitude for this submission.

Now, around this time, and certainly by June 1983, Dr Brian McClelland of the South East Scotland Regional Transfusion Centre had begun work on an AIDS donor leaflet. The steps taken by Dr McClelland in relation to that leaflet have been explored in evidence previously heard by the Inquiry, notably Dr McClelland's own oral and written evidence.

The Home and Health Department's involvement in that issue is set out in the written note. I'm not going to go into the detail of it here for reasons of time.

The evidence suggests that Dr McClelland's RTC in Edinburgh began issuing an AIDS donor leaflet in June 1983, suggests that the Home and Health Department had very little involvement in the preparation of its contents.

When Dr McClelland described orally to this Inquiry how he went about liaising with the Home and Health Department, he described essentially asking for forgiveness rather than permission after taking steps to

issue the leaflet.

The documents also show that around this time, so this is mid-1983, Home and Health Department officials were monitoring the development of a donor leaflet being prepared by the DSS and transfusion directors in England and Wales.

The documents show officials in Scotland liaising with their counterparts in the DHSS, and emphasising the need for the Home and Health Department to be consulted on the development of that UK leaflet.

If we move forward to 1 July 1983, when a DHSS submission on the publication of an AIDS leaflet was submitted to ministers in England and Wales, as we've seen with some of the other documents relating to AIDS, it was copied to an official at the Home and Health Department, that was Mr Wastle.

After that submission is copied to officials in the Home and Health Department, they begin to discuss it internally and to prepare a submission to go to their minister, Mr MacKay.

I'm going to turn to that document now, which is dated 11 July 1983, so about ten days after the DHSS submission.

It's SCGV0000147_157.

Again, from Mr Davies, once more to the Private

Secretary, to Mr MacKay, and I'm going to highlight the second paragraph, and what Mr Davies says there:

"Regional Transfusion Directors in England have now prepared the attached draft leaflet for printing and publication by DHSS (it is substantially based on an earlier draft by Dr McClelland at the Edinburgh and South East Scotland Blood Transfusion Service). The main aim of the leaflet is to discourage practising homosexuals from donating their blood and, in view of the sensitivity of the issue, DHSS have consulted their Ministers over its terms. Our understanding is that some reservations have been expressed and that DHSS officials are toning down the text somewhat, largely to make clear that, even in the US, only a small number of cases have been reported. DHSS Ministers have also asked for a formal statement to be available for use at the time of publication to diminish any risk of over reaction ..."

Mr Davies refers to a possible opportunity for that statement.

Then in the final paragraph of this page, he said:

"We consider that the leaflet should be issued on a UK basis, and are arranging for the text to be adjusted accordingly. The main change that is required is to alter references to the 'National' (ie English and

Welsh) Blood Transfusion Service. No separate Scottish announcement would be called for, but an important point for any press inquiries is that Scotland is virtually self sufficient in Factor VIII."

Sir, we can see here officials recommending to the Minister that a UK approach to this leaflet would be appropriate, suggesting that some changes might need to be made to its wording but really focusing on what might be considered to be more minor amendments to reflect that applies to Blood Transfusion Services in the whole of the UK and not simply England and Wales. And what we also see in the last sentence of this document is an emphasis again on self-sufficiency in Scotland.

I'm going to go very briefly to the Minister's response --

SIR BRIAN LANGSTAFF: The underlying reason for that presumably is an appreciation in mid-July 1983 that the public, or for that matter others, might think that if the blood is sourced from domestic national sources, it is safer than blood products imported from the United States.

MR BOUKRAA: That's exactly right, sir, yes.

SIR BRIAN LANGSTAFF: And making a virtue of that.

MR BOUKRAA: Absolutely making a virtue of that, sir, yes.

SIR BRIAN LANGSTAFF: Yes. Thank you.

MR BOUKRAA: It might be said to be tied not only to the public perception of the risk of domestically produced blood products but also what officials appear to understand the relative risks to be. I'll come to a document a little later on which lays out -- or which provides an insight into at least what some officials understood to be the advantages that were gained from blood products being produced domestically rather than relying on importing particularly American sources.

SIR BRIAN LANGSTAFF: Yes.

MR BOUKRAA: So the Minister's response which comes through his Private Secretary the following day. It's just a short document. SCGV0000147_153.

At the bottom we can see it's from Geoff Pearson, Private Secretary to Mr MacKay, directed to Mr Davies. It starts by simply noting that the Minister has seen the minute:

"[The Minister] enquired whether the surplus capacity at the Protein Fractionation Centre at Liberton could be used to increase UK production of Factor VIII - he believes the current English production is some only 60% of demand."

So that's the Minister taking on board the point that is implicit in Mr Davies's document, which is that domestically produced products are understood to be of

lower risk than imported ones, and wondering whether Scotland could help to pick up additional production and send some of it to England and Wales.

Now, the response to that enquiry doesn't come until some months later in October and I'll come to it.

The answer was essentially no, but it is perhaps notable, sir, that the points that are picked up by the Minister and the concern with -- or the emphasis placed on Scotland's self-sufficiency and the relative risks, as they were understood at the time, between Scottish and imported blood products.

Now, what the documents shown in the summer of 1983 is HHD officials continuing to be updated about the DHSS's approach to this donor selection leaflet, this AIDS leaflet which was still being prepared. It was eventually agreed to be distributed in Scotland as well as England and Wales from September 1983.

A separate Scottish press release was prepared at the time that that leaflet was introduced, and I'm going to turn it to very briefly. It's PRSE0002778.

So we can see the date of this document, 1 September 1983.

The first paragraph introduces the leaflet that's been published. It says it's by the Health Department in the UK for distribution in Scotland by the SNBTS.

In the second paragraph, AIDS is briefly described, and then I was going to highlight the third, where this press release said this:

"No cases of the disease have been confirmed in Scotland and the Scottish Home and Health Department emphasised today that there is no conclusive proof that the disease can be transmitted through blood or in blood products. There is however no screening test the BTS can use to detect people with AIDS and donors are asked not to give blood if they think they may have the disease or be at risk from it."

In the next paragraph:

"Scotland is self-sufficient in whole blood and virtually so in blood products. Nearly all the factor VIII issued for the treatment of haemophilia is produced from blood plasma donated to the SNBTS by blood donors in Scotland."

SIR BRIAN LANGSTAFF: And that links back, does it, to the second paragraph, the second sentence, where it described as AIDS as a "comparatively new disease to Britain"?

MR BOUKRAA: That's exactly right, sir, yes. So we can see that link being made, we can see the emphasis on self-sufficiency again. We can also see the use of the "no conclusive proof" line without a qualification

attached to it on whether or not a disease was likely to be transmitted by blood and blood products.

It was in October 1983, the next month, that Mr Davies provided a response to Mr MacKay's query about whether the PFC could produce additional Factor VIII for England and Wales. The response is summarised in the written note. I won't go to it now. The short answer was no, or rather, at least, no, not for the time being.

We move into late 1983 and the first half of 1984, and the Department's officials, based on the documents, appear primarily to have been monitoring developments related to AIDS and blood products, including proposals for further steps that might be taken in response.

Now, that included consideration of updates to the donor leaflet, changes to distribution arrangements. There's some reference to the possibility of small pool blood products being prepared, some reference to surrogate screening for AIDS, monitoring of AIDS cases, monitoring of the DHSS approach.

HHD officials' involvement around this time often seemed to take place by attendance at different meetings, in particular attendance at meetings of SNBTS directors, also attendance as an observer at meetings of transfusion directors in England and Wales, and we've summarised what we can get from the documents in the

written note.

I'm going to move forward fairly quickly, sir, to August 1984, when the Home and Health Department became aware that a haemophilia patient living in Scotland had contracted AIDS and the Minister was informed.

Lawrence, could we please go to SCGV0000147_073.

Sir, the date of this document is 29 August 1984, again from Mr Davies, and again to the Private Secretary, to Mr MacKay. Mr Davies wrote this:

"We have recently heard that a Scottish resident haemophiliac ... has [contracted] AIDS. We have hitherto reported that Scotland is virtually self-sufficient in Factor VIII, the blood product used in treating haemophiliacs; and therefore that there was no risk to Scottish haemophiliacs. This case may appear to provide contrary evidence, and may possibly be so reported by the Press.

"We are informed that the patient concerned has only recently moved to Scotland. He has hitherto been treated in Newcastle where imported Factor VIII has probably been used. The disease takes some time to manifest itself, and the Scottish product is not implicated".

Now, a number of points which arise from this document, sir. One of those that's perhaps most notable

is the way in which the risk arising from PFC factor products was described and appears to have been understood by Mr Davis:

"We have hitherto reported that Scotland is virtually self-sufficient in Factor VIII ..."

And that:

"... therefore there was no risk to Scottish haemophiliacs."

Rather than perhaps a reduced risk compared to other blood products.

Perhaps also of interest in the final sentence of this document is what seems to be a reference to the incubation period in AIDS:

"The disease takes some time to manifest itself ..." which will of course be relevant to an understanding of the risk posed by factor products.

That's August 1984, and I'm going to turn now -- and I've moved fairly swiftly through this period, of course there are a lot of fairly important developments that take place that are set out in the notes. I'm going to move forward to the Department's response to the discovery that group of patients treated PFC Factor VIII had developed antibodies to HTLV-III, a group of patients sometimes referred to as the Edinburgh cohort.

Now, the Inquiry has already heard evidence on the timing of this discovery from witnesses, Professor Ludlam and Dr McClelland. I'm not going to repeat it, but what that evidence would appear to suggest is that Scottish haemophilia clinicians and the SNBTS started to become aware of this development around or by late October 1984.

Now, the precise date on which the Department's officials first became aware of the results of the Edinburgh patients is not entirely clear from the documents. The earliest one we have involving the Home and Health Department is dated 20 November 1984, and it's a minute from officials to the Minister, and I'm going to go to that now.

It's SCGV0000147_058.

We can see the date at the bottom, 20 November 1984. It is from Hugh Morison, who was Under-Secretary at the Home and Health Department at the time, which is a grade higher than Assistant Secretary, effectively Mr Davies's superior. Addressed to the Private Secretary to Mr MacKay, and we can also see it is copied to the Private Secretary to the Secretary of State, so involving the Secretary of State in this development.

Now, in the first two paragraphs Mr Morison gives

an update on leaflets in particular in AIDS developments in relation to the AIDS donor leaflets. I'm going to draw your attention, sir, to the second half of this document, and in particular the paragraph that begins "A development", and Mr Morison wrote this:

"A development of particular concern in Scotland is that 16 Scottish haemophiliacs have been identified as having antibodies to the virus HTLV III, which is implicated with AIDS. The presence of the antibodies indicates that the patients have been exposed to the virus but does not mean that they will necessarily develop AIDS. A batch of Factor VIII (the blood clotting agent given to haemophiliacs) produced at the Protein Fractionation Centre at Liberton appears to be implicated. As Factor VIII is produced from plasma recovered from blood donations it must be assumed as probable that the batch was contaminated by a Scottish donor. The batch has been withdrawn and the SNBTS are taking vigorous steps to identify the source of infection. This, however, will not be an easy task since blood from many donors is used to produce a single batch of Factor VIII. In the meantime, work is urgently proceeding to introduce heat-treatment for Factor VIII in order to kill the virus, and to develop a screening test for HTLV III antibodies. No such test is, however,

likely to be readily available in the immediate future."

Then the final paragraph:

"It would not be appropriate at this stage to issue any statement on the discovery of the antibodies in the Scottish haemophiliacs. Suitable defensive briefing has however been given to the SIO."

SIO is a reference to the Scottish Information Office.

If we go over the page, we can see the first page of the briefing that's referred to in Mr Morison's note. As you can see, it's in the form of a Q&A. I'm not going to go through all of this document now. I'm going to highlight, please, the second half of this page which is of particular relevance to this Inquiry. It says:

"Antibodies in Scottish Haemophiliacs

"Antibodies to HTLV III, the virus which it is believed caused AIDS, have been discovered in 16 Scottish haemophiliacs. A batch of Factor VIII produced at the Protein Fractionation Centre at Liberton is implicated."

And then underlined:

"No statement is to be released on this at present. If however there are specific enquiries from the media on this matter, the following material should be used."

There's then a series of further questions and answers, and we just go to the last page, and the final entry which is prefaced with "Only if pressed", so it appears to be directed at those who may need to answer press enquiries or enquiries from others and are being pressed about this issue:

"What should Scottish haemophiliacs do?

"[Answer]. They should make enquiries of the consultant treating their case."

If we could go back, please, Lawrence, to the first page of this document, and the top manuscript addition. Now, this manuscript addition would appear to come from the Minister, Mr MacKay. It says this:

"Thanks: While I fully appreciate that a statement would give rise to great concern among haemophiliacs -- and indeed among recipients of blood generally -- I do not want us to be accused of a 'cover-up'. If we are approached we must be perfectly open."

Then the question:

"When is heat-treatment likely to be ready?"

SIR BRIAN LANGSTAFF: One of the curiosities about this particular document, if we just have a look back -- thank you -- is what is said in the last couple of sentences in the third paragraph:

"In the meantime, [it says] work is urgently proceeding to produce heat-treatment for Factor VIII in order to kill the virus, and to develop a screening test for HTLV III antibodies. No such test is, however, likely to be readily available in the immediate future."

This is 20 November.

There was a record on 15 November -- a reference for those who are interested is DHSC0002309_055 -- which in the Department of Health recorded a screening test -- that a screening test for HIV and blood products had been developed and a pilot scheme was due to start shortly. The cost was to come from existing RHA budgets of about £2 million.

So some -- almost a week earlier, not quite, the position in London at least had been appreciated that they -- there was a test in the wings, although it might take some time to go through its pilot process, et cetera, and it's perhaps curious that there is no mention of that in this memo to this minister, who is concentrating, therefore, on heat treatment.

MR BOUKRAA: That is absolutely right, sir. That is a curious feature of this memo.

We'll come a little later to look at what information was provided when to ministers in Scotland and, in particular, Mr MacKay about HTLV-III screening

and when it might be introduced and, in doing so, I'll seek to answer your question from this morning. But you're right, sir, there's no reference to that information that you've just described from the DHSS.

SIR BRIAN LANGSTAFF: Well, what that at the moment suggests to me -- and this is open of course to submission and may be entirely wrong -- is that those who had come by some knowledge or developments in England haven't necessarily been in regular and constant touch with those in Scotland who were dealing with the same issues.

MR BOUKRAA: That's right, sir. I'll make sure I get the timing right when we get to HTLV-III screening. From memory, by January 1985, we see information sharing between the DHSS and the SHHD. It could be that at this time, November 1984, we weren't quite there yet in terms of information sharing.

SIR BRIAN LANGSTAFF: Well, there may well have been sharing of information but it may not have been comprehensive.

MR BOUKRAA: Yes.

So as we've seen, there is a query from the Minister about when heat treatment is likely to be ready.

A further minute is provided from Mr Morison on 26 November 1984. I won't go to it now but it outlines developments in trials of heat treatment of PFC

Factor VIII, suggests when PFC heat-treated Factor VIII is likely to be introduced. Says that will be at the beginning of 1985. As for press statements, in this minute Mr Morison wrote:

"Mr MacKay's point on publicity about antibodies is well taken. We are keeping in close touch with the Blood Transfusion Service on the matter, which has not so far been picked up by the media."

This is late 1984. The Inquiry has previously considered some of the consequences of the time that passed between this discovery being made that Edinburgh patients had developed antibodies to HTLV-III, the time that passed between that recovery and the patients and their families being informed.

One of the consequences it might be said, of the time that it took for that information to be shared and to become public knowledge was that public discussions of the safety of PFC Factor VIII at this time, late November 1984, took place in the absence of that information.

I'm going to turn relatively briefly to a newspaper article, PRSE0003234.

We can see the date of this article in the top left, November 28, 1984. The title gives a good indication of what the article is about:

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Royal College of Physicians of Edinburgh and chairman of the Scottish National Blood Transfusion Service (the donors' representative body) says: 'I think the public should be reassured -- I do not think people in Scotland have anything to worry about, whether they are getting blood transfusions or other treatment with blood products'."

Thanks, Lawrence. That's all I wanted to cover with that document.

Now, the following day, 29 November 1984, a meeting took place with representatives of the HHD, the SNBTS, and the Haemophilia Centre Directors in Scotland to discuss issues related to the Edinburgh patients. The meeting also discussed positive test results in haemophilia patients elsewhere in Scotland who had been treated not simply with PFC Factor VIII but also with imported Factor VIII. I won't go to the document but it was chaired, that meeting, by Dr Bell, attended by other HHD officials. The meeting notes described discussion of what were termed "very difficult ethical problems", including whether to tell patients and their relatives of the results.

About a week later, 5 December 1984, the Minister was updated again. And I will go to this one.

It's PRSE0003032.

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"'Good Scottish blood' lessens the risk of disease"

I'm not going to go through all of it, sir, unless that would assist. I'll just highlight a couple of parts. We start with the introductory paragraphs:

"Not one person has contracted AIDS in Scotland as a result of blood transfusions or treatment with preparations made from Scottish blood.

"That's no nationalistic boast. It's a tribute to the Scottish Blood Transfusion Service who, from the first outbreak of AIDS here about two years ago, went on the alert for high-risk donations of blood."

Now, it might be noted that that first paragraph might be strictly true in the sense that what happened is that it has been discovered that patients had developed antibodies to HTLV-III rather than developed AIDS. This varies. It might be thought nonetheless that there is a disconnect there between how the risk is described in this introductory paragraph and what was known about the risk from PFC factor products by this point.

And if we could zoom out, please, Lawrence, and then the left-hand column that's headed "Caring", I just want to highlight the first paragraph there:

"Professor Ronald H Girdwood, president of the

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Sir, this is addressed again to the Private Secretary to Mr MacKay, copied to the Secretary of State's Private Secretary. It's dated 5 December 1984 and it's from Mr Davies.

Now, in the first two paragraphs of this minute there's a summary of the meeting that I just described, which took place on 29 November. There is then in the third paragraph, that begins, "From the figures available", a description of the position as it was then understood to be by the officials.

"From the figures available it appears that, out of the approximately 400 haemophiliacs in Scotland ..."

And actually, if we could perhaps zoom in on this paragraph, Lawrence. Thank you.

"... no more than about 10% have antibodies to HTLV III. Only other countries themselves self-sufficient in Factor VIII can match these figures. We understand that in England, where there is more reliance on imported Factor VIII, the incidence is therefore considerably greater. In the United States itself the great majority of haemophiliacs will have the antibodies. It should be stressed that, though antibodies to HLTV-III are believed to be a precursor to AIDS, their presence does not necessarily mean that the individual will develop that disease. Knowledge remains

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incomplete, but the current medical view is that only a small proportion (probably less than 10%) of individuals with antibodies will consequently contract AIDS."

If we go to the next paragraph there is a reference to recent press articles describing the position as it was understood by the press in Scotland, and then this:

"No statement can be made at the moment until the haemophilia directors resolve the very difficult ethical problem of what action to take with regard to their patients about the matter."

Reference to the position in England and Wales.

And then briefly just over the page, the top of the first paragraph on this page:

"The [Blood Transfusion Service] believe that they have now identified the donor responsible for the contamination of the batch of Factor VIII."

Then in the final paragraph, the Minister is informed that the PFC has started heat treating Factor VIII. The first batches are now being issued for trial, and for all Scottish-produced Factor VIII to be heat treated by the end of January. So that's 5 December 1984.

Mr MacKay's Private Secretary responded the

following day, on 6 December, relaying that the Minister hoped that the Blood Transfusion Service in England and Wales had been informed about this donor who had contributed to the contaminated batch so that they could decline his blood if offered.

We move forward again to 12 December 1984 when Home and Health Department officials were informed that a journalist from the Yorkshire Post had learned about the Edinburgh patients and intended to publish an article, but also that the journalist had agreed to postpone publication until 20 December.

I'm going to go to a document in which the Minister's response to this development is recorded. It's PRSE0001293.

Now, the date of this is 12 December. It's from Ms Teale, who's private secretary to Mr MacKay, addressed to Mr Davies, copied to various others, titled "AIDS: Yorkshire Post Inquiry". The first paragraph records that Ms Teale had discussed this issue with the Minister and then goes on to say that:

"Mr MacKay is firmly of the opinion that we should not make any announcement at this stage before those concerned have been told that they have been affected. He does however feel that it is now absolutely imperative that every effort should be made to inform

the haemophiliacs or their parents, as I understand that some of them are in fact children."

"Mr Hoy [who was an official in the Scottish Information Office] tells me that, if the Yorkshire Post do decide to follow up this story, it is not likely that they will publish it before a week tomorrow. It would therefore seem obvious that every effort should be made to inform the people concerned as soon as possible and definitely by the beginning of next week.

"In the meantime Mr MacKay feels that we should respond to any press inquiries with the line that we have identified various people with the problem, that we are taking steps to inform them and that in the meantime it would be extremely distressing for these people, particularly the parents of children, to read about it in a newspaper, not forgetting that press publicity on this before the people have been informed could stir up a totally unnecessary scare amongst the 400 haemophiliacs in Scotland."

Now, the meeting between patients and their families and haemophilia clinicians was organised for 19 December 1984. In the lead-up to that date we can see -- and around that date -- we can see the Department officials working on a press release to be issued at the same time as the publication of the Yorkshire Post

article which was expected on 20 December.

I'm going to turn briefly to that press release. It's PRSE0000225.

We can see the date at the bottom of the document is December 20, 1984. The title is "New measures to counter AIDS":

"The Scottish National Blood Transfusion Service has announced today that all Scottish produced supplies of Factor VIII have now been heat treated to counter HTLV III, the virus that can cause AIDS. Factor VIII is the blood product used in the treatment of haemophiliacs and supplied to the NHS in Scotland by the SNBTS."

So leading in this press release with developments related to heat treatment.

Then in the second paragraph, reference to the Edinburgh patients:

"This move follows the recent discovery that 15 ..."

And I should say, sir, by this point it had been clarified that it seemed that 15 rather than 16 patients were affected.

"... that 15 Scottish haemophiliac patients treated with a particular batch of Factor VIII have developed antibodies to HTLV III. It is suspected that the pool of plasma used to prepare this batch of

Factor VIII contained blood from a donor who had been exposed to the virus. The batch has since been withdrawn."

There is then, in the remainder of this press release, reference to the understanding at the time that developing HTLV-III does not necessarily mean contracting AIDS. Then this:

"The problem is much smaller than in most other countries, because in recent years Scotland has become virtually self-sufficient in the production of Factor VIII and has imported very little commercially produced Factor VIII which carries a greater risk of transmitting AIDS."

Just finally, before I leave this topic, picking up on the date there, this is December 20, 1984, in the introduction to the section has suggested that haemophilia clinicians and the SNBTS became aware of the results of at least some of the Edinburgh patients in late October 1984. We know that the HHD's officials and the ministers, the Minister involved, were made aware by 20 November 1984.

Sir, that was all I intended to say about this particular issue relating to the Edinburgh patients and their discovery. I'm going to move on fairly quickly, because we've got a lot else to cover, to the

introduction of screening for HTLV-III.

Now, as a broad brush summary, what the evidence suggests is that by the summer of 1984 HHD officials had begun considering the introduction of an HTLV-III screening test, had become -- had begun to become aware that a screening test was being developed.

The written note summarises their involvement in these developments in the summer and autumn of 1984, including their contact with the DHSS about the creation of a UK working party to consider the issue.

Now, we can see DHSS and SHHD officials corresponding directly during this period.

The document I intended to take you to, sir, in which we can see that happening, comes from January 1985, and it's when DHSS officials provide a copy of their ministerial submission on the introduction of HTLV-III screening, rather than anything earlier than that.

What we see in the documents is HHD officials, both administrative and medical, looking at that submission, beginning to consider the recommendation that they should make to Scottish ministers.

Now the actual DHSS submission has been considered by the Inquiry previously, and for reasons of time I'm going to avoid going to it, but I'm going to instead

focus on the response of the Department's officials to this development in England and Wales.

The first is a minute from February 1985. It's at PRSE000 --

SIR BRIAN LANGSTAFF: Can you just help me with this: a little earlier this morning I drew attention to the fact that the Minister wasn't told clearly that a screening test might be in the wings and undergoing pilot tests in England, and wasn't informed of that by his officials.

You're now telling me there'd been discussions in the summer and autumn of 1984, including contact with the DHSS in London, updating on the progress that science was making towards developing the screening test which had been after all anticipated when Dr Gallo made his announcement that he'd discovered the cause of AIDS back in the -- in April.

So what was the state of the knowledge of screening of HTLV-III amongst the officials in Scotland, and at the time the Minister was briefed? Do you have any information?

MR BOUKRAA: I hope that the documents we're about to look at will help our understanding of the knowledge of Scottish officials on that particular issue. The time the Minister was briefed, would appear to be, the

Minister in Scotland, 21 March 1985. I'll also come to that --

SIR BRIAN LANGSTAFF: Well, that's -- yes, but the document I drew attention to earlier was in November, I think, wasn't it?

MR BOUKRAA: Yes.

SIR BRIAN LANGSTAFF: About 20 November, I think. And if that is so, then what you're telling me at the moment, or what you've told me, you're summarising -- you're moving toward, I appreciate, to 1985, but you are summarising the knowledge they had been developing in the Department in Scotland in the summer and autumn of '84 I just want to understand what that broadly was.

Was it that that a test was about to be trialled? A test could be used? They must have appreciated that there was some form of screening if the Edinburgh cohort had after all tested positive for having antibodies to HTLV-III in their blood.

What was the position?

MR BOUKRAA: Most of the documents at least that we've summarised in the written note, and it may be that we can look at this further, seems to suggest a fairly high level state of knowledge. There's one document which might help, sir, from August 1984, which I could bring up now which gives some insight into this issue.

SIR BRIAN LANGSTAFF: Yes.
MR BOUKRAA: Lawrence, it's SCGV0000147_079.
SIR BRIAN LANGSTAFF: You mean_079?
MR BOUKRAA: I'm sorry, _079 is what I mean, yes.

Sir, it's a 16 August 1984 minute from Dr Bell to Mr Murray in the Department, and it's titled "Testing of blood donation of AIDS".

Dr Bell said this:

"I have information that research and development work in London is proceeding with the objective of introducing a screening test for HTLV III, the putative causal agent of AIDS. Intensive work in this field is, of course, also going on in the United States, suitably encouraged by commercial motivation.

"Dr Cash has already indicated to Mr Davis that additional revenue costs have to be foreseen for the introduction of an AIDS screening test for blood donation. I think Dr Cash's view that resources for this purpose will be needed in the year 1986/7 is probably right. The BTS in England are already addressing themselves to this problem and DHSS is in the picture. Until more information about the cost of a new test is available we can only work on the estimates already given by Dr Cash."

An example of a document which might be suggested

to illustrate a high level sort of knowledge in anticipation that a screening test was being developed and would eventually be introduced, not, at least from this document, an understanding that that was going to happen imminently.

SIR BRIAN LANGSTAFF: The other curiosity, I suppose -- you can tell me -- in the documents you've been looking at, has there been any reference to the article in The Lancet on 1 September 1984 which was reporting on North London, but plainly they'd conducted a fairly wide screening of people who were haemophiliacs being treated in North London, and had discovered that 34% of them had -- were positive for antibodies.

So that might have suggested that there was a test available, at least for the researchers, plainly it wasn't a general screening test, but any reference to that in The Lancet article at all in any of the material that you've looked at?

MR BOUKRAA: Not that I can recall off the top of my head, sir. We will double check and find out if there are any references to that article. I can put it this way: it sounds like the sort of article that I would have picked up and included in this section of the written note if it had been referred to, but we will double check the position and see if we can find any reference to it.

SIR BRIAN LANGSTAFF: Yes, thank you.
MR BOUKRAA: Sir, if you do want to get a clearer picture of this time period in the second half of 1984 and what the understanding of SHHD officials was, it may be worth looking briefly at a December 1984 SNBTS directors' meeting which was attended by officials from the Home and Health Department where there was an update on where matters had development in the introduction of screening test.

Lawrence, it's PRSE0001767.

Sir, we can see 11 December 1984, that meeting chaired by Dr Cash, attended by Dr Bell and Mr Murray.

And if you could zoom back out, please. Go over the page. Over the page again.

I'm sorry, I'm just going to have to identify the entry dealing with screening.

It's the second half of this page.

SIR BRIAN LANGSTAFF: It's when Dr McClelland reports back on the meeting he's been at in the late November.
MR BOUKRAA: That's right, sir, yes.
SIR BRIAN LANGSTAFF: That was the 27 November '84 meeting he was reporting back on?
MR BOUKRAA: 27 November '84, that's right. We've made reference to a note of that meeting which Dr McClelland believes he prepared, although I think it's not very

clear from the document itself he prepared it, but Dr McClelland believes he prepared that document, which recorded that he could get no clear picture of when or how a serviceable assay would be provided so suggests a good deal of uncertainty at this time about the timing of the introduction, the timing of the introduction for this screening test, and just in this document, there'd been unanimous agreement to test all donors once an antibody test was available, a matter of how to counsel and take care of antibody positive donors was acknowledged to be a very difficult problem.

All of those documents together appear to suggest the Department's officials being aware that work was ongoing to introduce a test but a good deal of uncertainty about when the screening test that could be used to screen blood donations and, in particular, for routine screening of blood donations would be available, so that's late 1984.

We get into January and February 1985, so January 1985 is when a copy of the DHSS submission is provided to officials in the Home and Health Department and we can then see how that -- the contents of that submission and developments in England and Wales are discussed by officials in the Department.

If we could go, please, first to PRSE0001054.

Now, this another minute from Mr Davies, dated 7 February 1985, to Dr Scott, copied to a number of other officials in the Department.

It begins with the following:

"DHSS Ministers have now agreed [and added in manuscript '(apparently with great reluctance)'] that all donations of blood in England should be tested for the presence of antibodies to HTLV III. We now have to decide whether we have any alternative to advising our Ministers that it is necessary to follow suit in Scotland.

"There are over [a quarter of a million] donations of blood in Scotland each year. As far as we are aware, only one destination to date has contained antibodies to HTLV III. We now require a signed statement from all potential donors that they are not in one of the at risk categories for contracting AIDS. Hence the number of 'infected' donations, already vanishingly small, should decrease still further."

There's then reference to some guidelines prepared by the ADCP, and then, staying in the same paragraph:

"Haemophiliacs in Scotland are now not at risk" --

I think that should say "at all" -- I'm so sorry it's right as it is:

"Haemophiliacs in Scotland are now not at risk as

all Factor VIII is heat treated -- the situation in England is different. In any case, only a proportion of those with antibodies develop AIDS. I have seen figures ranging from 10% down to one, several hundred."

There's some discussion in the next paragraph of the implications of introducing a routine screening test for blood donors. Reference to any test inevitably being imprecise, problems created by false positives, suggestion there may always also be false negatives.

The next paragraph, if I can summarise, deals with the potential financial implications of introducing a screening test as they were understood this time. In the middle of this paragraph, Mr Davies said:

"I have discussed the problem with Mr Robertson [who is in the finance department], and though the financial angle cannot be ignored, we are both agreed that it should not be the determining factor in this case."

In the final paragraph, the first sentence:

"It seems to me that the balance of rational argument would be heavily against introducing a test on all donations. I accept, however, that there is little rationality to be seen where AIDS is concerned."

So that's the view of Mr Davies in February 1985.

I'm going to briefly turn to Dr Scott's response

to this minute.

PRSE0003846.

In the first paragraph Dr Scott says that Mr Davies's minute summarised clearly and succinctly the problems associated with the routine testing of all donations of blood for HTLV-III, and then the third paragraph:

"From a cold objective scientific viewpoint the case for the introduction of a test for HTLV-III antibodies in the present state of development and without being properly validated is not clear cut. There is no doubt, however, that there is a lot of public interest and we are liable to be carried along on the rising tide of the motion. We are in a particular only difficult situation in that DHSS ministers have agreed, however reluctantly, to the introduction of the test. It is most unfortunate that a policy decision on this matter is not made at a UK level, though understandable, given the degree of public and media hysteria."

Further down the page, just the first sentence of the penultimate paragraph, Dr Scott says:

"in the end I think we shall have to put up a full submissions to Ministers, pointing out the issues as summarised in your minute and the distortion of

priorities that will arise, though in the end saying we doubt if they have an option."

Sir, one example here, as well as the issues particular to HTLV-III screening, one example of how the relationship between decisions taken by the DHSS and the SHHD may have played out, a suggestion here from Dr Scott that it was going to be necessary for Scotland to follow a decision which had been taken in England and Wales.

There's a further response to Mr Davies's minute, which I'm not going to bring up, from Mr Macpherson on 11 February 1985. It makes similar points. Accepts a lot of what Mr Davies says and then comments:

"... I very much doubt if we can hold this line now that English blood donations are being tested."

Comments:

"... the pressure on us to follow the English example will be irresistible."

The following month, on 21 March 1985, after work by medical administrative officials took place on the preparation of the submission, it goes to the Minister. We'll turn to that now.

It's PRSE00004593.

Now, the date of this is 21 March 1985. It's from Mr Macpherson in the Department. It's addressed to both

the private secretary, to Mr MacKay, and to the Secretary of State, headed "(AIDS)". It covers two broad issues, the first is notification of AIDS.

I'm not going to look at that issue any further. If we go through to the next page, please, to the bottom half of the page, the heading that begins "Blood Transfusion", there's reference to some of the background to this submission in paragraph 6, in particular reference to the Edinburgh patients, reference to the introduction of heat treatment in Scotland.

In paragraph 7, some more detail on tests. Mr Macpherson wrote:

"Tests are becoming commercially available for the screening of blood donations for the presence of HTLV III antibodies. The first of these tests, from the USA, was marketed in the UK at the beginning of March. DHSS Ministers have agreed in principle that, in England, all blood donations should be screened and that Regional Health Authorities should meet the cost of this."

There's then reference to an article that appeared in The Lancet from Professor Cash and others, supporting the introduction of HTLV-III screening, but on the basis that it took place after evaluation of tests before they

could be introduced for routine screening of blood.

Over the page -- this is a long document, sir, so I'm going to -- so I'm not going to go through all of it here unless that would assist. But what we see in the first few paragraphs of this page, the submission developing first of all by describing the risk as it was understood by officials at the time, some of which reflects the minute from Mr Davies that we saw earlier. Mr Macpherson wrote:

"As noted above, all Scottish Factor VIII [in paragraph 8] is heat treated; the risk from ordinary blood transfusions is believed to be very small; as far as is known, in Scotland where 280,000 donations are collected each year, there has only been one infected donation of blood (the one which contaminated the batch Factor VIII); there is other evidence that blood donated in Scotland is 'clean'; and donors are now required before giving blood to sign a statement that they are not in a group at risk of contracting AIDS."

In the next paragraph a description of what was understood at this time about the screening tests themselves and some of their drawbacks, in particular the higher rate of false positive rates may be 4%. An unpredictable false negative rate.

In the next paragraph, some discussion of the

financial implications, though again in the middle of paragraph 10 the point is made:

"Nevertheless, we should not wish to stand in the way of testing solely on financial grounds."

In paragraph 11, a description of what was understood to be a potential problem, which is at-risk individuals presenting themselves to the Blood Transfusion Service in order to have their blood tested and the need to set up alternative testing facilities for such individuals.

Then finally in paragraph 12, the conclusion and the recommendation:

"No doubt there will be public pressure for routine screening of blood donations once it is known that commercial tests are readily available. However, having regard to:

"(a) the limitations of currently available tests;

"(b) the disproportionate effect of a high rate of false positive findings; and

"(c) the need to provide alternative screening facilities to divert 'at risk' individuals from the Blood Transfusion Service,

"we recommend the adoption of a phased policy leading to the routine screening of blood donors, which would take into account a comparative evaluation of the

tests available, the need for ready access to testing facilities outwith the transfusion service and a recognition of the considerable requirement for additional testing, monitoring and counselling of donors with positive tests. We should be glad to go whether Ministers agree that we should proceed in this way."

So that was how this issue was put to Scottish Office Ministers on 21 March 1985 and how the evaluation programme was described.

At this point, sir, I'm going to try to answer the question that you asked me earlier, which came about in the context of the statement from Alexander Murray.

It may be helpful if we quickly go back to that statement, PRSE0002440, then to page 4.

Thank you.

The sentence:

"I believe the Scottish Ministers were told about the evaluation programme at this stage. Mr Macpherson's submission [then a reference given is] refers to this."

Now, from the preceding paragraphs of Mr Murray's statement, it looks like he's referring to a period around 21 February 1985. The submission he's referring to here for Mr Macpherson is the one that we just looked at, 21 March 1985. So when Mr Murray referred to Scottish Ministers being "told about the evaluation

programme at this stage", this appears to be referring to the period leading up and to around 21 March 1985, at least some time between 21 February and 21 March.

So I hope that assists with the question from this morning.

SIR BRIAN LANGSTAFF: Thank you.

MR BOUKRAA: Very briefly, the response from Mr MacKay to Mr Macpherson's submission, PRSE0000850.

Sir, not the easiest document to decipher immediately. The date of this is 22 March 1985. We get that from about the middle of this page. It refers at the bottom to Mr Macpherson's minute of 21 March, and includes comments from the Minister. He said:

"I fully appreciate the logic of this advice, especially the danger that 'at risk' men may use the transfusion service as a screen, and as the test is not absolutely reliable some blood may enter the system which is infected. Whatever we do on the BTS, recommendation 12(c) is essential."

Recommendation 12(c) related to the need to introduce alternative testing facilities for at-risk individuals.

The Minister added:

"Also we do have to keep in line or ahead of England, otherwise we will be subject to very severe

criticism."

Sir, I note the time. We're getting close to one o'clock and we started a bit earlier than we might otherwise have. I have a relatively small amount left on HTLV-III screening and I'm hoping to speed up a little bit as I move through the remaining topics I hope to cover today. Would it perhaps be a convenient moment for a break now, and we can pick up the end of HTLV-III screening after the break? There are --

SIR BRIAN LANGSTAFF: Roughly how much more have you got to do on HTLV screening? Roughly.

MR BOUKRAA: Roughly, I would say about ten minutes or so, I'd hope.

SIR BRIAN LANGSTAFF: Right, okay. Let's do that at 2.00, shall we?

MR BOUKRAA: Thank you, sir.

SIR BRIAN LANGSTAFF: So 2.00.

(12.58 pm)

(The Luncheon Adjournment)

(2.00 pm)

SIR BRIAN LANGSTAFF: Yes?

MR BOUKRAA: Sir, the last document we looked at on the introduction of HTLV-III screening was from March 1985 and it was that ministerial submission. I'm going to move forward to late June 1985, when a further update,

albeit a brief one, was provided to the Minister.

We can see that in the following document, SCGV0001146_042.

20 June 1985, again from Mr Davies to the Private Secretary to Mr MacKay. We can see from the first paragraph that it's prompted by a recent DHSS press notice in response to an article:

"Mr MacKay will wish to see the attached DHSS Press Notice. It was issued yesterday in order to refute a report in the Guardian that one particular test [for HTLV-III screening] had already been chosen and was about to introduced."

And in the second paragraph:

"The SNBTS are taking steps to ensure that the test will be introduced in Scotland as quickly as possible, once the evaluations have been completed and facilities for suitable confirmatory tested are available. We are not convinced that the DHSS timetable is achievable, but the intention is that routine testing should start at the same time throughout the United Kingdom."

Now, I don't need to go to the press notice but, as a summary, on the timetable, what it says in the press notice is that the DHSS hopes to introduce routine screening in four to five months' time.

So that will take us to about October/November. And that's what Mr Davies appears to be suggesting might not be achievable, and then the final important point to pick up from this document is:

"... the intention ... that routine testing should start at the same time throughout the United Kingdom."

The following months show that SNBTS and SHHD officials began discussing and referring to an anticipated start date for screening of October 1985. There are also further repeated references in the documents to the simultaneous introduction of screening throughout the United Kingdom.

In terms of ministerial involvement, and to round off the picture on this topic, I'm going to move forward to 20 September 1985 with one more document, PRSE0001516.

This a further submission to the Minister copied to the Secretary of State. It's dated 20 September 1985 and it comes from Mr Liddle. It addresses a number of different topics related to AIDS. The one which is of interest to us is over the page under the heading "Blood Tests", paragraph 6. I'm not going to go through the whole of this paragraph. I'd highlight the first sentence in particular. It says:

"Since AIDS can be transmitted through transfusion

of blood or blood products from an infected donor, arrangements have been made to screen all blood donations as from mid October."

There is then mention of alternative testing facilities, confirmatory testing facilities, and funding, and then the final sentence in this paragraph:

"The commercially available test kits for the detection of HTLV-III antibody have been evaluated by a panel of experts from the Public Health Laboratory Service on behalf of the DHSS and we have made a summary of the results available to Health Boards."

Now, that would appear to be the key documents during the course of 1985 that seek to involve ministers in these decisions and to inform them both that an evaluation programme were to take place, the anticipated timing of the introduction of HTLV-III screening, and that it was intended for screening to be introduced throughout the United Kingdom simultaneously.

Now, a press release was subsequently issued on the introduction of screening from mid-October 1985. We've summarised its contents in the written note.

A bit faster than ten minutes in the end sir, but that was all I intend to cover on the HTLV-III screening, and I am going to move on to a new topic now, which is the Department's knowledge of and response to

the risk of non-A, non-B hepatitis, and hepatitis C.

Now, the Inquiry has previously heard a significant amount of evidence on these areas, particularly on surrogate screening, that includes the evidence of Dr McClelland, it also includes the evidence of witnesses like Mr Macniven. I am not going to cover surrogate screening in a great deal of detail. I'm going to attempt to highlight in particular documents that relate to the Department's understanding of the risks posed by non-A, non-B hepatitis, dividing the period up roughly to pre-1986 and post-1986.

I start with pre-1986.

Relatively little evidence is available in the documents on the Department's understanding of non-A, non-B hepatitis before that period, about the mid-1980s. Most of the available documents relate to officials attending meetings or working groups.

One example that we've highlighted in the note is from 6 March 1980. It's a meeting of the reconvened advisory group on hepatitis B testing, that meeting was attended by Dr Bell. During the course of it there was reference made to work by the Medical Research Council on non-A, non-B hepatitis. The minutes record that:

"Members were concerned about the incidence of non-A, non-B hepatitis and the possibility that new

viruses were perhaps being introduced through the use of commercial blood products, namely Factor VIII and Factor IX."

So linking non-A, non-B hepatitis to factor concentrates.

The minutes add that:

"Members agree that the hazard from non-A, non-B hepatitis should now be recognised and brought to the attention of the appropriate departmental bodies responsible for control of hepatitis."

The following year, 1981, another meeting highlighted in the written note which took place on 25 June 1981, there was a meeting of the MRC's Blood Transfusion Research Committee attended by Dr Bell. During that meeting, Dr Gunson described the work of the Working Party on Post-transfusion Hepatitis.

The minutes record that Dr Gunson reported that reach was being carried out into identifying the agents of non-A, non-B hepatitis, that that was complex research. And perhaps significantly, Dr Gunson noted during that meeting that:

"... large-pool blood products were especially likely to cause liver damage in haemophiliacs."

One more document from the first half of the 1980s that I would highlight is from 23 May 1984. It's from

Dr Bell to Mr Murray, so an internal departmental document. It's about funding for heat treatment of Factor VIII at PFC, and it will probably be easiest if I bring it up.

It's PRSE0004029.

As we can see, it's a minute from Dr Bell to Mr Murray, May 1984, and if we go into the second paragraph, which is in the context of an application for funding for heat treatment, Dr Bell said:

"At present nearly all 'virgin' (newly-treated) haemophiliacs become infected with non-A, non-B hepatitis, though not usually of dramatic severity. About 40% show evidence of infection by hepatitis B. The longer term effects of such infection in haemophiliacs is not known with certainty because until relatively recent years haemophiliacs had little prospect of living into middle or old age. However a significant proportion of 'normal' patients infected with hepatitis B go on to suffer severe liver impairment which, apart from the personal aspect, makes significant demands on health care resources."

Now, that's referring both to impact from hepatitis B and non-A, non-B hepatitis. I flag it as one of the documents we have, which are relatively few, providing insight into the Department's understanding of

non-A, non-B hepatitis in the first half of the 1980s.

From around late 1985, the evidence we have relating to this issue becomes closely linked to the question of whether or not surrogate screening for non-A, non-B hepatitis and surrogate screening of blood donors should be introduced in Scotland.

We're finished with that document, thanks.

The official at the Department who seems to have been most involved with this topic was Dr Forrester. Dr Forrester replaced Dr Bell in 1985.

In March 1986, Dr Forrester attended an SNBTS directors meeting at which this issue, the possibility of surrogate screening for non-A, non-B hepatitis, was discussed. He prepared a note of the meeting for his departmental colleagues, sent it to Dr McIntyre and Dr Scott shortly afterwards.

I should say that Dr Forrester's notes of meetings, such as this one of SNBTS directors, often provide useful insight into his thinking around this issue in the years that we're looking at. I won't go into the document, this one, but I'm going to go to some later ones.

In this one, which is from March 1986, Dr Forrester described non-A, non-B hepatitis as a medley of conditions.

He wrote that:

"... any additional test [like surrogate screening] ... must necessarily be non-specific and could well prove expensive ..."

He said that he'd made further enquiries and discovered that the number of cases of non-A, non-B hepatitis due to blood transfusion in Scotland was probably exceedingly low.

He referred to a PhD thesis, and we'll come on in a moment to which thesis that was.

He also reported that it had been argued by directors at the meeting that urgent action was required with respect to surrogate screening for non-A, non-B hepatitis, and that the case was comparable with that of AIDS.

Dr Forrester said that he challenged this comparison on the basis that the steps taken to deal with AIDS were taken in a face of a rapidly rising incidence whereas the incidence of non-A, non-B hepatitis as far as he knew, was small and steady. He said there was no justification for panic measures and that there might be a justification for research, rather than what he described as panic measures.

Now, the thesis referred to by Dr Forrester was by Dr Dow, and was earned at the University of Glasgow

in 1985. It related to research into non-A, non-B hepatitis in the West of Scotland under the supervision of Dr Mitchell and Dr Follett, and Dr Forrester obtained a copy of that thesis.

We can see how it informs Dr Forrester's understanding of non-A, non-B hepatitis in a document from June 1986. I'm going to go to that now.

It's PRSE0000857.

Now, this document is dated 12 June 1986. It's a note prepared by Dr Forrester titled:

"Transmission of non-A, non-B hepatitis by blood and blood products: is it practicable to reduce or prevent it by introducing ALT testing of donations?"

ALT testing of donations, I'm sure that everyone who has followed the Inquiry will be familiar with, is one of the methods by which you carry out the surrogate screening for non-A, non-B hepatitis.

Now, in the first paragraph Dr Forrester recorded.

"1. The information in this note is mostly derived from the PhD thesis entitled: 'Non-A, non-B Hepatitis in the West Scotland', completed in 1985 by Dr BC Dow under the supervision of Dr Follett and others."

If we look at paragraph 4, we can see Dr Forrester's description of non-A, non-B hepatitis.

He says:

"... it is not uncommon in the population ..."

The suggestion of an incidence in Scotland of 184 cases per year, but a suggestion that might not be a reliable figure.

"It is common among drug-abusers."

And then:

"But in association with blood transfusion it is very uncommon in the west of Scotland. Over the last 8 years, 1-5 cases are found each year there, and there is no upward trend. There are peculiar difficulties in identifying its presence in haemophiliacs since their blood exhibits diverse reactions because of repeated administration of blood products, but Dr Dow found no evidence of any substantial problem. Dr Dow recons that the proportion of donations infected with non-A, non-B hepatitis may be 18 per hundred thousand."

He goes on to discuss the merits of surrogate screening before concluding in the last paragraph that Dr Dan Reid and Dr Follett do not recommend the introduction of ALT testing of Scottish blood donations, for reasons he describes in the note.

Now, over the months that followed and during further meetings attended by departmental officials, there appears to have been an increasing emphasis on the

need to carry out further research before additional consideration could be given to whether or not to introduce surrogate screening.

This issue was also considered in Scotland alongside consideration elsewhere, for example, in the reconvened UK Working Party on Transfusion Associated Hepatitis.

We can see Dr Forrester referring to some of these issues in January 1987 at PRSE0001376.

Now, this is dated 26 January 1987. We can see at the top its title, "Material for PMO Report".

This morning I described one of the means by which Dr Macdonald said that the CMO and DCMO were kept up to date with what was happening amongst medical officials in the Department, described monthly PMO reports. We don't have those reports but this looks like a contribution to one such report prepared by Dr Forrester.

If we go down to the second half of this document, at paragraph 2:

"Blood transfusion and non-A, non-B Hepatitis (Dr Forrester)"

This is how he describes the condition:

"This 'hepatitis' is a residual rag-bag when Hepatitis B and Hepatitis A are excluded, and

consequently no specific test can detect it. It is relatively benign. But US blood banks have noted that the combination of a liver function test and a test for the core (not the surface) antigen of Hepatitis B distinguishes perhaps a third blood donations which would convey non-A, non-B 'Hepatitis' and allows them to be excluded. Exclusion is far from complete, and besides, some 2% of 'innocent' donations may also be excluded.

"Nevertheless, US blood banks are evidently about to adopt this pair of tests and shoulder the expense. Here, it is intended instead to enquire into the number of relevant donations and the characteristics of the donor, before taking any further step."

So now no doubt you may wish to consider and hear submissions on the characterisation of non-A, non-B hepatitis that we see in this document in particular, the suggestion that it's relatively benign and how that falls to be considered alongside all of the other evidence the Inquiry has heard about non-A, non-B hepatitis.

The final sentence I've highlighted here picks up the view that further research needed to be undertaken before any decisions could be made about the introduction of surrogate screening. So that's

January 1987.

In March 1987, on 3 March of that year, a meeting of SNBTS directors took place. It was attended by Dr Forrester. The minutes of that meeting record that the directors, following a discussion, decided to recommend to the SHHD that non-A, non-B surrogate screening should be introduced in Scotland. I won't go to the minutes today but what they record is the following recommendation:

"To recommend to the SHHD that surrogate testing for [non-A, non-B] should be implemented with effect from 1 April 1988 as a national development requiring strictly new funding."

That was a meeting attended by Dr Forrester.

Dr McIntyre picked up on this recommendation in a minute to departmental colleagues on 6 April 1987. I won't go to the document but he summarises the background. Dr McIntyre wrote that in the USA:

"... largely one suspects because of the fear of litigation, there has been a great deal of pressure to introduce this indirect screening for 'Non-A, Non-B Hepatitis' ... we understand this is likely to happen soon. A similar situation is said to exist in Germany."

He added that the directors of the SNBTS were

"unanimous" and that they were "pressing fairly strongly" that this screening should be instituted in Scotland, while adding that the directors were:

"... perfectly aware that it would be costly and could not abolish transmission completely, they could then claim to have taken all steps open to them to reduce transmission. Before embarking on such an expensive programme it would seem logical to participate in the proposed research [that was discussed elsewhere in the document] and to delay any further action until the results of this were known."

What we see around this time, and later into 1987 is some uncertainty around Scottish participation in a proposed UK study of non-A, non-B hepatitis. As well as a concern in the Department that the SNBTS directors might simply begin surrogate screening without direct SHHD authorisation.

We move into 1988. By this point little progress seems to have been made on the introduction of surrogate screening, or on decisions about the introduction of surrogate screening. Despite some of those departmental fears, SNBTS directors did not in fact introduce screening unilaterally.

By the time that we get to a 12 April 1988 meeting of SNBTS directors, attended by Dr Forrester, there was

a suggestion that directors were already undertaking their own research on this issue leaving open the possibility that they might introduce surrogate screening in the future, and the minutes include the following, and this passage is particularly relevant to the relationship between decisions in Scotland and decisions in the rest of the UK:

"... it was confirmed that it had been agreed not to introduce ALT testing in Scotland until it had become UK policy, but Directors wished to reserve their position on this matter in the light of reports at the commencement of ALT testing in at least one [England and Wales] RTC."

Now, by the time we get to later in 1988, the question of whether to introduce surrogate screening for non-A, non-B hepatitis in Scotland became interlinked with and was eventually overtaken by developments related to the discovery of the hepatitis C virus, and I'm going to turn to that issue now.

That was a fairly quick move through, sir, the evidence that we have relating to non-A, non-B hepatitis. There is, as ever, more detail contained in the written note.

Now hepatitis C screening.

The chronology and our understanding of this

section might conveniently be thought of to begin with the announcement in May 1988 that the Chiron Corporation in the USA had discovered the non-A, non-B hepatitis virus, which of course became known as hepatitis C.

It appears that departmental officials became aware of this discovery by at least June 1988 through their attendance at meetings of SNBTS directors.

Soon thereafter an important development in this chronology is the creation around late 1988 and early 1989 of two Advisory Committees which worked at UK level: the Advisory Committee on the Virological Safety of Blood, ACVSB, and the Advisory Committee on Transfusion Transmitted Diseases, ACTTD.

Both of those committees played an important role in considering the introduction of hepatitis C screening. The written note makes brief reference to their creation. Their deliberations have been considered previously by the Inquiry. I'm only going to refer very briefly to the outcome of some of their meetings.

A point to note for our purpose is that departmental officials attended meetings of the ACVSB as observers. It was usually Dr McIntyre who attended those meetings in this period. Officials don't seem to have attended meetings of the ACTTD.

Now, as hepatitis C screening was considered by officials in the Department from early 1989, one of the issues that emerges is the relationship between a decision to be taken in Scotland on both the principle and timing of the introduction of screening, and decisions taken elsewhere in the UK. What we see in the documents from 1989 are a number of references to a UK-wide approach to the introduction of screening.

One example of that sort of reference is in an August 1989 letter from Dr McIntyre to Professor Cash, which made reference to the work of the ACVSB, and in which Dr McIntyre wrote:

"If it is considered desirable to introduce a further routine screening test for blood donors [ie, the screening test] I understand that this will be done simultaneously throughout the UK -- as was done in the case of the current HIV test."

I note that at this stage, that policy decision, if it can be described in that way, didn't yet seem to have been put to ministers in the Scottish Office.

I can turn to what seems to be the first time that officials bring this issue to the attention of ministers in the Scottish Office, in the summer of 1989.

It's the document at PRSE0000558.

Now, this is a minute prepared by Mr Tucker, who

replaced Mr Macniven as Assistant Secretary in the HHD, directed to Mr Forsyth, the Private Secretary to Mr Forsyth. We can see what's prompted this document in the first paragraph.

"This note is to advise the Minister about an article in today's Guardian [attached is a copy] ... which seems likely to prompt other media enquiries."

I note at this stage in parentheses, earlier on this morning we looked at Mr Murray's description of some of the factors or circumstances which might lead to ministers being updated or informed of developments, he included media interest or media articles, and this seems to be an example of that happening.

Now, Mr Tucker set out the background to this issue in the first few paragraphs. I'm not going to go through all of that now. I'm going to pick up in paragraph 4 his description of the effect of infection with hepatitis C.

"Only a minority of those infected with HPC [ie hepatitis C] display any symptoms either in the short or long term ..."

It suggests that the way this point had been described in The Guardian article was unnecessarily alarmist.

Over the page, there's reference to the work of

the ACVSB. In paragraph 7 Mr Tucker wrote that:

"The accuracy of the test for hepatitis C has not been fully established ..."

Describes further work which was considered to be essential to be undertaken. And then finally, the line to take.

"If asked to comment it is suggested that the Minister uses the following:

"(a) Donors should not be deterred from giving blood."

It highlights entry (d):

"The prevalence of HPC in the population in this country has not been established, nor has the role of blood in its transmission."

Finally:

"This is a UK issue and D of H [Department of Health] will be taking the lead but SHHD and SNBTS will be represented in any meeting and the Minister will be consulted before any decisions are taken."

Now, over subsequent months the introduction of hepatitis C screening was considered at meetings of those two committees I mentioned earlier, ACVSB and ACTTD. The Department was kept informed of their deliberations, in particular from Dr McIntyre's attendance that the ACVSB meetings.

I've highlighted one of those meetings, it's referred to in the note, on 17 January 1990 when the minutes of the ACVSB record a general consensus that routine testing should not be introduced in advance of an FDA decision on whether to licence this particular hepatitis C screening test. It was suggested that scientifically not enough is known yet about the screening test to justify its introduction.

One more document involving ministers from around this time, SCGV0000230_145.

Now, this is from 1 February 1990. It's a minute to the Private Secretary to Mr Forsyth, copied to the Secretary of State. As will be apparent from the title it is primarily concerned with a different issue which we'll come back to later. If you go over -- sorry, not over the page, to the bottom of this page, please. There's discussion of challenges from a budgetary perspective facing the Department and, in that context, brief reference to the possible introduction of hepatitis C screening:

"All budgets are likely to be very tight next year ..."

The CSA budget was described as:

"... likely to come under severe pressure from a number of sources which were not foreseen at the time

of framing bids for [the budget]. (Eg the prospect of a two year settlement for pay of ambulance staff and the introduction of routine blood testing for Hepatitis C which is expected to become unavoidable following expert advice that such testing should be introduced in order to prevent the risk of future claims against the Government similar to those now pending in respect of haemophiliacs with HIV.)"

So that's February 1990. I'm going to move forward to mid-1990, when officials in the Department became aware that the FDA had approved hepatitis C testing, had granted a licence for a screening test.

In response to that, a meeting of the ACVSB was brought forward. We can get some insight into Dr McIntyre's view of that development in this document. It's PRSE0003099.

So this is a 6 June 1990 minute from Dr McIntyre to Dr Young, copied to colleagues in the Department, including Mr Tucker, headed "Hepatitis C Testing".

If we zoom in on the first half of the page, Dr McIntyre reported:

"Things are moving very fast on the Hepatitis C front. The FDA have now approved the Hepatitis C antibody test. Until this approval was given in the country in which the test originated the Advisory

Committee on the Virological Safety of Blood was reluctant to recommend its introduction in the United Kingdom. It was agreed at the last meeting that there should be a study to investigate the significance of positive finding using the ELISA Hepatitis C antibody screening tests followed up with an extended study of RIBA and PCR techniques."

We then can see the paragraph towards the bottom of this current view:

"I am in little doubt that for a variety of reasons, many of them non-scientific, it will be decided that there is no alternative but to recommend the introduction of the test."

If we go down to the bottom of this page, Mr Tucker -- sorry, not Mr Tucker, Dr McIntyre wrote:

"As you will remember one of the problems in the litigation in relation to HIV infection of haemophiliacs is whether or not the HIV testing was introduced as early as was possible. Although Hepatitis C is not such a fatal condition as HIV infection litigation would be possible if a patient was subsequently to determine that he had been transfused with Hepatitis C positive blood -- or blood which had not been tested for Hepatitis C antibodies. It is of course well known that there are many patients who suffer from Hepatitis C who

never have blood transfusions. The whole issue is something of a minefield."

Now, the ACVSB meeting which was brought forward in response to the FDA announcement took place on 2 July 1990. It was attended by Dr McIntyre. As will be familiar to the Inquiry, it was recommended, or rather it was agreed at that meeting to recommend hepatitis C screening to ministers after a pilot study to determine whether one of two tests, the Ortho or the Abbott test, was most suitable for use in Regional Transfusion Centres, and the estimated timescale for study was around four months. That's July 1990.

If we move forward to November 1990, Dr McIntyre attends another meeting of the ACVSB. He prepares a note of the meeting and circulates it to colleagues in the Department. In that note there's some discussion of possible start dates for hepatitis C screening.

Dr McIntyre's note of the meeting recorded that some attendees wanted testing to start forthwith, while the Chair of the Committee was said to have suggested that 1 April 1991 might be more realistic.

Dr McIntyre also suggested that the Department should wait to receive a draft submission being prepared by the Department of Health. So we see in that November 1990 note, reference to a possible start date,

1 April 1991.

Now, the DoH submission was finalised and put to ministers in England and Wales on 21 December 1990. It was copied to the SHHD. That submission recommended the introduction of hepatitis C screening. It recorded that other UK Health Ministers were being asked to approve the introduction of screening in their transfusion services. So that's December 1990. As we'll see, and this is to jump ahead, the submission which went to ministers in Scotland on this particular issue, and addressing it directly, didn't go in until July 1991.

So December 1990 the DoH submission is made. The departmental officials in Scotland had become aware of it by January 1991. They also became aware that ministers in the Department of Health had given their approval to the introduction of hepatitis C screening. Officials in Scotland then began considering a submission to their own ministers.

As I've said, that submission was not eventually -- was not put in until July 1991. What we see over the months between January 1991 and July 1991 is what appears to be an awareness amongst officials in the Department of the start date, the proposed start date, for routine screening of hepatitis C being pushed back.

It seems that around late February 1991, following an ACVSB meeting, officials in the Department came to understand that the likely start date for screening was being pushed back from 1 April to 1 July 1991.

It appears that by late March, they became aware of a suggestion that that 1 July date might be pushed back again. We can see an example of that in a letter from Professor Cash, which is at PRSE0003692, dated 27 March 1991. It's a letter from Professor Cash to Mr McIntosh, who I understand was a general manager of the SNBTS at the time.

If we go over the page we can see the letter was copied to Dr McIntyre in the Department.

Professor Cash wrote, and if we can go back to page 1, please:

"You will want to know that our NBTS colleagues are struggling, on a number of accounts, to meet the 1st July deadline, as previously discussed and I thought agreed. We believe the fundamental problem is one of financial resourcing.

"At a meeting of the UK BTS Advisory Committee on Transfusion Transmitted Diseases in Manchester [the previous Monday], the following was agreed:

"(a) Harold Gunson would advise DoH that the 1st July start date should be delayed until such time as

an evaluation of the new generation of HCV screening tests had been completed. If this is accepted it could push a start date to September."

Some more material, I know, sir, related to these developments and the introduction of new second generation screening tests will have been considered by the Inquiry previously. We can see here the officials in the HHD becoming aware -- being made aware of these developments. I'm also going to try to decipher, in the top right-hand corner, a manuscript note, which seems to be between two officials in the HHD. I believe it's from Mr Panton to Mr Hogg, dated 2 April 1991.

"This is worrying. [Please] speak to DoH. We can't go to the Minister until we know the start date".

Now, a number of other documents which are summarised in the written note suggest that officials in the Department continue to monitor the position in the Department of Health and developments in the ACVSB over subsequent months. It became apparent that the start date was in fact pushed back to 1 September 1991.

Now, the extent to which officials in the Department considered proposing an earlier start date to Scottish ministers is unclear from the available documents. We have some evidence, some of which I've just pointed to, of officials becoming aware of

proposals and an agreement to push the start date back.

What we don't seem to have clearly from the documents is the extent of any thinking about whether officials should go to ministers in Scotland to say, "The start dates have been pushed back, would you like to make a decision about whether to introduce screening earlier in Scotland than the rest of the UK?"

We, in fact, have couple of documents from July 1991 which suggest that Dr McIntyre thought it might be possible that the start date would be pushed back further from September 1991. We can see that in a letter that Dr McIntyre wrote to Dr Metters to his, I believe, DCMO in the Department of Health. The letter was prompted by an article that had been published in the British Medical Journal about sexual transmission of hepatitis C. Dr McIntyre explained in the letter that he thought that might lead to difficulties around counselling of patients who tested positive for hepatitis C, enquired whether that might have an effect on the September start date and whether it might be pushed back.

I'm going to look at Dr Metters' response to that letter. It's at PRSE0001103, so 11 July 1991, from Dr Metters to Dr McIntyre.

I only need to summarise very briefly the contents

of the letter in essence towards the bottom of the page. Dr Metters says that it was thought unlikely that this recent article that had been published would have an impact on the September 1991 start date. But if we go up the page to the manuscript notes which seem to be between officials in the Department, it says:

"We can now proceed with the Hep C submission. We must get it up this week before Recess."

So it appears to suggest a belief that it was necessary to get an answer to Dr McIntyre's letter before finalising and putting a submission to ministers in Scotland.

Now, that submission was finalised and put to Mr Forsyth, as he then was, on 24 July 1991. I'm not going to go to it. It was considered in Lord Forsyth's evidence.

The URN for those who would wish to have it to hand is PRSE0004608.

That submission recommended that hepatitis C testing of blood donations be introduced in Scotland from 1 September 1991, after setting out some of the arguments for and against screening.

Lord Forsyth accepted that recommendation, asked that a press release be prepared to announce it. That press release was issued by the Scottish Office on

2 September 1991 to announce the introduction of hepatitis C screening in Scotland.

Now, again, sir, I've moved fairly quickly through that material. As ever, there's more in the written note. That all I intend to say for the moment about the introduction of hepatitis C screening in Scotland.

The next topic which comes up for those following using the written note is prisons. It's a very short section. There's not a great deal in there. I'm going to suggest that those who are interested in reading more about that topic look at the written note and I'm going to move to a final set of issues/topic for today: compensation, litigation, and financial support.

Now, I can pick up the chronology on these issues in early 1987, when the Department became aware of calls for the Government to compensate haemophilia patients who had been infected with HIV blood products.

The documents suggest that at this stage, early 1987, officials in the Department were emphasising the importance of following, at the very least having regard to the DHSS position, following it closely.

I'm going to go to a document which shows how officials put this issue to ministers in early 1987.

It's SCGV0000229_232.

Sorry, sir, if I could just have one moment to get

the document in my notes.

(Pause)

Sir, we can see the document is dated 9 February 1987. It is addressed from Mr Lugton to the Minister of State. At this time that Minister was Lord Glenarthur. The minute describes correspondence which had been received as part of a campaign to obtain compensation for haemophiliacs infected with the AIDS virus via contaminated Factor VIII.

In paragraph 2 I pick up the way in which that infection is described: from supplies which were unwittingly provided before treatment was introduced to minimise the risk of Factor VIII containing the AIDS virus.

Mr Lugton goes on to explain the reasons behind the Government position at the time, which was not to accept calls for such compensation. We can see that at the end of paragraph 3 where he says:

"Before compensation to haemophiliacs could be seriously considered, therefore, it would have to be clearly established that they were a unique group who could be clearly distinguished from any other victims of drug mishaps or other medical accidents."

It made some reference to a Pearson report of 1978 on no-fault compensation, and at paragraph 6 it says:

"Against this background, we consider that the Minister's replies should not hold out any hope of a change of the Government's policy on this matter ..."

It also makes reference to responses which had been sent by Lady Trumpington in the Department of Health.

Now, the written note describes Lord Glenarthur's response to this minute in which he asks for some changes to be made to the draft replies which had been prepared to these letters while, it seems, not challenging the substantive policy decision which was to refuse calls for compensation.

I'm going to move forward to autumn 1987, by which time Lord Forsyth had replaced Lord Glenarthur as the Minister in the Department with responsibility for Health.

What we see in the documents is the SHHD position being maintained, refusing calls for compensation with officials in the Department monitoring developments at the DHSS.

As will be familiar to the Inquiry, the position changed, at least to some extent, in November 1987, when there was no acceptance that compensation was appropriate, but a UK Government decision was taken to make an ex gratia payment to haemophilia patients and

their families who had been infected with HIV.

Now, that decision was considered at a meeting of the Subcommittee on AIDS of the Home and Social Affairs Committee, H(A) Committee, on 10 November 1987, worth noting that that was a meeting and a committee attended by Malcolm Rifkind, who was at that time Secretary of State for Scotland. So Mr Rifkind, as Secretary of State for Scotland, was involved in the discussions and the decision-making process that led to the announcement of the ex gratia payment in November 1987.

The documents suggest that in early 1988, the course of 1988, after this announcement was made, officials in the Department had relatively little involvement in the setting up of the Macfarlane Trust which was to administer this ex gratia payment. That's 1988.

We're going to jump forward again to November 1989, the reasons I'm jumping forward will I hope become apparent. In November 1989, Kenneth Clarke, the Minister in England and Wales, announced that an additional ex gratia payment to the Macfarlane Trust would be made. Part of the reason for jumping forward in the way that I did is that decision seems to have been taken without any consultation or discussions with officials in the Scottish Office so,

effectively, November 1989, Scottish Office officials and ministers learn that this decision had been taken.

There then followed discussion within the HHD and with the Department of Health about whether the Scottish Office should be required to contribute to the funding of this additional payment, particularly given that the Department hadn't been consulted at all, before the decision was taken and announced, if it should be asked to contribute, how much of the funding should it be asked to provide.

It was eventually agreed that the Scottish Office should contribute, and that it should do so on the basis of the proportion of haemophilia patients infected with HIV from blood products who lived in Scotland.

Now, that agreement to contribute to this funding was obtained by officials in the Department from Lord Forsyth in early February 1990, following a submission which was put to the minister setting out the background to the announcement, setting out the discussions which had followed it about the Scottish Office's contribution or potential contribution to the funding, and we can see that Lord Forsyth accepted that the Department should contribute to this additional payment.

I'm moving on now, sir, to the HIV Litigation.

Moving back slightly in time from November 1989, when the additional ex gratia payment was announced, to 1988, and the documents show that claims in the HIV Litigation began to be lodged in the Scottish courts against Scottish health boards, the SNBTS, and the Secretary of State for Scotland.

Now, those three individuals and bodies referred to in the Scottish litigation generally as defenders. What we can see in the document summarised in the notes, during the course of 1988, representatives from those different defenders, so the Secretary of State, the Health Boards, the SNBTS, met to discuss their responses to the claims. The documents suggest that at this time they shared the view that the actions should be defended.

In early 1989 the Health Minister in the Department, Lord Forsyth, asked for an update on the litigation in light of a newspaper report. And I'll go to that document in which he was provided the update now. It's SCGV0000229_052.

Sir, this is advice provided by Mr MacNiven to Mr Forsyth. We can see that the article was prompted by -- sorry, the advice was prompted by an article in the Daily Record, January of that year, that said, "You gave us AIDS". In response to it, the Minister made

a request for advice.

Mr MacNiven begins by summarising the background and the nature of the claims. If we go down, we can see that in paragraph 5. Paragraph 6, the number of claims to date is outlined. Then in paragraph 7, at the bottom, Mr MacNiven noted that the Department was working with the Solicitor's Office to prepare defences on behalf of the Secretary of State for keeping in touch with the other defenders in the action. Then over the page:

"Should the Minister be asked to comment on any of these cases I would advise him to point to the £10m ex gratia payment (which was evidence of the Government's concern and sympathy for the plight of the haemophiliacs infected with HIV) and to say that the cases alleging negligence are a matter for the courts to decide."

In other words, reflecting the UK Government position that compensation was not to be paid in response to these claims.

Now, as we've seen in late 1989, the additional payment to the Macfarlane Trust was announced without any consultation with the Scottish Office, and then during the course of 1990, the following year, officials continued to monitor the Department of Health's position

on the HIV Litigation, particularly in light of their experience with the announcement of the additional payment to the Macfarlane Trust, to try to understand the position of the Department of Health and the possibility that any further payment might be made.

Now, there is some suggestion in the documents that in early December 1990, the Scottish Office came to believe that there was some possibility that a payment might be made to settle the litigation. That's a brief handwritten reference in some of the Scottish Office SHHD documents we have rather than anything formal from the Department of Health to the Scottish Office.

Then on 11 December 1990, the Prime Minister announced, in response to a Parliamentary question, that the Government had agreed in principle to settle the HIV Litigation.

Now, similarly with the announcement of the additional payments to the Macfarlane Trust, the Scottish Office does not seem to have had any involvement in the negotiations leading to this announcement. The documents indicate that this resulted in difficulties for the Department's attempts to settle the Scottish claims.

As well as Scottish Office officials expressing their concern to other UK Government officials, the

documents show solicitors acting for the litigants in Scotland expressing their dismay at being excluded from the negotiations leading to this announcement. What became clear was that negotiations had been taking place in England and Wales between the lawyers, the litigants there, and the Department's representatives. The parties of the lawyers in Scotland, as well as the officials, had been excluded from those negotiations.

We can see that dismay being expressed in a letter from Mr Tyler, who worked at Balfour and Manson solicitors, and who was also chair of the Scottish Haemophilia HIV Litigation Group. That was an association of Scottish firms representing individuals in Scotland who were involved in the litigation.

One point to note, my understanding here is that the procedural rules that applied in Scotland at this time didn't allow for a group litigation claim, as was the case in England. Instead, you had a number of different claims but which were coordinated through this association of which Mr Tyler was the chair.

Now, from December 1990, after this announcement, officials in the Scottish Office, both in the Department and in other departments, like those in the Scottish Legal Office, worked on preparing and negotiating settlement terms for the Scottish claims. That involved

a number of challenges, and this is a trite point for which I apologise, but Scotland having a separate legal system, it was not simply the case that the terms could be proposed, agreed in England and Wales, and be transposed to Scotland. Work had to be undertaken in Scotland to make any potential settlement work there.

One of the key issues that became apparent in the months that followed, so from December 1990, in the first few months of 1991, was that additional time was going to be necessary for this process to take place and, in particular, for the lawyers representing the Scottish litigants to be able to investigate their clients' claims.

Issues related to funding for lawyers, the availability of Legal Aid and other funding, meant there had been relatively little investigation of the facts underlying the claims. This was a point considered internally by Scottish Office officials, discussed with lawyers representing Scottish litigants. It became apparent that it was going to be necessary for the Scottish lawyers to have some additional time to those in England and Wales to investigate and consider their claims.

Now, this issue was addressed in a minute from Mr Tucker to Mr Forsyth and the Secretary of State who

at the time was Ian Lang. That minute came about following a suggestion from Mr Forsyth that the Department should try to move speedily towards a settlement in Scotland. Mr Tucker described some of the factors I've just outlined, and suggested that additional time be given for litigants in Scotland to consider the possibility of settlement.

Now, in order for that to be possible, it was suggested that ministers and, in fact, the Secretary of State for Scotland get in touch with his counterpart in England and Wales in order to ask for additional time for litigants in Scotland.

We can go just briefly to a couple of documents before the break on this issue.

The first is DHSE0003660_009.

This is a letter dated 17 January 1991. It's from the Secretary of State for Scotland, Mr Lang, to William Waldegrave, the Secretary of State for Health.

If we go down, we'll see in the first paragraph the letter describes some of the background to the recent agreement in principle that had been reached in England and Wales to settle the litigation.

Then, on to the next paragraph, the letter sets out that there are separate Scottish legal actions for compensation that hadn't progressed as far as the

English claims, that the Scottish lawyers concerned were not represented on the Steering Committee and had not been party to the preparation of the proposals nor involved in the discussions which had taken place with the Steering Committee:

"This has placed the Scottish Office in a difficult position since all the discussions on the details of the settlement have been in relation to the English plaintiffs and there have already been representations made to me by the Scottish lawyers that they were not consult before the offer was made public. They consider that they are not in a position to advise their clients on acceptance or otherwise until they know and can assess the contents of the offer and conditions of acceptance but also until they are fully investigated their clients' claims."

That summarises some of the points I was just trying to make.

If we move down to the bottom of this page, and on to the next one, we see that the letter sets out that the Scottish lawyers estimate that they would need some additional time, over the page, to carry out the further assessment of the acceptability of the proposals for the settlement. Mr Lang proposes that a reasonable further period be allowed to the lawyers in order for them to

consider the settlement offer.

If we go just briefly to Mr Waldegrave's reply, which is at DHSC0003660_010, 30 January 1991.

The letter records that a deadline of the acceptance of the offer made in England and Wales had not yet been set. Down the page, the Secretary of State, Mr Waldegrave, comments:

"... I quite understand the difficulties you would face in trying to complete a settlement in Scotland in the same timescale [as has had been proposed in England and Wales]. I have no objection, therefore, to your proposal to set a reasonable period for Scottish litigants to be advised by their lawyers on a response to the offer."

Then in the next paragraph:

"While differences over timing are manageable, I think that the terms to of the settlement must be the same for all to avoid reopening the whole issue."

Then the bottom of this paragraph, the final sentence:

"I hope, therefore, you will accept that the size and categories of payment on offer must be common to all litigants wherever they have pursued their action."

So an emphasis on the need for the nature of the settlements in Scotland and England and Wales to match,

even if some additional time might be needed in Scotland as a result of the way that the compromise announcement was made.

Sir, I note the time. I have a few -- a number of further documents and issues to highlight in relation to litigation, including one I prefaced right at the beginning of today, this morning, the question of the waiver which applied in Scotland as against the waiver which applied in England and Wales. I wonder if it might be a convenient moment.

SIR BRIAN LANGSTAFF: Well, let's take a break then until 3.45. 3.45.

(3.14 pm)

(A short break)

(3.45 pm)

SIR BRIAN LANGSTAFF: Yes.

MR BOUKRAA: Sir, I'm going to continue with documents relating to the HIV Litigation in Scotland and I'm going to pick matters up shortly after the correspondence we looked at before the break, a minute dated 8 February 1991 from Mr Tucker to the Private Secretary to the Secretary of State.

The reference is SCGV0000232_110.

Now, we can see in paragraph 1 of this document that Mr Tucker made reference to the correspondence we

looked at a little bit earlier.

In paragraph 2, I just want to pick up a few points in the first part of this paragraph.

Mr Tucker wrote:

"The Secretary of State for Health seeks assurance however that the terms of settlement in relation to the size and categories of payments must be common to all litigants and we can readily give this assurance."

So making the point that the size, the category of payment for litigants in Scotland should be the same as that in England and Wales.

"On the matter of informal soundings, Solicitor's Office has already shown a draft settlement adjusted to reflect the Scottish legal situation to the solicitors representing the main group of Scottish litigants. But the main difficulty to a speedy conclusion of the consideration of the offer, and consequently the reason for a more protracted timescale in Scotland, lies in the investigative work which Scottish solicitors require to undertake if they are to be in a position to give advice to their clients as to the merits of settlement. In the vast majority of cases Scottish solicitors are unable to undertake that work until legal aid has been granted."

Then some more detail on how that problem might be overcome, concluding with a recommendation at the bottom

of this paragraph that an additional three months be offered to litigants in Scotland.

So we can see there officials agreeing that effectively the settlement, at least in terms of size and categories of payment, should be the same in Scotland as in England and Wales, referring to some of the reasons that I outlined earlier for why more time might be needed in Scotland, and also referring to draft settlement terms having been shown by Scottish Office solicitors and lawyers involved to those representing litigants in Scotland, so that's February 1991.

Over the months that follow, and I'm going to start by going up to May 1991, there are a series of letters, meetings going back and forth between officials in the Scottish Office and officials in the Department of Health, and also lawyers representing Scottish litigants, on the terms of settlement in Scotland, negotiations over their terms and liaising between the two departments about what the settlement terms should look like and how they should be framed exactly in their detail.

In the addendum notes that the Inquiry is going to provide to Core Participants as quickly as we can, we are going to attempt to trace the back and forth of some of that correspondence over the months with an eye, in

particular, to developments which relate to the question of a waiver for those who agreed to the settlement terms. This waiver issue related to an undertaking that litigants were asked to give. In order to get the benefit of the settlement, the undertaking was to effectively give up the right to bring a further claim against the different defendants or defenders to these actions arising from infection with blood products, Factor VIII and Factor IX.

Now, the particular issue that we're concerned with was whether that undertaking was supposed to or was intended to and did waive litigants' rights to future claims concerning only infection with HIV or also infection with hepatitis.

Now, the detail of the correspondence and the drafts of terms and drafts of declaration of trust for the Macfarlane Trust No 2 that's eventually declared is going to come in the note. For the purposes of today, I can pick up the chronology on 3 May 1991 with a declaration of trust for the Macfarlane (Special Payments) (No 2) Trust.

That is at MACF0000083_004. We have a date at the top, 3 May 1991:

"Declaration of Trust

Constituting

"The Macfarlane (Special Payments) (No 2) Trust"

Now, this is the document which reflects compromise reached in England and Wales for the HIV Litigation. At the time that this trust deed was executed, negotiations over the Scottish settlement were still ongoing and some of the contents of this document reflect that.

Before I go to the parts of it that relate to Scotland, I just want to pick up on page 22, please.

This was the undertaking to be given by litigants in England and Wales. We don't need to go through all of the technical detail. What we can see is that what this undertaking required is to undertake that:

"... I will not at any time hereafter bring any proceedings against the Department of Health, the Welsh Office [various other defendants] or any other Government body [and this is towards the bottom of this passage] involving any allegations concerning the spread of the human immuno-deficiency virus or hepatitis viruses through Factor VIII or Factor IX (whether cryoprecipitate or concentrate) administered before 13th December 1990."

So an undertaking that appears to cover both future claims relating to HIV and hepatitis viruses.

If we go, please, first to page 24. We don't need

to go to the detail of these pages but this is a schedule 3, which modifies some of the provisions of the trust deeds so that they can apply to the settlements. In Scotland they cover a number of particular issues. If we could go to page 27, schedule 4, an undertaking to be given --

SIR BRIAN LANGSTAFF: Just go back for a moment to schedule 3, please.

MR BOUKRAA: Of course.

Back to page 24, please.

SIR BRIAN LANGSTAFF: Thank you.

Thank you.

MR BOUKRAA: And if we go back to page 27, please, Lawrence, schedule 4.

Here we have the undertaking to be given by a qualifying person in Scotland to receive payment from this Trust.

The second half of the page, please. I won't go through all the detail but I'm going to pick out few references. Paragraph 1:

"I hereby discharge the said Secretary of State [the Secretary of State for Scotland] and all other Ministers [different defenders] ... from any liability they may have in respect of the infection of [X person] with human immunodeficiency virus or hepatitis viruses,

alleging arising out of treatments before 13th December 1990 with Factor VIII or Factor IX ..."

This document continues over the page with references made at various points to both HIV and hepatitis, for example we can see that in paragraph 4.

"I undertake not to bring any proceedings against the Crown or any health service body now or at any time in the future in respect of infection ... by [HIV] or hepatitis viruses."

So what we appear to have here is it being envisaged that in Scotland, as in England and Wales, there will be an undertaking to waive the right to bring future claims and that waiver will cover both hepatitis and HIV.

SIR BRIAN LANGSTAFF: Just one question about it.

MR BOUKRAA: Yes.

SIR BRIAN LANGSTAFF: The waiver, so far as it related to England and Northern Ireland, et cetera, was a waiver which in terms, as I read it on the screen, that the proceedings were not related to the spread of or spreading of HIV or hepatitis viruses. This is rather different because it doesn't mention the words "spread" or "spreading"; it does means the infection of somebody, which I think the first part of the first waiver doesn't. Am I right in that distinction?

MR BOUKRAA: Sir, you're right that on their face those two different versions of this waiver ...

SIR BRIAN LANGSTAFF: Yes, so you say this waiver, there are two different waivers. They may come to the same effect but the one is in respect of the spreading of, any allegation about the spread of, which is peculiarly vague, and -- or might be thought to be -- and this one, which is much more specific to the individual, which is the infection, presumably of the individual, that's the blank, by HIV or hepatitis. Does anything turn upon that distinction or do you want time to consider that?

MR BOUKRAA: Time to consider it, sir.

SIR BRIAN LANGSTAFF: Thank you.

MR BOUKRAA: That sounds to me like one of the issues which should and could sensibly be addressed in the addendum notes that we are intending to disclose. Looking at those differences in the wording of these waivers, the extent to which their legal effect changed as a result of that different wording, "spread" versus "infection", as a part of trying to disentangle the nature of the infection that they covered.

SIR BRIAN LANGSTAFF: Can you help at all, this waiver -- can we just go back to the start of this waiver. Thank you.

"A qualifying person" it relates to. The

undertaking so far as the English and Northern Irish and Welsh claimants were concerned was -- it excluded those under a disability. In other words, it excluded children from the waiver, so it wasn't a question of the waiver being a contract, or a minor's contract, which was given validity by the judge's approval. That issue never arose, presumably. But I don't know. You can tell me. Or you may want to time to --

MR BOUKRAA: I think that will be another one to address in the notes, sir.

SIR BRIAN LANGSTAFF: In due course, very well.

MR BOUKRAA: In due course. It's certainly the case that we can see in the documents referred to in the current presentation note that we have, that the Scottish lawyers who were involved in trying to reach agreement on settlement terms in Scotland were alive to differences between England and Wales and Scotland on issues like minors, under 18s, and how these settlements might apply to them.

SIR BRIAN LANGSTAFF: Yes, well, I would expect -- I expect that to be the case, but I'm just curious about the position of those in England and Wales, as it happens, who were under a disability, that is not legally capable of giving consent to a waiver, not legally capable of making a contract, at least in the minor's case, without

an approval if the contract was thought to be for their benefit. But I'm summarising the provisions of the Act, but that I think would be the position in England and Wales. And presumably Northern Ireland as well.

MR BOUKRAA: Sir, we'll seek to bottom out some of those differences that I've described and that you've alighted on.

For today's purposes, we can turn next to the formal offer that was made by the Scottish Office to solicitors representing litigants in Scotland to settle the litigation, which took place nearly two months, six, seven weeks after this document of 24 June 1991.

Can we please go first to DHSC0003635_065.

So a document dated 24 June 1991, addressed to Balfour and Manson. It comes from Richard Henderson, from the Scottish Solicitor's Office.

If we look at the second paragraph, Mr Henderson wrote:

"I am authorised on behalf of the Secretary of State to offer formally to you terms of settlement for individual claims at the instance of pursuers listed in Annex A to this letter and for the settlement of claims for damages against the Secretary of State on behalf of those claimants listed in Annex B. The terms of settlement are set out in the document labelled Annex C

attached with this letter.

"I also attach a copy of the Macfarlane (Special Payments)(No 2) Trust dated 3 May 1991 [the document we just looked at] together with a copy of revised draft Schedule 4 to the Deed of Trust. Arrangements are being made to vary the terms of the Deed of Trust to facilitate payments in terms [I think that should say 'in terms'] ... of settlement. This will entail substitution of Schedule 4 and also Schedule 3 (Form of Undertaking). The appropriate Form of Undertaking is set out in Schedule 1 to the terms of settlement. I understand that you will arrange for the offers to be communicated to the individual pursuers and claimants through their appropriate legal advisers."

Just over the page, the first paragraph there, Mr Henderson writes:

"Upon receipt of that pro forma letter and schedule, we will issue the appropriate certificate to the Macfarlane Trust."

So outlining the procedure for claims to be settled.

"We understand that thereafter the Trust should be in a position to release payments to individual claimants."

Now, the detailed terms of settlement with the

proposed substituted undertakings which accompanied this letter, we understand to be the document at BNOR0000329.

Now, we can see in the top right-hand corner, annex C, which was the same annex letter referred to in that cover letter we just looked at, the title of this document:

"Detailed Terms of Settlement of HIV/Haemophilia Claims in Scotland"

Now, we don't need to go through all of the terms that are offered in this document. If we could please go through to page 11, we have an undertaking which, as we'll see, is different to the undertaking contained in the 3 May 1991 declaration of trust. The title:

"Undertaking to be given by a qualifying person to receive payment from the Macfarlane Trust"

If we go down to the bottom half of the page:

"I hereby discharge the said Secretary of State [Secretary of State for Scotland] and all other Ministers of the Crown, Government departments and other bodies from any liability that they may have in respect of the infection of X person with immunodeficiency virus ..."

No reference to hepatitis viruses:

"... allegedly arising out of treatment with Factor VIII or Factor IX, whether cryoprecipitate or

concentrate."

The remainder of the undertaking sets out other forms of wording, discharging parties from agreeing to give up the right to bring future claims. Again, it seems relating only to HIV and not hepatitis viruses.

Sir, we seem to see, in this document, a different undertaking and a waiver that's different in its scope addressing only HIV and not also hepatitis.

I can then move on, please, to the variation to the deed of trust which took place in September 1991. A minute ago, when we looked at the cover letter that was sent to Scottish litigants' representatives, it pointed to the fact that -- or suggested that it was going to be necessary to vary the deed of the Macfarlane Trust.

And we can see that document at MACF0000083_003.

So, 19 September 1991, deed of variation relating to the Macfarlane (Special Payments) (No 2) Trust. And over the page, following an introductory wording, at the bottom of this page, now this deed witnesses as follows:

"Substitution of schedule 3. For schedule 3 to the Trust Deed there shall be substituted the following ..."

And if we go over the page, a different schedule 3 is proposed. For current purposes, going to focus on

page 7, where there is substitution for schedule 4, and this schedule 4 appears to be in the same terms as that which we just considered, in other words only containing a waiver for HIV, also containing a waiver for hepatitis.

What that suggests is that waiver which applied in Scotland rather than England and Wales, applied only to future payments relating to HIV and not also to hepatitis. We are going to come back in the note that we're going to disclose to try and trace in a bit more detail how it was that came about, if indeed that's right, as well as addressing, sir, the points that you raised in our discussion earlier.

Now, one of the issues that arose following the settlement of the main HIV Litigation claims in Scotland related to a category of claims which was termed "Category G". The written note sets out some detail on this issue. It arose around September 1991, concerns Category G claims. Broadly put, these were claims for compensation by spouses, parents and children of HIV-infected haemophiliacs, who had not themselves been infected with HIV, but were at risk of doing so because of their close and regular contact with an infected haemophiliac.

Now, those claims were restricted by certain

criteria because of differences in the way the litigation in England and Wales proceeded and that in Scotland. Because of ways related to the settlement was being reached the restriction on eligibility for Category G claimants had the effect of excluding more claims in Scotland than England and Wales. This issue arose. It was considered by officials in the Scottish Office. There were discussions between those officials and representatives of the Department of Health.

What appears to have happened is that the eligibility criteria in Scotland were changed. As a result, more claims became eligible, and this was at least an attempt to mitigate or reduce the disparity that seemed to have arisen for this category of claims between Scotland and England and Wales. There's some detail contained in the written note and I'm not going to address it any further today, sir.

Now that concludes what I intended to cover today about the HIV Litigation. I'm going to finally address quite briefly compensation claims and decisions related to HIV infection through blood transfusion.

Now, if we go back in time, we can see in the documents that around the time of the additional payment to the Macfarlane Trust in November 1989, consideration

was given within the HHD to the question of compensation or other payments for patients who had been infected with HIV through blood transfusions rather than treatment with factor concentrates.

In early 1990 Lord Forsyth, who was the relevant minister at the time, was advised that the UK Government position was that compensation would not be paid to such individuals. So no doubt you'll recall Lord Forsyth gave oral evidence on this issue. He described, if I can paraphrase it, being unconvinced by some of the reasons that were put to him by officials for this position. Nonetheless, the overall policy position of the Home and Health Department remained in line with that of the wider UK Government, and the position was that no money would be paid to such patients.

This issue arose again a little while later in early 1991 in the context of the HIV Litigation. The document suggested that around this time when the issue came up again, Lord Forsyth effectively reaffirmed the view that he'd expressed previously that the distinctions that were being sought to be made between haemophilia patients and transfusion patients didn't stack up.

We can see a number of documents that are summarised in the written notes in which this particular

issue was discussed by departmental officials, discussed with lawyers in the Scottish Office, and that some of those discussions were prompted by correspondence which had been sent by campaigning groups to the Department of Health and responded to by Department of Health Ministers. The HHD became involved. There was some criticism we can see in the documents summarised in the notes of the distinction which was being maintained between haemophilia patients and transfusion patients.

Nonetheless, the position continued to be that of the wider Government, which was no payments would be made. We can get an insight into Lord Forsyth's views from a contemporaneous document at SCGV0000234_198.

Now, it's dated 2 May 1991. I haven't gone to the minute which preceded this document, but it was one which reaffirmed the Government position that no money was to be paid to individuals who'd been infected with HIV through blood transfusion, and it records this. It's from Mr Forsyth's private secretary:

"Mr Forsyth has seen Mr Tucker's minute of 29 April 1991 and your minute of 1 May 1991 about whole blood transfusions. Mr Forsyth considers that this is an extremely serious matter and that the Government's position is indefensible. He has commented that we are in danger of losing a lot of goodwill carping over

a small financial obligation. Our refusal to release information on records leaves us particularly vulnerable. Mr Forsyth hopes we might try to change the Government's line on this matter."

Now, despite the view that was expressed there on behalf of Lord Forsyth, the Government position adopted by the Scottish Office was maintained for most of the rest of 1991.

The position changed in December 1991 when the Secretary of State for Health in England and Wales recommended a change of policy to the Treasury that was accepted.

Now, similarly to other examples we've considered today, that change of policy appears to have happened with little or no consultation between the UK Government's Secretary of State for Health and ministers and officials in Scotland. Despite that lack of consultation there was again a request for Scotland and the other departments in the UK to contribute some of the funding that would be required for this change of policy, and there are a number of documents in which officials and subsequently ministers address this question of how much -- whether and how much they should be expected to contribute to the payments to these individuals, despite the lack of consultation from

Central Government.

These issues were set out in a minute, a submission from Mr Tucker to ministers in December 1991, which proposed that the Scottish Office should accept the change of policy and also that a financial contribution should come from the Scottish Office to these payments. That was accepted by ministers.

Now, there was then over the next few months work to finalise and set up the scheme through which payments would be made to individuals who had been infected with HIV by blood transfusion or tissue transfer.

In the last document I'm going to bring up today, I'm going to highlight how the document describes the scheme, which was agreed and set up, but also link back to the waiver issue we were discussing earlier.

It's dated April 1992 and it's at SCGV0000239_024.

Now, this is a minute dated 9 April 1992 from Mr Tucker to the chief executive of the NHS in Scotland, I believe it was Mr Cruickshank at the time, seeking his approval for the Scottish scheme for payments to HIV infected recipients of blood and tissue and we can see that from the first paragraph.

The remainder of this document sets out the detail of the scheme, the background to it and I'm not going to

go into that detail now. I'm just going to pick up on page 2, the section headed "Differences with English Scheme", and then paragraph 9.

"I should also draw to your attention the terms of Annex 1 to the Scheme which sets out the form of undertaking to be given by the applicant. Our form does not require an undertaking discharging the Secretary of State in respect of liability for infection of the applicant with hepatitis virus. In that respect it differs from the English form of undertaking. However again we consider ourselves to be bound by the terms of the haemophilia settlement which did not limit an applicant's rights in connection with hepatitis infection. We have had strong representation against extending the undertaking into this area. Our medical and legal advisers specifically support the exclusion of reference to hepatitis from the undertaking."

So again, difference in the nature of the waiver undertaking applicable in Scotland as with England and Wales, to be explored further in the note which will be prepared by the Inquiry team and disclosed as soon as we can.

So that completes the material I intended to cover today. We've covered a large number of documents, a large number of documents. I hope it's been of

assistance in setting the framework and the structure of the detail which is contained in the written note, which has already been disclosed.

SIR BRIAN LANGSTAFF: Yes. Well, thank you very much indeed.

Tomorrow?

MR BOUKRAA: Sir, tomorrow we return with a witness who will be attending remotely, John Canavan, an official from the Department of Health.

SIR BRIAN LANGSTAFF: So John Canavan tomorrow at 10.00. 10.00. Thank you very much.

(4.20 pm)

(The hearing adjourned until 10.00 am the following day)

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