**INFECTED BLOOD INQUIRY:**

**ROLE OF THE CHIEF MEDICAL OFFICER**

Contents



## Introduction

1. This Note is intended to provide an overview of the role of the Chief Medical Officer ('CMO') with a focus on the 1980s. The preponderance of available documentation relates to the role of the CMO for England, but the Note also touches on the role of the CMO in Scotland, Wales and Northern Ireland.

**Chronology and key players**

2. Sir Henry Yellowlees was the CMO for England from 1973 to the end of 1983. He was succeeded by Sir Donald Acheson, who held the post from October 1983 (overlapping with the previous CMO) to 1991. His 2007 autobiography, *One Doctor's Odyssey*[1] and his witness statement to the BSE Inquiry,[2] are sources of material for this note. Sir Kenneth Calman was CMO for England from 1991 to 1998. He has provided a draft witness statement to the Inquiry which will be disclosed in due course.

3. During Sir Henry Yellowlees' time in the role, he worked with the following Secretaries of State: Keith Joseph, Barbara Castle, David Ennals, Patrick Jenkin and Norman Fowler. Lord Fowler, who was Secretary of State from 1983 to 1987, then worked closely with Sir Donald Acheson when he was CMO. Lord Fowler was succeeded by John Moore (1987-1988). The next Secretary of State was Kenneth Clarke (1988-1991), who had previously also been Minister of State for Health (1998-1990). William Waldegrave was Secretary of State from 1991 to 1992, and Virginia Bottomley from 1992 to 1995.

4. On the Civil Service side, the Permanent Secretary to the Department for Health and Social Security ('DHSS') from 1975 to 1981 was Sir Patrick Nairne. He was followed by Sir Kenneth Stowe (1981-1987) then Sir Christopher France (1987-1992), who was the first Permanent Secretary of the Department of Health ('DoH') following the splitting of the DHSS into two Departments of State in 1988. Sir Graham Hart succeeded Sir Christopher as Permanent Secretary.

5. In Scotland, Sir John Reid was CMO from 1977 to 1985, followed by Dr Iain Macdonald from 1985 to 1989. Sir Kenneth Calman was the CMO for Scotland from 1989 to 1991 before becoming the CMO for England. He was succeeded by Dr Robert Kendell (1991-1996).

6. The first CMO for Wales was Dr Richard Bevan, from 1969 to 1977. Professor Gareth Crompton was Welsh CMO from 1978 to 1989. He was succeeded by Dame Deirdre Hine, who held the post from 1990 to 1997.

---

[1] WITN0771088
[2] MHRA0011433

7. The Northern Irish CMO role was filled by Dr Thomas Terence Baird from 1973 to 1978, followed by Dr Bob Weir from 1978 to 1986, Dr James McKenna from 1988 to 1995 and Dr Henrietta Campbell from 1995 to 2006. Dr McKenna has provided a witness statement to the Inquiry.[3]

8. The Inquiry has obtained or is in the process of obtaining evidence from a number of politicians and officials from the DHSS and DoH about the role of the CMO. These include Sir Kenneth Calman and Dr McKenna (as is noted above), a number of Secretaries of State and other Ministers, senior civil servants, and Dr Diana Walford, who in 1989 was appointed Deputy Chief Medical Officer ('DCMO'). Sir Donald Acheson and Sir Henry Yellowlees are both deceased. Other DCMOs from the 1980s and early 1990s, Dr Edmund Harris, Dr Michael Abrams and Dr Jeremy Metters, are deceased.

**Overview of the role**

9. The role of the CMO can be traced back to the antecedent post of Medical Officer to the General Board of Health, which was established under s.2 of the General Board of Health Continuance Act 1855:

> '*The said Board may appoint a Medical Council, consisting of such Number of Persons as the said Board, with the Consent of the Commissioners of Her Majesty's Treasury, may deem expedient, and may appoint a Medical Officer, and may assign to such Council and Medical Officer such Duties as the Board may think fit…*'

10. The creation of the post was in response to the then recent epidemics and typhus fever, which had revealed the need for a centralised approach to public health and sanitation.[4]

11. In 1919, the Ministry of Health was established, and the role of Chief Medical Officer moved to the new department. It has remained with the department through its subsequent incarnations as the DHSS from 1968 to 1988, DoH from 1988 to 2018, and Department of Health and Social Care ('DHSC') from 2018 to date.

12. The post of DCMO was created in 1932, possibly to create a 'line of succession' to CMO.[5] For example, Sir Henry Yellowlees joined the Ministry of Health in 1963 as Principal

[3] WITN6983001
[4] *The Nation's Doctor: the role of the Chief Medical Officer 1855-1998,* Sheard & Donaldson, CRC Press, 2018, p.1
[5] Ibid p.28

Medical Officer and was promoted to DCMO in 1967 before becoming CMO in 1973.[6] Sir John Reid was DCMO in England prior to becoming Scottish CMO.[7] The number of DCMOs has fluctuated over time (between one and four posts).

13. During the timeframe relevant to this note, the CMO role had (at least) threefold responsibilities: providing advice to Ministers, providing public health information to the medical profession and the wider public, and providing leadership to the medical officers working at the DHSS. Lord Fowler has described the CMO role as follows:

> "*The position of the CMO for England was (and is) as the Government's principal medical adviser. He was in my time, although this changed later, also Head of the Medical Civil Service. The CMO is an externally recruited qualified medical practitioner and a member of the senior civil service who carries the equivalent rank of Permanent Secretary. Within the Department of Health, the CMO was responsible to the Secretary of State for all medical matters within both the wider Department and the NHS Executive.*
>
> *I understood, in general terms, that the CMO's role included providing independent advice on public health issues and recommending policy changes to improve public health outcomes. I also considered the CMO to have some responsibility for keeping the public informed on health issues of public concern and explaining the Government's response.*" [8]

14. In the leadership aspect of the role, the CMO was the head of the medical hierarchy in the department, which ran parallel to the Civil Service hierarchy. Until 1995, the CMO acted as the ultimate line manager for over 100 medical and around 40 scientific personnel.[9] As explained by Lord Glenarthur:

> "*The department was hierarchical. At the political level, the chain of command was: the Secretary of State, the Ministers of State (one for Health and one for Social Security) and the Parliamentary Under Secretaries of State.... There was also, of course, a civil service hierarchy headed by the Department's Permanent Under Secretary of State. The official hierarchy was supplemented by a parallel medical hierarchy, headed by the*

[6] Ibid p.33
[7] Ibid p.34
[8] WITN0771001 paras 8.14-8.15
[9] WITN6965002 para 4.22

*Chief Medical Officer ("CMO"), who was supported by a number of Deputy Chief Medical Officers and other medical advisers. All would have been accessible to me if required.*"[10]

15. Given the breadth of the CMO's remit, it would not be possible for the CMO to be personally involved in every public health issue of concern. A summary of the CMO role set out in the BSE Inquiry Report says:

> "*Paper comes into the CMO's office on a scale which normally applies to Ministers rather than to officials. There is an abnormally heavy commitment to meetings (both internal and external) and essential representational functions and international work- has to be dealt with. Demands being made on the CMO in the field of public health are also unusually heavy.*"[11]

16. Dr Hilary Pickles, who worked for DHSS / DoH from 1982 to 1994, has explained how in practice decisions might be taken as to whether a matter ought to be escalated to the CMO:

> "*12.2. In terms of the criteria for that which could be shared with the CMO, there were no hard and fast rules and much depended on the topic and its topicality. The CMO needed to be up to speed on any topic on which he might be asked to advise Ministers at short notice, including whatever was dominating the news media. He would also want to be aware of any major areas of controversy affecting the medical profession, as an ex-officio member of the GMC. If in doubt about how much to involve the CMO, then the DCMO was there to advise. He could ask for briefing on any topic, with his extended team expected to respond.*
>
> *12.3. Most major submissions on planned topics were sent up the administrative route with decisions about the copy list left primarily to the originator. If there was a DCMO on the copy list, or the submission was sent up through the DCMO, then whether to include CMO on the copy list or to direct the submission through the CMO might be left to him. Some subjects, like AIDS and BSE, were of such interest to Sir Donald Acheson when he was the CMO that any significant developments would be shared with him. There were also many briefings and submissions on hot topics which were in direct response to a request from the `top of the office' (TOTO) and would be directed*

[10] WITN5282001 para 1.3
[11] WITN6965002 para 4.18; see also WITN5282001 at para 97.1

*appropriately. The route for this submission was agreed jointly, in discussion and via comments on a draft.*"[12]

17. Dr James McKenna has described the role of the CMO for Northern Ireland as follows:

> "*7.1 As CMO l was a leading voice in Public Health in Northern Ireland. I was Leader of the Medical Team in the Department. l was a member of the Top of the Office Group which was responsible for policy and reallocation of resources generally. I had access to all Northern Ireland Ministers but of course most of my contact was with the Departmental Minister whom I was responsible for advising on all aspects of public health risk. I supported the Minister in contacts with outside bodies. I was occasionally called upon to advise the Secretary of State when he was dealing with health matters.*
>
> *7.2 I liaised with other Health Departments within the UK and the Republic of Ireland. I was the Department's main link to medical professional bodies and the local profession generally. I was responsible for advising the public on matters of public health and I informed the public about the state of the public health in an Annual Report which I instituted on that topic. I advised Ministers on all health issues and provided the basis for health policy decisions. I cannot recall issuing guidance or advice to particular groups of patients but I was frequently in the position of providing health advice to the public at large.*"[13]

**Relationship with ministers**

18. Dr Walford has given evidence that in the context of the parallel administrative and medical hierarchies at DHSS, "*the CMO had access to Ministers whenever he wished.*"[14]

19. Lord Fowler has described his reliance on medical advice from the CMO:

> "*The post of CMO had a pivotal importance. The CMO was the chief adviser to the Secretary of State, supported by experienced health professionals, and head of the medical divisions. Politicians did not have the necessary expertise to decide the medical issues that came before government so on purely medical issues, their advice was crucial. It would have been unthinkable for a politician to act against their medical advice.*"[15]

---

[12] WITN6965001 paras 12.2 & 12.3
[13] WITN6983001 para 7.1-7.2
[14] WITN4461001 para D1
[15] WITN0771001 para 0.30

20. In his autobiography, Sir Donald Acheson reflected positively on his working relationship with Lord Fowler:

> "*Although I saw four Secretaries of State come and go, it was Norman Fowler with whom I worked for several years who I got to know best. Ours was a productive partnership which included not only the largely successful policies for the control of HIV/ AIDS, Legionellosis and salmonellosis but the revival of public health. Norman's success was based on a rare capacity to choose the right priorities together with the self-discipline to pursue them single-mindedly to a conclusion.*"[16]

**Relationship with the medical profession**

21. The CMO's relationship with the medical profession was a two-way conduit; the CMO both took advice on medical issues and promulgated information for clinicians.

**Advice from clinicians**

22. The CMO had access to specialist advice in some areas of medicine through appointed Consultant Advisers. As Dr Walford explained:

> "*2.28... The CMOs were each advised by an external expert, who was designated the Consultant Adviser in Blood Transfusion. Such Consultant Adviser appointments existed for only a few other specialties.*
>
> *2.29. Initially, when I joined Med SEB, Dr Geoffrey Tovey, Chairman of the Regional Transfusion Directors Meetings, was the Consultant Adviser. He would meet with the CMO in private and declined to let me know what was discussed, as a result of which I was in the dark about what advice he was giving.*
>
> *2.30. This was highly unsatisfactory but, happily, in 1981 Dr Harold Gunson was appointed to replace Dr Tovey. Dr Gunson and I had an excellent working relationship. Although the meetings between the Consultant Adviser in blood transfusion and the CMO continued to be held in private, Dr Gunson kept me informed. The good working relationship with Dr Gunson proved particularly useful on occasion; see for example the work which we did on an AIDS leaflet for blood donors in spring 1983*"[17]

23. Dr Pickles also recalls that:

---

[16] WITN0771088 p.170-171
[17] WITN4461001 para 2.28-2.30; see also transcript of 19 July 2021 at p.30-32

"*Until Dr Rejman was in post, I had fairly frequent contact with Dr Gunson (the CMO's advisor on blood transfusion) who I also saw as my main source of advice on blood transfusion. He was the person I consulted on any difficult issue, even after the ACVSB was established, and helped me navigate the various interests. We spoke on the phone, met in the margins of meetings, and corresponded. I had little direct contact with the Regional Transfusion Directors, but I got to know some of the main players and attended some of their meetings.*"[18]

24. In 1998, Sir Donald Acheson wrote in his statement to the BSE Inquiry:

"*The Chief Medical Officer is the principal adviser on medical and public health matters, not only to Ministers in the Department of Health but to the Ministers in other government departments and to the Government as a whole. It follows that the field over which. The CMO is required to provide advice extends far beyond his own personal professional experience. It is therefore necessary for him to be supported by an extensive advisory machinery. In addition to a number of expert Standing Committees on vaccination and immunisation, toxicology, air pollution and health, and environmental carcinogens) he has at his disposal a panel of upwards of about eighty personal consultant advisers drawn from the top ranks of the medical profession and covering all the specialities....*

*When I became CMO in 1983 the prestige of the post built up since it was created in 1858 was such that, without exception, distinguished members of the medical profession and other scientists were prepared to give priority to advising the CMO, and through him Ministers.*"[19]

25. The minutes of a Consultant Advisers' Meeting in 1981 show at that time seven specialisms were represented (statistics, pharmacology, blood transfusion, geriatric medicine, biochemistry, drug addiction, cardiothoracic surgery and nutrition).[20] This tends to confirm Dr Walford's recollection that there were originally a limited number of consultant advisers. By the time Sir Donald Acheson gave his statement to the BSE Inquiry, the number had grown to the over eighty consultant advisers he there described.

[18] WITN6965001 para 19.1
[19] MHRA0011433 para 12-13
[20] NHBT0001065

26. The Inquiry has copies of correspondence between Sir Donald Acheson and Dr Gunson, examples of which are discussed further below.

27. Dr Gunson attended his first Consultant Advisers' Meeting on 27 November 1981, at which time he referred to the progress being made concerning HBV testing.[21] Sir Henry Yellowlees chaired the meeting. There was a Consultant Advisers' Meeting in the summer of 1983, during Sir Henry Yellowlees' tenure, at which Dr Gunson spoke about the risk of AIDS.[22] The minutes of the Consultant Advisers' Meeting on 22 November 1985 show Sir Donald Acheson chaired and Dr Gunson gave an update on the introduction of HLTV-III antibody testing and training of counsellors.[23]

28. The CMO's Annual Report for 1983 referred to the establishment of the MRC's AIDS Working Party in October 1983, stating, *"The MRC Working Party is the Department's main source of information concerning European and World Health Organisation AIDS research initiatives."*[24]

29. At the end of 1984, the CMO (Sir Donald Acheson) sought the establishment of a new advisory group. The Expert Advisory Group on AIDS ('EAGA') met for the first time on 29 January 1985.[25] Its remit was *"To provide advice on such matters relating to AIDS as may be referred to it by the Chief Medical Officers of the Health Departments of the United Kingdom."*[26]

**Providing public advice and guidance**

30. A key part of the CMO role has been to share information with the medical profession to promote better public health. Lord Fowler recalls:

> *"The CMO's remit was very wide indeed and covered a huge range of health issues. The CMO would himself have been reliant on expert advice from specialist doctors in the fields of haemophilia care and treatment with blood or blood products. Whether information was provided to clinicians, health bodies or patients would have been a matter for the CMO. I do not consider it would have been part of the CMO's role to provide "instruction" to clinicians: the management of individual patients was, and*

[21] NHBT0001065
[22] NHBT0001067; referred to in letter from Dr Gunson of 9 June 1985
[23] NHBT0001061
[24] DHSC0007005 p.45; this report was authored by Sir Donald Acheson
[25] PRSE0002734
[26] DHSC0003711_105

*remains, a matter for their treating clinicians. There was not central direction, supervision or management of clinicians by DHSS in that manner.*

*There were occasions —which I have seen in the available papers —where the CMO (or members of his team) would write to clinicians and health bodies, to share information or to announce new developments."* [27]

31. These announcements were made by way of 'Dear Doctor' letters circulated to the medical profession via local medical officers and GPs. For example:

    a. On 31 December 1981, Sir Henry Yellowlees issued a 'Dear Doctor' letter regarding 'Hepatitis B and NHS Staff', appending 'Guidance on Hepatitis B Surface Antigen Carriers Among NHS Staff'. He relayed advice from the Rosenheim Committee that members of staff found to be carriers of the hepatitis B surface antigen (HBsAg) should not work in renal dialysis units. Carriers who appeared to have been the source of infection in patients would be limited to non-operative work. Otherwise, carriers could continue to work in any NHS role with advice on avoiding transmitting infection. Routine screening for HBsAg was not recommended for patients or staff.[28]

    b. On 15 October 1982, Sir Henry Yellowlees together with Dame Phyllis Friend, the Chief Nursing Officer, sent a 'Dear Doctor' letter regarding the 'Hepatitis B Vaccine: Guidance on Use'. They wrote:

        "*A vaccine will shortly be available in very limited quantities, which has been shown on initial trials to be effective in the prevention of hepatitis B. The number of overt cases of hepatitis B identified in England and Wales appears to be low, averaging about 1,000 cases a year. Asymptomatic infections occur and some of those infected become chronic carriers of hepatitis B antigen; a small proportion of antigen carriers develop chronic hepatitis. Certain occupational and other groups are known to be at increased risk of infection although in comparison with other countries, the incidence of the disease is low.*
        *Whether or not to give the vaccine will be for the individual doctor to decide but in view of the relatively low incidence of the disease, the*

[27] WITN0771001 paras 8.16-8.17
[28] NHBT0000070_042

*pressures on Health Service resources, the cost of the vaccine and its very limited availability, it is suggested that vaccine should be reserved for specific individuals within the groups known to be at increased risk. The Joint Committee on Vaccination and Immunisation guided by the Advisory Group on Hepatitis have advised on which groups of staff and patients should receive priority for vaccination, and these are set out in the appendix to this letter.*"[29]

c. On 3 December 1984, a 'Dear Doctor' letter enclosing 'Guidance for Health Care Personnel Dealing with Patients Infected with Hepatitis B Virus' was circulated to all regional and district medical and nursing officers by CMO Sir Donald Acheson and Chief Nursing Officer Mrs Anne Poole. They advised that "*Routine screening of all patients for HBsAg is impracticable as well as unnecessary in a country with a low overall prevalence rate*", and that general precautions against transmission by needle and sharp injuries should be taken.[30]

d. On 15 May 1985, Sir Donald Acheson issued a 'Dear Doctor' letter regarding AIDS, enclosing an 11-page paper titled 'AIDS – General Information for Doctors' and a leaflet from the Health Education Council.[31] In the enclosed paper, he advised doctors to bear the diagnosis in mind (*"Probably the most important factor in making a diagnosis of AIDS is to think of it."*[32]) He described possible clinical presentations and outlined precautionary measures. He also set out the new powers local authorities would have to detain patients with AIDS under the new Public Health (Infectious Diseases) Regulations 1985.[33] In the press release regarding the letter, he was quoted as saying:

> "*This latest initiative is part of a series of public health measures aimed at health professionals and people at risk. I hope it will provide doctors with information which they will find helpful in the diagnosis and*

[29] NHBT0000069_017
[30] CBLA0005565
[31] DHSC0105232; an equivalent letter was circulated in Scotland from DCMO Dr Graham Scott – see LOTH0000267_019
[32] Ibid, p.3 of enclosed paper
[33] Ibid, p.11 of enclosed paper

*treatment of the disease and in counselling those who have worries about it.*"[34]

e. On 23 September 1985, Sir Donald Acheson issued a 'Dear Doctor' letter on 'Acquired Immune Deficiency Syndrome (AIDS) HTLV III Antibody Testing Outside the National Blood Transfusion Service (NBTS)'. This referred to general testing facilities which he sought to raise awareness of in advance of the introduction of testing for blood donors. He wrote: "*It is important that doctors, particularly general practitioners, are fully aware of the local facilities which have been established when they are approached by patients about the need for a test.*"[35]

f. On 1 October 1985, Sir Donald Acheson (CMO for England) and Dr John Reid (CMO for Scotland) each issued a 'Dear Doctor' letter on the 'Introduction of a Test for HTLV III Antibody', regarding universal screening of blood donors.[36] Enclosed was 'AIDS Booklet 2: Information for Doctors concerning the Introduction of the HTLV III Antibody Test.' Both referred to the importance of alternative testing facilities for people in high-risk groups, and of counselling for donors testing negative. Sir Donald Acheson undertook radio and TV interviews to publicise the new guidance.[37]

g. On 23 April 1986, Sir Donald Acheson issued a 'Dear Doctor' letter enclosing 'Guidance for surgeons, anaesthetists, dentists and their teams in dealing with patients infected with HTLV III'.[38]

h. On 12 September 1986, Sir Donald Acheson and Mrs Poole issued a joint letter on the risk of transmission of AIDS through use of jet injectors.[39]

i. On 2 March 1987, Sir Donald Acheson issued a 'Dear Doctor' letter on 'HIV Infection and Tissue and Organ Donation', recommending that "*The same guidelines that are used for selecting blood donors must be used for organ and*

[34] DHSC0002269_049
[35] NHBT0057007_001
[36] DHSC0000177, PRSE0002654
[37] WITN0771110
[38] HMTR0000006_083, BART0000737
[39] DHSC0003899_028

*tissue doners even if the initial removal of tissue was for the benefit of the donor.*"[40]

j. On 14 January 1986, Sir Donald Acheson issued a 'Dear Doctor' letter regarding 'Children at School and Problems Related to AIDS' appending an information booklet on that topic. He wrote:

> *"Doctors... have an important role to play in achieving improved health education on the HTLV Ill infection. Members of the general public who have worries about AIDS and those who are directly involved with infected people need to be told about the nature of the HTLV III infection and reassured about the limited ways it can be spread.*"[41]

k. On 2 December 1986, Sir Donald Acheson issued a 'Dear Doctor' letter titled 'AIDS: The Acquired Immune Deficiency Syndrome and HIV: the AIDS Virus'. The purpose of the letter was to update clinicians about the next phase of the public education campaign on AIDS, and to give further information about advice to give individuals at higher risk and seeking testing.[42] On 5 January 1987, he followed this with a letter enclosing a copy of the new AIDS leaflet that was being sent to all households.

l. On 4 July 1989, Sir Donald Acheson and Mrs Poole issued a 'Dear Doctor / Nursing Officer' letter on 'HIV Infection, Breastfeeding and Human Milk Banking in the United Kingdom'.[43]

m. On 26 April 1990, Sir Donald Acheson issued a further 'Dear Doctor' letter on 'HIV Infection, Tissue Banks and Organ Donation', updating the guidance given in March 1987 in response to an incident where a bone graft recipient in the United States developed AIDS from an implant from a donor who had initially tested negative for HIV but was subsequently found to be infected.[44]

n. On 3 April 1995, Sir Kenneth Calman issued a 'Dear Doctor' letter regarding the look-back exercise for HCV-contaminated blood transfusion.[45]

---

[40] WITN6965002
[41] BART0000728
[42] OXUH0002238_007
[43] PHEN0000940
[44] WITN6406031 p.119-123
[45] NHBT0002796_002

32. The extent to which the CMO could direct clinicians without infringing on their decision-making autonomy has been commented on by various sources. Sir Donald Acheson wrote in his witness statement to the BSE Inquiry:

> "*The term 'Chief Medical Officer' is a misnomer as it implies that the CMO leads a national hierarchy. While the CMO may offer guidance on medical or public health matters to all doctors or to Directors of Public Health neither he nor his predecessors, at least since 1919, have had a management line or any power of direction to doctors outside the Department of Health. As far as the Medical Officers of Health and their successors, the Directors of Public Health, are concerned, at best CMO may be seen as primes inter pares. They are free to accept or reject his advice.*"[46]

33. Lord Clarke's evidence was that:

> "*Whether and what information was provided to clinicians and health bodies would have been entirely a matter for the CMO, who would not have sought my views on this. It seems to me that the CMO would have been reliant on expert advice from specialist doctors when it came to information or guidance about haemophilia care or the use of blood products. Moreover, it would not have been appropriate for the CMO to provide "instruction" to clinicians about the treatment of their patients. The Department did not then and does not now supervise how patients are treated and clinical freedom was and remains an important and respected principle.*"[47]

34. Lord Fowler's evidence was that:

> "*This type of guidance was not (and I do not think was intended to be) direction to clinicians on when they should or should not prescribe certain treatments with blood or blood products or on what information should be provided to patients. The CMO's role — as I understood it — did not extend to giving prescriptive guidance to clinicians of that kind. Clinical decision making was for the practising professionals themselves and that freedom was seen by them as important and was generally respected.*"
>
> "*… it was not general practice for the CMO (and the Department more generally) to dictate prescribing practice to treating doctors.*"[48]

---

[46] MHRA0011433 para 14
[47] WITN0758001 para 8.5
[48] WITN0771001 paras 8.19 & 6.83

35. Dr Pickles' evidence was that:

> "*In relation to guidance on clinical management… I am not sure this should be the CMO's role, and traditionally front-line clinicians would not have taken kindly to have been told how to manage their patients by a distant bureaucrat, even one as eminent as the CMO. Decisions needed to be local to the patient when it was more a question of optimising rather than banning treatment. In the areas of specific concern to the Inquiry, there was often scope for genuinely justifiable exceptions to what might be best practice overall, meaning there could not be hard and fast rules to be policed by others like the pharmacy. Clinical freedom enabled advances to be made, but also enabled others to fail to keep up with best practice.*"[49]

36. When giving her oral evidence she further stated that:

> "*I think the feedback* [Sir Donald Acheson] *was getting from the general practitioners is basically he had to be -- not to overwhelm them. They had so much else they had to do that if he didn't choose wisely on the topics that were of -- that he wrote to them about, then he would switch them off, basically. Not only they wouldn't have time to look at it but they'd be very negative about the really important ones they did receive. So the ones that went to all general practitioners, or all doctors, had to be chosen very, very carefully, and there was quite a barrier to get them accepted by the Chief Medical Officer, really because he had -- they were very precious and had to be saved for the really, really important topics. And that's why a listing would be quite helpful. And I know that I got -- when I was in the AIDS Unit, I got a disproportionate number of CMO letters because of his interest, and I think I had colleagues complaining that they couldn't get letters on their topics sent out.*"[50]

37. Dr Walford similarly recalled that "*the Department's medical staff — including the CMO - did not attempt to interfere with the practice of clinicians, who jealously guarded the concept of clinical freedom*".[51] In her oral evidence, she highlighted the concluding paragraph in the first 'Dear Doctor' letter concerning AIDS, which says, *"I take the liberty of sending this information because AIDS is a new disease…*"[52] In her view, that showed

[49] WITN6965001 para 11.3
[50] Transcript of 12 May 2022 p.
[51] WITN4461001 para D3
[52] DHSC0105232

*"that there was a need for this dissemination, that he felt he had to almost beg their pardon for having intervened in this way and having written to them".*[53]

38. An example of the limits on what seems to have been thought appropriate by way of central advice from the CMO and DHSS can be found in the approach taken to confidentiality and testing for HIV/HTLV-III. A document entitled 'Brief for Meeting: Dr Donald Acheson, Chief Medical Officer, DHSS 20 February 1986 at 2.30pm' summarised information issued by DHSS to the medical profession regarding confidentiality of AIDS patients.[54] The briefing note referred to the 'AIDS Booklet 2: Information for Doctors concerning the Introduction of the HTLV III Antibody Test' circulated by the CMO on 1 October 1985, in which the following guidance had been given regarding confidentiality:

> "*The strictest confidentiality must be maintained when an HTLV III antibody positive individual is identified. Where a person is tested for HTLV III infection or for its complications and it is thought to have been sexually transmitted, health authorities have an obligation to maintain confidentiality of information under the terms of the National Health Service (Venereal Diseases) Regulations 1974 (SI 1974.9). Unless the patient has given his consent, personal health data relating to him must not be disclosed to anyone for any purpose other than the health care of that patient, except where the disclosure is necessary to prevent the spread of infection. Disclosure of this information for purposes other than medical or public health reasons could lead to serious consequences for the informant. Adequate safeguards to protect individuals against unauthorised disclosure must be adopted.*"[55]

39. The briefing note went on to excerpt a 'Telephone Discussion with Mr Tom Murray – Administrator in Charge of AIDS Section DHSS, 20th December 1985'. That telephone conversation appears to have been between Mr Murray and Sir Donald Acheson, in that it recorded

> "*(i) The CMO's emphasis on confidentiality is to enable people to be reassured that by coming forward there would be no breach in confidentiality.*
>
> *(ii) It is accepted however, that 'sex partners' would be left unprotected. The DHSS are agreed that the best of way of tackling the problem is for doctors to use their skills in*

[53] Transcript of 21 July 2021 p.
[54] BMAL0000010_012
[55] Ibid p.5 and for the original document see DHSC0000177 para 11

*counselling patients to enable them to persuade persons with positive test results to involve their partners or contacts.*

*(iii) The DHSS does not want to get involved directly in advising doctors on this matter. The DHSS does not want to make new regulations or get directly involved in further explanations as to a redefinition of 'exceptional circumstances', which are appropriate for the disclosure of AIDS confidentiality.*"[56]

40. The briefing note concluded:

"*The Professional Division concurs with the advice of the DHSS when giving guidance to doctors by letter or telephone: doctors should use their skills in counselling patients to enable sex partners to be brought into the problem and advised accordingly when the situation warrants. General practitioners should not expect to be contacted by AIDS clinics doctors or counsellors regarding their patients, except in exceptional circumstances.*"[57]

41. There was no further CMO guidance issued on what might constitute 'exceptional circumstances' warranting a limitation on confidentiality, although the previous advice on the importance of confidentiality was subsequently reiterated. [58]

42. The DHSS also published health guidance which did not come from the CMO. For example, in March 1984, the DHSS circulated to all regional and district health authorities Health Circular HC(84)7 on 'Blood transfusion: record-keeping and stock control arrangements'. The Circular requested that they review policies and procedures to, amongst other things, *"enable each unit of blood to be traced from donation to disposal"*. [59] In January 1985, DHSS issued Health Circular HC (85)3, 'Leaflet: AIDS Important New Advice for Blood Donors', asking RHAs to ensure that a revised donor leaflet was distributed individually to every donor.[60] In June 1986, the DHSS issued Health Notice HN(86)20 concerning revised Guidelines drawn up by the Advisory Committee on Dangerous Pathogens, on safety measures for working with HLTV-III positive patients.[61]

---

[56] BMAL0000010_012 p.5-6
[57] Ibid p.6
[58] OXUH0002238_007
[59] CBLA0001819
[60] DHSC0002159
[61] WITN0771215

43. It can be surmised that systemic issues requiring organisational measures were more likely to be addressed by way of a Departmental circular, whereas CMO 'Dear Doctor' letters concerned issues affecting individual clinicians' practice (though there is no bright line distinction between the two).

44. When Sir Donald Acheson was CMO, he also saw correcting public misinformation as part of his role. See, for example, the 'Dear Doctor' letter addressing stigma for children in schools, referred to above. [62] In his autobiography, he recalled an occasion when the BMA announced that people who had had more than one sexual partner in the previous two years should not donate blood; this advice was withdrawn *"just in time to prevent the collapse of the transfusion system for want of donors"*.[63] A Daily Mirror article from January 1987 cites his response at the time:

> "*But the advice from the British Medical Association expert brought immediate protests. Government Chief Medical Officer Sir Donald Acheson said it was totally unnecessary.*"[64]

**CMO Annual Reports**

45. One function of the CMO role (since the 1859 Public Health Act)[65] was to report annually on the state of the nation's health. These reports provide an insight into the knowledge and priorities of the CMO and the medical personnel at DHSS.

46. The CMO's Annual Report for 1980, published in 1982,[66] contained an update on hepatitis infection figures, although the focus was on HAV outbreaks, and no mention was made of non-A non-B hepatitis.[67] It also provided an update on the redevelopment of the Blood Products Laboratory ('BPL') and the establishment of a new Advisory Committee on the National Blood Transfusion Service ('NBTS'). The goal of self-sufficiency in blood products was reflected as follows:

> "*For the NHS to be self - sufficient in blood products, two inseparable conditions must be fulfilled. The first is that the new Blood Products Laboratory must be redeveloped, to modern pharmaceutical manufacturing standards, with the capacity to manufacture*

---

[62] BART0000728
[63] WITN0771088 p.192; in the same section he also describes applying for a High Court injunction to protect the identities of two NHS doctors who were HIV positive
[64] SHTM0000772
[65] *The Nation's Doctor* p.149
[66] DHSC0007003; Sir Henry Yellowlees' introduction was dated December 1981
[67] Ibid p.51

*products to the required level; the second is that the NBTS must expand its plasma collecting capacity to provide a sufficient supply of plasma to enable the redeveloped laboratory to meet production targets. It will be several years before redevelopment of the Blood Products Laboratory can be completed but planning and design has already begun."*[68]

47. The 1981 Annual Report, published in 1982, [69] noted a rise in notifications of infective jaundice; rates had declined in the decade to 1979 then increased. The rise was attributed to the incidence of HAV; it was thought *"unlikely that there has been much change in the incidence of hepatitis B or hepatitis non-A/non-B".*[70]

48. The first mention of AIDS appeared in the 1982 Annual Report,[71] in relation to the Communicable Disease Surveillance Centre ('CDSC') collecting data on Kaposi's sarcoma and AIDS. The report dedicated half a page in the 'Communicable Diseases' chapter and one paragraph in the 'Sexually Transmitted Diseases' chapter to AIDS.[72] This report also referred to the new HBV vaccine and recommended that it should be "*reserved for specific individuals within groups known to be at increased risk*".[73]

49. The 1983 Annual Report[74] included a one-page section on AIDS under the 'Communicable Diseases' chapter and a further paragraph in the 'Sexually Transmitted Diseases' chapter.[75] It was noted that 31 cases and 16 deaths had been reported in the UK between February 1982 and 31 December 1983. There were two cases in haemophilia patients treated with imported American factor VIII.[76] The report described the publication of the leaflet 'AIDS and how it concerns blood donors', which asked people in high-risk groups to refrain from giving blood. The public information function of the CMO was reflected in the paragraph 'AIDS and the general public', which stated: *"Expert opinions suggests that there is no risk*

---

[68] Ibid p.148
[69] DHSC0007002; Sir Henry Yellowlees' introduction was dated November 1982
[70] Ibid p.41
[71] DHSC0007004; published in 1983, Sir Henry Yellowlees' introduction dated October 1983
[72] Ibid p.53 & 62-63 / e-page 61 & 70-71
[73] Ibid p.51-52
[74] DHSC0007005; published in 1984, Sir Donald Acheson's introduction dated December 1984. In the introduction he acknowledged that *"The work described was done when my predecessor, Sir Henry Yellowlees, was Chief Medical Officer."*
[75] Ibid p.44-45 / e-page 54-55, p.56 / e-page 66
[76] Ibid p.44 / e-page 54 & p.56 / e-page 66

*of contracting AIDS as a result of casual or social contact with AIDS patients e.g. on public transport, in restaurants or in private dwellings.*"[77] Further on, the report stated that:

> "*The cause remains unknown, but is likely to be a viral agent transmitted by sexual contact, transfusion of blood and certain blood products. The incubation period can be as long as three years or more.*"[78]

50. The 1983 Annual Report also contained a half-page section on 'Viral hepatitis' under 'Communicable Diseases', which only referred to HAV and HBV (incidence of which remained stable); there was no reference to NANB hepatitis.[79]

51. The Annual Report for 1984[80] contained a paragraph on AIDS in the 'Introduction',[81] 2.5 pages under 'Communicable Diseases'[82] and a further paragraph under 'Sexually Transmitted Diseases'.[83] It reported the identification of the HLTV-III retrovirus as the causative agent of AIDS.[84] There had been 108 cases of AIDS in the UK, including 3 in haemophiliacs.[85] It was thought that presence of HLTV-III antibody was a marker of infectivity, though noted that the virus had been isolated in seronegative individuals, possibly in an early state of infection; the report stated that "*[t]he fact that many infected persons are infectious but unaware that they have been infected creates serious problems for control of spread of infection*". There had been three cases of seropositivity following a blood transfusion from one donor who subsequently developed AIDS.[86] Further on, the report stated that of those identified to be HTLV-III positive, "*it is uncertain how many then will develop AIDS but it seems to be at least 10%.*"[87] The measures taken to combat AIDS were set out, including: the establishment of the Expert Advisory Group on AIDS ('EAGA'); interim guidelines for medical and nursing staff; distribution of information leaflets; development of a screening test to be introduced in 1985; development of heat

---

[77] Ibid p.44-45 / e-page 54-55,
[78] Ibid p.56 / e-page 66
[79] Ibid p.50 / e-page 60
[80] DHSC0007006; published in 1986, Sir Donald Acheson's introduction dated October 1985
[81] Ibid p.2 / e-page 8
[82] Ibid p.35-37 / e-page 41-43
[83] Ibid p.50 / e-page 56
[84] Ibid p.2 / e-page 8
[85] Ibid p.35 / e-page 41
[86] Ibid p.36 / e-page 42
[87] Ibid p.50 / e-page 60

treatment; and the ongoing work to redevelop the BPL, with the aim of achieving self-sufficiency.[88]

52. The 1984 volume also contained a short section on 'Viral hepatitis' which noted a 62% increase in reports of HBV, thought to be attributable to intravenous drug use in the 15-24 age group.[89] Again, there was no mention of NANB hepatitis.

53. The 1985 Annual Report[90] devoted to AIDS a page in the 'Introduction',[91] and seven pages under 'Communicable Diseases'.[92] It advised with regard to AIDS that "*A latent period of up to 5 years may exist between the date of infection and the development of the illness but not all carriers of HTLV III antibodies develop the syndrome*", making it very difficult to control the spread of the disease.[93] In the absence of an antiviral drug or vaccine, the three most important defences were: public education, providing a safe supply of blood and blood products, and advice to infected people on how to avoid infecting others. In an expanded section under 'Communicable diseases', it was reported that there had been 167 new cases that year, bringing the total to 275, of whom 140 had died. Of 9 cases in haemophiliacs, 8 had died, and of 5 cases in recipients of blood transfusions, 4 had died. [94] It was estimated that 25-100 persons were likely to have been infected for every reported case (thus 5,000 to 27,500 in total).[95] Preventative measures taken were outlined, including: surveillance, Advisory Committee on Dangerous Pathogen guidelines, HTLV-III antibody testing, leaflets for prospective blood donors, and heat treatment of clotting factor concentrates. There was no section on hepatitis in the 1985 report, perhaps reflecting the CMO's strong focus on the emerging AIDS crisis.

54. In the 1986 Annual Report,[96] Sir Donald Acheson addressed AIDS as the first topic covering two pages in his 'Introduction', noting that cases of and deaths from AIDS showed exponential growth. There had been 5,0009 HIV positive tests reported from England to 30 June 1987.[97] He emphasised that the principal means for reducing spread was public education and referred to the ongoing public information campaign. He stated that following

---

[88] Ibid p.37 / e-page 43
[89] Ibid p.45 / e-page 51
[90] DHSC0007007; published in 1986, Sir Donald Acheson's introduction dated July 1986
[91] Ibid p.4-5 / e-page 12-13
[92] Ibid p.41-48 / e-page 49-46
[93] Ibid p.4 / e-page 12
[94] Ibid p.41 / e-page 49
[95] Ibid p.42 / e-page 50
[96] DHSC0007008; published in 1987, Sir Donald Acheson's introduction dated September 1987
[97] Ibid p.1-2 / e-page 9-10

an MRC proposal, the Government had allocated £14m over 3 years to research for a vaccine and anti-viral drugs; "*The DHSS has given research into AIDS a top priority.*"[98] More detailed statistics were provided further on in the report in a further six-page section on AIDS under 'Communicable Diseases'; of 339 cases of AIDS identified in the UK in 1986, 21 were people with haemophilia and 9 were recipients of blood.[99] Again, there was no section on hepatitis.

55. The 1987 Annual Report[100] again addressed AIDS in the 'Introduction', but less prominently with 1.5 pages towards the end of the section, with a focus on international cooperation.[101]In this report for the first time there was a dedicated chapter titled 'AIDS, HIV Infection and Sexually Transmitted Disease', with 12 pages devoted to AIDS.[102] In this chapter, it was noted that a cumulative total had been reached in the UK of 8,017 HIV positive tests and 1,227 cases of AIDS. In England, there were 61 cases in people with haemophilia, of whom 45 had died; there were 16 cases from blood transfusion abroad, of whom 10 had died, and 5 UK transfusion cases, of whom 4 had died.[103] The NBTS continued to screen all blood donations, and 90 prospective donors had tested positive.[104] Public education was still the principal strategy for limiting the epidemic.[105]

56. In this report, there was a short section 'Hepatitis B' under 'Communicable Diseases'[106] which stated there had been a sharp decline in HBV cases reported to PHLS since 1984. It was noted that the warnings about HIV transmission may have had a beneficial effect on rates of HBV. The JCVI guidance on use of the HBV vaccine was set out.

57. In his introduction to the 1988 Annual Report,[107] Sir Donald Acheson stated that the rate of spread of HIV was slowing, although *"it would be a gross error to allow this change to engender complacency"*.[108] He noted that a fall in other sexually transmitted diseases suggested that public education aimed at minimising the spread of HIV infection was taking effect. This conclusion was supported by statistical evidence further in the report; there were

---

[98] Ibid p.2 / e-page 9
[99] Ibid p.55 / e-page 63
[100] DHSC0007009; published in 1988, Sir Donald Acheson's introduction dated August 1988
[101] Ibid p.7-9, e-page 15-17
[102] Ibid p.115-126/ e-page 123-
[103] Ibid p.115, p.118 / e-page 123, 126
[104] Ibid p.121 / e-page 129
[105] Ibid p.121 / e-page 129
[106] Ibid p. 104 / e-page 112
[107] DHSC0007010; published in 1989, Sir Donald Acheson's introduction dated September 1989
[108] Ibid p.12 / e-page 18

1,630 new positive HIV tests reported in 1988 (considerably fewer than 1987).[109] Again, there was no section on hepatitis.

58. In the 1989 Annual Report,[110] the statistics showed that the flattening of the curve continued.[111] Public education campaigns also continued at a local and national level.[112]

**Relationship between CMOs for England, Wales, Scotland and Northern Ireland**

59. A summary of the CMO role set out in the BSE Inquiry Report stated that:

> "*Although there were CMOs for Wales, Scotland and Northern Ireland, advising their respective Ministers on matters affecting those parts of the United Kingdom, the responsibility for advising the UK Government on matters affecting the United Kingdom as a whole fell to the CMO for England.*"[113]

60. The BSE Inquiry heard evidence that Sir Donald Acheson "*regularly met his fellow CMOs for Scotland, Wales and Northern Ireland on an informal basis*".[114] Sir Kenneth Calman's draft statement suggests that these meetings took place on a quarterly basis. Dr James McKenna wrote in his statement to this Inquiry:

> "*The 4 CMOs met regularly and at those meetings ranged widely over several current topics. I have no recollection of any discussions in that forum about blood products, the licensing and regulation of pharmaceutical products, companies and products, self-sufficiency in blood products or the risk of infection from blood or blood products.*"[115]

61. Perhaps because of the informal nature of these meetings, the Inquiry has not been able to find any contemporaneous documents which relate to them.

62. There were meetings of the Ministerial Steering Group on AIDS. At the first meeting on 2 December 1985,[116] attendees included Sir Donald Acheson, the CMO for England and Dr Gareth Crompton, the CMO for Wales. However, the Northern Ireland Office was represented by Dr Robert McQuiston, Assistant Secretary, Health Services Division, DHSS (NI),[117] and the Scottish Office by Dr Andrew Young. Dr Young was later a Scottish

---

[109] Ibid p.122 / e-page 128
[110] DHSC0007011; published in 1990, Sir Donald Acheson's introduction dated September 1990
[111] Ibid p.90 / e-page 98
[112] Ibid p.94 / e-page 102
[113] WITN6965002 para 4.17
[114] Ibid para 4.27
[115] WITN6983001 para 15.1
[116] HMTR0000005_073
[117] WITN5572001

DCMO. At the second meeting on 15 April 1986, the only CMO to attend was Dr Gareth Crompton. Dr Harris, DCMO, attended from DHSS.[118]

63. On 18 February 1985, an internal Ministerial Submission to the Parliamentary Under Secretary of State in the Welsh Office set out the view of the CMO for Wales (Dr Professor Gareth Crompton) on the question of whether AIDS should be made a notifiable disease, or other powers introduced in the name of supposed "public protection". The papers show that at that time there was considerable political pressure to introduce some form of legislation, including the power to detain "dangerously infectious" patients in hospital, but that many health officials were opposed.[119] The Ministerial Submission of 18 February 1985 reflected this position:

> "*Medical colleagues in the Welsh Office including the Chief Medical Officer have carefully considered the Expert Advisory Group's conclusions and the DHSS advice, and have expressed reservations about the DHSS conclusions in favour of option iii* [making regulations for necessary powers under the Public Health Act without making the disease notifiable]. *They believe that the reasoning of the Expert Advisory Group is sound and that the best course at present would be to take no action to introduce hospital detention powers in respect of patients with AIDS.*
>
> ...
>
> *However, they recognise that the political pressure on Ministers to do something about the public health risk posed by AIDS sufferers who refuse to stay in hospital may require some action to be taken immediately. If so, they consider option ii* [making AIDS a notifiable disease] *to be out of the question for the reasons given by the Group but would reluctantly accept option iii.*
>
> *... in the light of the DHSS administrative view that regulations are required in order to enable them to deal with very difficult individual cases, they are prepared (reluctantly) to support the action proposed provided that the powers sought under the Act are strictly limited to those felt to be absolutely necessary to deal with such cases and that the package is carefully presented in order to make it clear that there is no*

[118] SHTM0001036

[119] See also Virginia Berridge, *"AIDS in the UK: The Making of Policy, 1981-1994"* (Oxford: OUP, 1996) (2002 reprint), p.71.

*immediately* [sic] *danger of a public epidemic and that the powers will only he used in very extreme circumstances when all other avenues have been explored.*"[120]

64. At the second meeting of the Ministerial Steering Group on AIDS on 15 April 1986, there was a discussion about confidentiality of information relating to AIDS. Dr Gareth Crompton is recorded as contributing as follows:

> "*In further discussion, Mr Hayhoe pointed out that the medical profession were already guided on confidentiality by a well established ethical code. Dr Harris said that if a doctor had a sero-positive patient, the doctor would normally advise his patient to disclose details of his infection to his sexual partner(s) who could be at risk. If the patient refused, the doctor had the discretion in exceptional circumstances to disclose information to protect someone who was at risk. Dr Crompton said that the ethical rules for the medical profession were clear; AIDS was not highly infectious and there were no reasons for doctors to deal with it any differently from other diseases. Mr Dunn queried whether a doctor who withheld information about seropositivity from a sexual partner who subsequently became infected would be liable in law. Mr Hayhoe said that DHSS would pursue this.*"[121]

**Response to infected blood risks**

**Hepatitis Advisory Group**

65. A proposal for a new advisory group was submitted for the CMO's attention on 24 July 1979 by Dr T Geffen, Senior Principal Medical Officer at DHSS.[122] He explained that at least three, and possibly more, agents were known to cause viral hepatitis,

> "*with differences in their mode of spread and other epidemiological features and requiring different methods of control and treatment... At present hepatitis B presents the majority of problems and is responsible for the majority of enquiries but non-A/non-B hepatitis may well also become a major source of concern.*" [123]

66. The paper set out the 'most important' problems arising, including the possible hazards of the use of blood and blood products. A freestanding committee was required, "*To advise the Chief Medical Officer of the health departments of Great Britain on the prevention and*

[120] SHTM0001064
[121] SHTM0001036 para 2.7
[122] NHBT0000186_006
[123] DHSC0002193_092

*control of viral hepatitis*." Dr Geffen noted that "*It would be necessary to discuss representation with Scotland and Wales and possibly with Northern Ireland.*"[124]

67. On 13 February 1980, DCMO Dr John Evans responded:

> "*ADVISORY GROUP ON HEPATITIS*
> *Dr Harris* [DCMO] *and I discussed this matter with CMO last week. It was agreed that the numerous problems arising in relation to hepatitis need to be brought together into one Advisory Group on Hepatitis rather than be dealt with in a scattered fashion by various ad hoc groups. The advisory group should take the form of other major infectious disease advisory groups such as that on lassa fever and rabies, le it should meet once or twice to consider the major problems at present facing us but then be convened only as the work demands. The terms of reference should be wide enough to cover medical advice on all aspects of communicable hepatitis. In particular the specialist advice needed by blood transfusion experts for example on what kind of test it is best to use — would certainly fall to the new advisory group even though in practice such highly specialized questions might be remitted to special groups.*
> *Could you and colleagues please prepare a note so that CMO can tell Ministers what is proposed?...*"[125]

68. Sir Henry Yellowlees agreed that a new advisory group should be convened, and on 13 June 1980 he submitted the following proposal:

> "*1. As the Minister probably knows already, there have recently been many problems confronting the Department in relation to hepatitis, and there.is an urgent need to pull together our various sources of advice on hepatitis into one proper professional advisory group capable of giving authoritative and coherent medical advice about these diseases. Recent developments in our knowledge of the epidemiology of hepatitis, and particularly the recent Lancet Paper about a cluster of surgical patients all apparently infected with hepatitis from the same surgeon, have greatly added to the pressures on the Department for advice. My colleagues in the Scottish Home and Health Department and in the Northern Ireland Ministry of Health and Social Services are experiencing similar, pressures and would like to pool knowledge with us rather than have to cover similar ground by themselves.*

---

[124] Ibid
[125] DHSC0000857, see also DHSC0000859

*2. I therefore propose to form an Advisory Group on Hepatitis similar to those which I already have on rabies and Lassa fever. It will be an expert professional group which I can call together from time to time as necessary or consult by correspondence on all medical aspects of communicable hepatitis.*

*3. It will subsume two existing advisory bodies - the Expert Group on Hepatitis in Dentistry and the Advisory Group on Testing for Hepatitis B Surface Antigen and its Antibody - which will now cease to meet.*

*4. These changes may put some increased load on the secretariat but the work would principally fall on the medical staff who are, at present, trying to handle many hepatitis problems without the benefit of advice from an expert group...*"[126]

69. He attached a paper setting out his rationale for setting up the new group, including that HBV had "*been a source of considerable anxiety in recent years*". He also noted that "*Infections resembling those due to hepatitis B are known to be caused by one or more other agents which have not been fully identified.*"[127]

70. The new Hepatitis Advisory Group met for the first time on 3 October 1980.[128] The DHSS was represented on the group by DCMO Dr Harris and others, but the CMO did not attend personally.

71. As noted above, the CMO's Annual Reports for 1980[129] and 1981[130] referred to a recent increase in notifications of infective jaundice, attributed to outbreaks of HAV. However, they did not discuss the broader concerns which led to the establishment of the Hepatitis Advisory Group.

72. On 31 December 1981, the CMO issued advice regarding NHS staff who tested positive for HBsAg.[131]

**Hepatitis B vaccine**

73. In April 1984, a supply of the new HBV vaccine was offered to DHSS by Merck Sharp and Dohme Ltd.[132] Dr Geffen, DCMO, supplied a briefing to ministers on the vaccine.[133] He

---

[126] DHSC0000880 p.1
[127] Ibid p.2
[128] DHSC0002199_066
[129] DHSC0007003 p.51
[130] DHSC0007002 p.41
[131] NHBT0000070_042
[132] DHSC0001728
[133] DHSC0001724, DHSC0001726

noted that the Joint Committee on Vaccine and Immunisation ('JCVI') had recommended that the vaccine should be given to defined groups of people, but this would have *"considerable resource implications"*. He advised:

> "*In view of the high cost of the vaccine in relation to the prevention of serious cases of the disease and of difficulties of ensuring that the available supplies are used for those with the highest priority, it is not thought that it has a strong claim for scarce NHS resources…. It is suggested that the agreement of the manufacturer be sought to limit the quantity and distribution of the vaccine in order to contain the cost and ensure that it is used only for the high priority groups.*"[134]

74. The Minister of State for Health, Kenneth Clarke, declined to centrally purchase the offered vaccine supply in reliance on that advice.[135] The Inquiry has seen no evidence that the CMO, Sir Henry Yellowlees, had any personal involvement with that decision. However, he did issue a 'Dear Doctor' letter on 15 October 1982, jointly with the Chief Nursing Officer, advising that very limited use should be made of the new HBV vaccine (i.e., only to the highest risk individuals even within the JCVI's priority groups). [136] This letter was prepared with input from the Hepatitis Advisory Group[137] and a draft was submitted for approval to ministers.[138]

75. The CMO's Annual Report for 1982 noted that the number of cases of acute HBV identified in England and Wales was 1,009 in 1980, 1223 in 1981 and 1251 in 1982. However, it was noted this was still low compared with other countries. The increase was attributed to improved reporting and *"increased cases among drug users"*. The report described the new HBV vaccine from the USA and noted that other countries including the UK were currently developing vaccines of their own. The advice from the 15 October 1982 'Dear Doctor' letter was reiterated:

> "*The decision to give hepatitis B vaccine to a particular patient is a decision for the individual doctors, but in view of the relatively low incidence of hepatitis B in this country, the cost of the vaccine in relation to other pressures on health service*

---

[134] DHSC0001724
[135] WITN0758001 paras 5.16-5.18
[136] NHBT0000069_017
[137] WITN4461113 p.2
[138] DHSC0002221_030

*resources, and its limited availability, it is recommended that the vaccine should be reserved for specific individuals within groups known to be at increased risk.*"[139]

**Early knowledge of and response to AIDS – Sir Henry Yellowlees**

76. The CMO's Annual Report for 1982, published in 1983, stated:

> "*Acquired immune deficiency syndrome ('AIDS')*
>
> *During the past four years a new and frequently fatal syndrome has been described in the United States. It consists of the development of immuno-depression of cell mediated immunity, infection with opportunistic micro-organisms and, in many cases, the development of Kaposi's sarcoma.*
>
> *Over one thousand cases have been reported in the United States mostly among young homosexual men and the death rate has been over 40 per cent. Cases are now being reported in England and Western Europe. The cause of this serious and often fatal syndrome is unknown. The situation requires careful surveillance, and this is already being undertaken by the Communicable Disease Surveillance Centre (CDSC).*"[140]

77. The Inquiry has seen no evidence that the CMO Sir Henry Yellowlees was directly involved in briefing ministers on AIDS in 1982 or the early part of 1983. He was not copied into a key briefing on 3 May 1983, which included the 'line to take' *"there is as yet no conclusive proof that AIDS has been transmitted from American blood products"*. This was accompanied by a Q&A guidance note which gave the fuller advice, "*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*"[141]

78. Lord Fowler, who was Secretary of State at the time, has commented in his written evidence to the Inquiry on whether the 'line to take' was appropriate:

> *"I would observe that one might have hoped that the CMO would have picked up on a line to take not getting the balance right, as the risk was, after all, the subject of advice from medical officials. However, Sir Henry Yellowlees was a less effective figure than his successor Sir Donald Acheson. Nevertheless I do accept that both we as Ministers,*

[139] DHSC0007004 p.51-52 / e-page 59-60
[140] DHSC0007004 p.62-63 / e-page 70-71; the Inquiry cannot explain the reference to AIDS having been described for the past 'four years'
[141] DHSC0001651, HSSG0010056_035

*and our senior non-medical officials, could ourselves have spotted the tension to which the Inquiry refers.*"[142]

79. He added in his oral evidence:

"*I think that had the CMO taken a grip of this thing now, then we might have a -- we might have had a better picture. But, in all honesty, it was a pretty obscure picture in any event.*

…

*I think that if Sir Donald Acheson had been Chief Medical Officer then, and not a couple of years later, I think more action would have been taken.*"[143]

80. A few days later, on 6 May 1983, in a DHSS internal minute, Dr Mary Sibellas, Senior Medical Officer, wrote to Senior Principal Medical Officer Dr Oliver:

"*Dr Spence Galbraith telephoned from CDSC this morning with the following information:-*

*The male patient (aged 23 years) in Cardiff who is a known haemophiliac now, appears to have the right symptoms and signs for a diagnosis of AIDS. (He has an opportunistic infection - oesophageal candidiasis - and also epididymo orchitis of unknown aetiology). He has been ill for a month and has been treated with American F VIII. We have no further news of the haemophiliac patient in London (as mentioned in the press on Sunday 1 May 1983).*

*Dr Galbraith last night received information from Spain that three haemophiliac patients there are thought to have AIDS and have also been treated with American F VIII. (Dr Galbraith thinks that the product is irradiated but we are all aware that this would not eliminate a transmissible agent, say of the slow virus type.)*

*Dr Galbraith asks that the Department should consider the matter as a priority - and asks that any top level meeting should include CDSC (who are collecting all data on AIDS cases for us). I assured him we would liaise with CDSC and also told him that we had already met (C.A. in blood transfusion) and he was in touch with Regional Transfusion Directors - and that alternative supplies of F VIII are being considered but*

[142] WITN0771001 para 6.13(vi)

[143] Transcript of 21 September 2021, p.137 & 141; it should be noted that Sir Donald Acheson joined DHSS in October 1983, five months later.

*are not going to be easy to come by - the matter is under active consideration. (Swiss supplies are considered doubtful - is Germany a possibility)?*"[144]

81. Dr Galbraith himself wrote to Dr Ian Field, Senior Principal Medical Officer at DHSS, on 9 May 1983, to reiterate the urgency of the situation and recommend that *"all blood products made from blood donated in the USA after 1978 should be withdrawn form use until the risk of AIDS transmission from these products has been clarified... Perhaps the subject could be discussed at an early meeting with haematologists, virologists and others concerned so that a decision may be made as soon as possible."*[145] He attached a paper entitled 'Action on AIDS', in which he set out the basis for concluding that *"The agent is probably transmitted by blood and blood products*" and that Factor VIII concentrate and pooled products appeared to have a high risk of being contaminated with the agent.[146]

82. The Inquiry has seen no documentary evidence that Dr Galbraith's concerns were escalated to and discussed with the CMO. Lord Fowler was asked during his oral evidence whether Dr Galbraith's letter of 9 May 1983 ought to have gone to the CMO. He replied:

"*I would be slightly surprised if it didn't, and I'd be even more surprised if, it having been, I imagine, given a certain amount of publicity, I assume, that the Chief Medical Officer hadn't asked for it. So one way and another it should have gone to the Chief Medical Officer.*"[147]

83. The Inquiry has identified no evidence to suggest that Sir Henry Yellowlees provided any comment or response on Dr Galbraith's letter of 9 May 1983.

84. On 9 June 1983, Dr Gunson wrote directly to Sir Henry Yellowlees, also raising serious concerns about AIDS:

"*You will have been aware that during recent weeks considerable publicity has been given in the Press to the condition of Acquired Immune Deficiency Syndrome (AIDS). This syndrome was first reported in the U.S.A. and since 1981 some 1,300 [annotation:1,450 by end May] cases have been diagnosed in that country. The patients exhibit an impairment of the immune system which makes them susceptible to certain types of cancer, e.g. kaposi's sarcoma and to opportunistic infections, and the condition*

[144] DHSC0002227_021
[145] CBLA0000043_040 p.1
[146] Ibid p.2, p.3
[147] Transcript of 21 September 2021, p.158

*carries a high mortality. The syndrome has been found, strikingly, in male homosexuals (75-80 per cent) particularly with those with multiple partners, but it has also affected male and female heterosexuals, of whom 60 per cent admit to intravenous drug abuse. Two different ethnic groups are also involved; Haitians and people from Central Africa (Tehad and Zaire).*

*The etiology of the disease is not known, but there is a strong possibility that the syndrome is caused by a transmissable infectious agent and in this context it has been implicated in transfusion of blood and blood products. In the U.S.A. several patients suffering from haemophilia-A have contracted AIDS and some have died; all of these patients received repeated infections of Factor VIII concentrate derived from human plasma. In England there is one patient with haemophilia who is suffering from a condition which fulfils the U.S.A. definition of AIDS and there is one other possible patient suffering from haemophilia who may have the syndrome.*

*Although relatively few cases of AIDS have, as yet, been reported in this country, the significance of the condition with respect to the transfusion of blood and blood products are two-fold.*

*(1) To ensure that persons in a high risk group with respect to AIDS are not enrolled as blood donors. In order to achieve this aim, the Regional Transfusion Directors, with the agreement of Senior Medical Officers at the D.H.S.S. have prepared a pamphlet which gives information to donors on AIDS and asks those persons in high-risk groups not to donate blood. Additional questions are to be asked of donors with respect to their health, but it is unanimously agreed that the sexual practices of donors cannot be questioned directly.*

*(2) Approximately one-half of the Factor VIII concentrate used in the treatment of haemophilia in England and Wales at present is derived from plasma imported from the U.S.A.*

*The Press have been keenly interested in this aspect and there is, in my view, no alternative to the continuation of this policy in the short term. As you will appreciate, the commercial companies producing this product in the U.S.A. have been subjected to considerable pressures to produce safe material and since April, 1983, restrictions have been placed on donors in high-risk groups with respect to AIDS, and the importation of the product prepared before April, 1983, is being carefully monitored. In the medium term, the Blood Products Laboratory, Elstree, is being rebuilt so that it*

*will have the capability of preparing blood products at a level which will make this country self-sufficient. The necessity of an adequate supply of plasma from our volunteer donors to the new laboratory from the regional transfusion centres cannot be over-emphasised.*

*AIDS is not a major problem in this country at present and, frankly, we do not know whether it will be in the future. However, it is being taken seriously in European Countries and the Ministers of the Council of Europe are to be asked to approve recommendations designed to minimize the effect of AIDS. These recommendations are not in general incompatible with the measures being taken in this country.*

*Although the situation with respect to the transfusion of blood products and the incidence of AIDS has been closely observed by the transfusion service for some time, it has to be admitted that press publicity, albeit some of it ill-informed and alarmist, has resulted in a reconsideration of this problem and the formulation of the policy outlined above.*

*Since this has occurred since the closure of the agenda for the meeting of the Consultant Advisers on 17th June, 1983, I will be grateful if you will allow me a few minutes under Any Other Business to appraise members of the Committee, of the problems of AIDS in relation to the transfusion of blood and blood products and the measures being undertaken to minimize the effects of this potentially fatal syndrom*e."[148]

85. The Inquiry has not identified any record of the CMO's reply. There may have been a verbal conversation; a later letter refers to Sir Henry Yellowlees consulting Dr Gunson at *"the meeting of Consultant Advisors"* in the summer of 1983.[149] It was around this time that the CMO was personally involved in commissioning a briefing on AIDS (for the first time, as far as the Inquiry can establish). In a note dated 22 June 1983, Dr Oliver circulated a note stating:

> *"Sir Henry Yellowlees has asked me to provide some information on AIDS for Lord Glenarthur* [then Minister responsible for blood products]. *I attach a paper prepared by Dr Walford which gives the background and up-to-date position. We are at Lord Glenarthur's service if he would like to discuss the matter in greater detail."*[150]

[148] NHBT0001067
[149] NHBT0001066
[150] DHSC0002309_123

86. The attached paper referred to 12 cases of AIDS in the UK, including one suspected case where the patient was a haemophiliac.[151] It explained that an information leaflet for blood donors had been prepared by the Regional Blood Transfusion Directors and would be published by the DHSS.[152] Dr Walford wrote:

> "*It is thought that the greatest risk to haemophiliacs at present is from the use of Factor VIII concentrate prepared from American plasma. Although the Blood Products. Laboratory is to be redeveloped over the next three years at a cost of £21 million to achieve national self-sufficiency in blood products, until this time, some 50% of the Factor VIII concentrate needed to treat haemophilia will have to be imported, mainly from the U.S.A.*"[153]

87. On 13 July 1983, representatives of DHSS including Dr Walford and Dr Oliver – but not the CMO – attended a meeting of the Committee on the Safety of Medicines, Sub-Committee on Biological Products. The Committee concluded that the risk of licensed blood products was *"small"* and that *"Balanced against the risk of AIDS ... are the benefits of their use"*. It was considered not to be feasible to withdraw clotting factor products altogether, and disproportionate to withdraw American products.[154]

88. Lord Glenarthur has given evidence that he was unaware of this meeting. He said in oral evidence:

> "*I suspect that -- whether it happened or not I don't know -- looking at those that are recorded as attending this meeting that that information should have gone up the medical chain of command to the Chief Medical Officer and the Chief Medical Officer ought to have taken a view that these were matters of such seriousness that ministers ought to be involved and asked the system to arrange that that should be so but, apparently, that didn't happen.*"[155]

89. The next day, on 14 July 1983, Dr Gunson wrote to Dr Oliver "*following our conversation yesterday about the proposed leaflet on AIDS*", that:

---

[151] DHSC0002309_124 p.2
[152] Ibid p.3
[153] Ibid
[154] ARCH0001710
[155] Transcript of 22 July 2021, p.174

> *"it will only require one patient to die with an authenticated diagnosis of AIDS contracted after a blood transfusion, for there to be an accusation for the Government failing to take measures which have been advocated in the U.S.A. and recommended by the Council of Europe."*[156]

90. It is unclear whether this minute was escalated to the CMO. The following day, 15 July 1983, Sir James Gowan, secretary of the Medical Research Council ('MRC') wrote to the CMO to correct a mistaken announcement by Lord Glenarthur that the MRC would coordinate an AIDS working party. He wrote, *"Please forgive the terseness - I do realise that you know nothing of this matter"*.[157] He was not copied into internal memoranda regarding the development of an AIDS leaflet.[158]

91. Witnesses have given evidence that Sir Henry Yellowlees was *"a less effective figure"*[159] than his successor Sir Donald Acheson when it came to engaging with and responding to the AIDS crisis. However, it should be noted that it also seems to have taken Sir Donald Acheson some time to appreciate the gravity of the situation, as is discussed further below.

**Response to AIDS late 1983 to mid-1984 – Sir Donald Acheson**

92. Sir Donald Acheson was an outside appointment to the role of CMO, having previously been Dean of Medicine at Southampton University Medical School. He commenced in post on 1 October 1983 to shadow Sir Henry Yellowlees for three months before fully taking over the CMO role from 1 January 1984.

93. On 14 October 1983, two weeks into his appointment, he wrote to Dr Gunson:

> *"You will remember that at the meeting of the Consultant Advisers in the summer, Sir Henry Yellowlees asked whether you would be kind enough to send a brief account, of the advances in your specialty that have occurred in the past five years and the problems and opportunities which you can anticipate in the next five years. I look forward very much to receiving this as it will be an essential part of my briefing for my new post. The replies which I have already received from colleagues on this matter have been extraordinarily interesting - and have reminded me how little it is possible*

[156] DHSC0002321_024
[157] MRCO0000439_158
[158] E.g. DHSC0002327_016
[159] Lord Fowler - WITN0771001 para 8.25(5); Lord Clarke – transcript of 27 July 2021 p.35

*for one person to know about the advance of medical science! I look forward eagerly to your letter.*"[160]

94. Dr Gunson wrote back on 18 October 1983, enclosing a paper 'Five Years Back and Five Years Forward' regarding the state of the blood transfusion services.[161] He focussed on the need to achieve self-sufficiency, noting that approximately 60% of factor VIII was purchased commercially, and largely imported from the USA. He warned that "*the problem of non-A, non-B hepatitis remains and there is now the potential transmission of AIDS, about which I spoke at the last Consultant Advisers' Meeting*". He went on to say:

> "*With respect to AIDS, it is too early to anticipate the effects in the U.K., but it is important that every opportunity is taken to investigate possible ways in which the blood donor population can be screened.*" [162]

95. Soon afterwards, an internal briefing was prepared, 'Consultant Advisers Meeting – Briefing on AIDS for CMO', dated 4 November 1983.[163] (It does not state which CMO was the intended recipient.) The briefing explained that no specific marker test had been developed and that cases continued to rise, with 24 notifications in Britain including two haemophiliacs.

96. On 14 November 1983, Kenneth Clarke answered a Parliamentary Question regarding whether imported factor VIII could be contaminated with the causative agent of AIDS; he stated:

> "*There is no conclusive evidence that acquired immune deficiency syndrome (AIDS) is transmitted by blood products. The use of factor VIII concentrates is confined almost exclusively to designated haemophilia centres whose directors and staff are expert in this field. Professional advice has been made available to all such centres in relation to the possible risks of AIDS from this material.*"[164]

97. Lord Clarke's evidence to the Inquiry regarding this statement was:

---

[160] NHBT0001066
[161] Ibid
[162] Ibid
[163] DHSC0003823_173
[164] PRSE0000886

"*At the relevant time, I trusted the advice that I was receiving from the CMO and his team of medical advisors which, as I have already observed, I had no reason to challenge.*"[165]

98. The Inquiry has identified no contemporaneous evidence to show whether the CMO was personally involved in briefing this line to take. As noted above, the public information the CMO issued in his 1983 Annual Report, published at the end of 1984, was that "*The cause remains unknown, but is likely to be a viral agent transmitted by sexual contact, transfusion of blood and certain blood products.*"[166]

99. On 13 February 1984, Dr Gunson wrote to Dr Harris, DCMO,[167] appending a report titled 'Plasma Supply for Self-Sufficiency in Blood Products'.[168] He wrote that when the new BPL (at that time under refurbishment) re-opened, it could not be assumed that sufficient plasma would be available for its successful operation. He recommended additional blood collection should be financed through the CBLA. Dr Harris replied on 15 February 1984,

"*We are taking this matter extremely seriously in the Department and, following discussion with Sir Donald Acheson and my DCMO colleagues, we have decided that a submission to Ministers will be required. This will state the nature of the problem and suggest Secretary of State should impress upon Regional Chairmen at an early meeting the importance Ministers attach to increasing plasma supply so as to make us self-sufficient.*"[169]

100. This shows that the CMO was personally involved in discussing the issue of self-sufficiency in early 1984. However, it appears that proposed submissions to Ministers was not forthcoming. Instead, the issue of plasma supply was raised, with Dr Harris' knowledge and involvement, through other methods, including the NHS Management Group and a circular that was sent by the DHSS to all Regional Health Administrators on 10 August 1984.[170]

101. There is then a lack of evidence to show any personal involvement of the CMO in matters relating to AIDS between February and October 1984. This may, in whole or in part, reflect

---

[165] WITN0758001 para 7.119
[166] Ibid p.56
[167] DHSC0001966
[168] DHSC0001967
[169] DHSC0046942_114
[170] DHSC0002333_024; CBLA0001870; WITN5282001 para 80.7; see also transcript of 23 July 2021, p.129-138

a gap in the available documentary evidence identified by the Inquiry. Alternatively, it could be suggested that the lack of documentary material indicates that Sir Donald Acheson was not, at that stage, personally involved – or at least extensively personally involved – in the DHSS's response to the AIDS crisis. In his autobiography, Sir Donald Acheson wrote:

> "*On my arrival in Whitehall, a handful of cases of a mysterious new disease soon to be labelled with the acronym 'AIDs' had already occurred in Amsterdam and San Francisco among gay men. But these had not yet been shown to be due to an infection and their significance was uncertain. Soon two developments were to occur which changed that forever. The first, in 1984, was the discovery that AIDs was in fact due to a retrovirus - HIV - and likely to prove incurable. The second, an even greater bombshell, erupted the following year. I heard from Robert Redford, a colleague in Washington at the Walter Reed Military Institute, that in American soldiers a few of the early cases had been due to infection during vaginal not anal intercourse with an HIV positive person.*
>
> *Perhaps due to wishful thinking I did not at first grasp the full implications of this. But the defining moment was not long delayed. It occurred early in the following year and came from a different continent. A package marked 'Urgent, for CMO's personal attention' arrived by messenger from the Foreign and Commonwealth Office across the road. This confirmed as correct, rumours which were circulating of a disaster engulfing parts of Africa. In Zambia, and as I heard later, also in Uganda, HIV was spreading like wildfire in the general population. In some places few adults other than the elderly survived and it was proving difficult to find people to bury the dead. A generation of orphaned children was beginning to appear.*
>
> *I was horrified. If this could happen in Africa what would an apparently identical virus do in Britain? Having decided that it would be folly to assume that in the UK HIV/AIDs would continue to be confined almost exclusively to gay men, I sought an urgent appointment with my political boss Norman Fowler, the Secretary of State for Health. Norman's reaction was one of deep concern and for the rest of my time in Whitehall, with his unfailing encouragement and support, I was able to give the AIDs epidemic a place close to the top of my priorities.*"[171]

[171] WITN0771088 p.183-184

102. This suggests that Sir Donald Acheson came to a full realisation of the gravity of the AIDS crisis in 1985.

103. When Lord Fowler gave oral evidence to the Inquiry, he was asked why it took Sir Donald Acheson a year from his appointment to request a briefing regarding AIDS (described below). He replied that:

> "*[H]e needed time to actually find his feet around this enormous Department, but when he did he made it happen*".[172]

**Increasing focus on AIDS from late 1984 - Sir Donald Acheson**

104. Sources concur that Sir Donald Acheson came to prioritise the response to AIDS. Dr Pickles, who joined the AIDS Unit at DHSS in a newly established post from the spring of 1986,[173] has given evidence that although she theoretically had a reporting line through a SPMO and DCMO, in practice she mostly reported directly to Sir Donald Acheson. The DCMO, Dr Harris "*had to deal with much of the rest of the departmental business when the CMO was so preoccupied with AIDS.*"[174] Sheard and Donaldson have suggested, on the basis of interview evidence:

> "*Acheson's handling of the acquired immune deficiency syndrome (AIDS) crisis in the 1980s marked him as a talented CMO.... However, AIDS has tended to overshadow Acheson's other achievements, and perhaps also some of the issues which his 'outsider' status highlighted.*"[175]

105. Virginia Berridge wrote in 'Aids in the UK: The Making of Policy, 1981-1984' that: *"There is no doubt that Acheson, as one source put it, 'ate and slept AIDS' from 1985 onwards."*[176]

106. Sir Donald Acheson's increasing focus on AIDS is also evident from the contemporaneous documents. In the CMO's Annual Report for 1984 (published in 1986), control of the virus causing AIDS was described as *"undoubtedly the greatest challenge in the field of communicable diseases for many decades"*.[177]

---

[172] Transcript of 22 September 2021, p.44
[173] Transcript of 12 May 2022 p.21
[174] WITN6965001 paras 5.2 & 9.1
[175] *The Nation's Doctor* p.367
[176] *Berridge*, "AIDS in the UK", p.68
[177] DHSC0007006 p.35

107. A briefing minute from Dr Alison Smithies, Principal Medical Officer, dated 19 October 1984, was sent in response to the CMO's request for "*information about the problems of AIDS and blood donations*".[178] He had asked specifically, "*When can we expect that no blood/plasma will be donated without prior testing*", and "*What is the position about blood transfusion/plasma related AIDS in the UK and its controls*"?

108. Dr Smithies responded that only pilot studies had so far been carried out into blood donor testing for HLTV-III, and there was a limited supply of test reagent so that the timeframe for universal testing was uncertain. She said, *"it is felt that there is a danger in making this* [testing] *too public in the event of high risk groups using blood donations as a means of finding out their HLTV antibody status"*.[179] In reply to the CMO's second question, she wrote:

> "*We have yet no known cases of AIDS reliably related to blood transfusions (there are about 40 cases in the United States). Officially there are three cases of haemophiliacs who have contracted AIDS one of whom has died. In view of the prevalence of HLTV III antibody in haemophiliacs, about 35 per cent, it is likely there will be more. The two cases which have arisen long enough ago to be well documented had received Factor VIII from the United States. The other recipients of these batches are being followed up through Dr Craske of PHLS. DHSS has allocated research funds to his study. Dr Craske will also be following up through the Haemophilia Centre Directors concerned the recipients of the recent batches known to be associated with AIDS donors one of which came from the United States and one of which was contaminated by a .donor from Wessex*
>
> *The only protection recipients of blood and blood products have from contracting AIDS from donors is the publicity given to the possibility of transmission from high risk groups. The risk of transmission is theoretically highest from Factor ~III and IX which are made from large pools of plasma and their production does not involve the use of alcohol in fractionation or heat treatments as many other blood products do. A leaflet advising donors from high risk groups for AIDS to desist from giving blood was issued by Regional Transfusion Centres in August 1983. Ministers have just agreed a redraft*

[178] DHSC0002323_009
[179] Ibid p.1

*of this leaflet which strengthens the advise* [sic] *and includes all practising homosexuals as being in the high risk group.*"[180]

109. The CMO's office replied, at his direction, on 25 October 1984. He said:

"*It is agreed that we should move to the position where HTLVIII testing is put on the same basis as Australia antibody ie negativity is a prerequisite for donation of blood or plasma. Also what is the timetable and cost?*"[181]

110. On 20 November 1984, Dr Smithies submitted a further minute for the attention of the CMO, updating him that the CBLA had announced they would heat treat all factor VIII from April 1985. She noted that *"The use of heat treated Factor VIII (which reduces the yield of Factor VIII from plasma by 15 per cent) requires to be balanced with a screening test for all donations"*. She further explained that pilot trial had shown heat treatment to be ineffective against NANB hepatitis.[182]

111. On 20 December 1984, the Guardian newspaper published an article referring to two cases of HLTV-III seropositivity linked to receiving a blood donation. The CMO gave media interviews and issued a press statement stating:

"*Donations of blood and blood plasma have been given by a person who was subsequently admitted to hospital in Wessex in October and later diagnosed as suffering from AIDS.*

*His donations of both blood and blood plasma have been traced, and all possible remedial action taken.*

*His donations of blood were given to 3 recipients. They have been identified and are being followed up. Two of these recipients were a mother living in Birmingham and a 78 year old man living in Wessex - neither came from Brighton as reported in the Guardian. The third is a man aged about 40 from Wessex. All three recipients when tested have proved positive in the HTLVIII antibody screening test but none of them has AIDS.*

*His donations of blood plasma were used in the manufacture of one batch of Factor V!II at the Blood Products Laboratory, Elstree. When the diagnosis of AIDS was learnt,*

[180] Ibid p.1-2
[181] DHSC0000569
[182] DHSC0002249_034

*the remainder of this batch was withdrawn from use; however 38 patients, in Wessex and South Wales, suffering from haemophilia had already received some of this batch of Factor VIII. These patients have been traced and are being monitored; it will not be possible however to say whether any who prove positive in the HTLV III antibody screening test were affected by this batch of BPL Factor VIII or other commercially imported products.*

*None of the recipients of the blood donations or the Factor VIII made from this donor's blood plasma has shown any clinical signs of developing AIDS...*

*I should like to stress that anyone who is advised to have a blood transfusion, or who has been given a transfusion, should not worry because the risk of getting contaminated blood is extremely small. Even if a person is proved positive in the antibody screening test it does not mean that he or she will develop AIDS. Only a very small proportion of people with positive results go on to show symptoms.*"[183]

112. The press statement further noted that: a revised leaflet on high-risk groups advised not to donate blood would be issued shortly; a screening test was being developed but still needed 'considerable work'; and it was hoped that routine heat treatment of factor VIII would commence in April 1985.[184]

113. A briefing for Ministers on the CMO's press statement that day sought 'urgent' Ministerial approval of revised text of the donor AIDS leaflet. The briefing said:

> "*CMO has corrected the factual inaccuracies in the press report, set the incidence of transmission in perspective, reassured potential recipients of blood transfusions, and emphasised the need for high-risk groups not to donate blood.*"[185]

114. On 31 December 1984, Dr Smithies submitted a further briefing paper *"setting out the current position with regard to AIDS as requested by CMO"*.[186] In it, she stated that "[i]*t is now accepted that the isolates of retrovirus HTLV III...are probably the causative agent of AIDS either singly or in association with other unknown agents.*"[187] In the UK, 102 cases of AIDS had been identified to the end of November 1984, and 44 people had died. Those

[183] BART0000814
[184] Ibid
[185] DHSC0002327_127
[186] DHSC0001693
[187] Ibid p.1 of enclosed paper

figures included three cases in haemophiliacs, two of whom had died. It was believed that all three had been infected through the use of commercial factor VIII. The incidence of HLTV-III seropositivity in 800 haemophiliacs screened in the UL was about 35%, and in patients with severe haemophilia is was 75%.[188] A UK RIA antibody screening test was under development, although it was not possible to say when it would be available for universal use in RTCs.[189] The only way to prevents AIDS spreading into the general population was to instigate screening of all blood donations. [190] The NBTS Working Group on AIDS had advised that screening should be introduced *"as soon as possible"*. [191] Dr Smithies wrote:

> "*no one has yet contracted AIDS from a blood transfusion in the UK there are three sero positive recipients of blood from a donor in Wessex who now has AIDS. There may well be other donors who are unaware that they are infected.*" [192]

115. On 11 January 1985, Dr Smithies sent a draft Ministerial submission to the CMO's Private Office, with a covering summary:

> "*CMO wished to consider this submission prepared with administrative colleagues for Ministers to obtain approval in principle for the introduction of a screening test for AIDS antibodies in the National Blood Transfusion Service. The UK test is currently being used at the Middlesex Hospital and at the Central Public Health Laboratory, Colindale to detect antibody carriers amongst patients thought to have AIDS or the AIDS related complex, haemophiliacs and male homosexuals attending STD Clinics. Scale up of production of the reagent is necessary before the test can be applied more widely.*"[193]

116. The draft submission 'AIDS and Blood Transfusion - Introduction of HTLV III Antibody Screening Test for all Blood Donations' set out the statistics: there had been 108 UK cases, 46 of them had died. Three haemophiliacs had AIDS. Three recipients of blood donations from a donor who developed AIDS had been infected. Plasma from the same donor had been used to make factor VIII. In Scotland, another batch of factor VIII had been contaminated by an undetected donor. There was no method of treating the disease and

---

[188] Ibid p.1 & 6 of enclosed paper
[189] Ibid p.2 of enclosed paper
[190] Ibid p.3 of enclosed paper
[191] Ibid p.42 of enclosed paper
[192] Ibid p.3 of enclosed paper
[193] DHSC0000562

mortality was believed to be in the region of 80%.[194] The development of screening methodology was described, and costs forecast to be in the region of £2-4 million per annum, plus funding for counselling prospective donors who tested positive. The 'balance of advantage' lay clearly with the introduction of a routine test of donations as soon as possible.[195]

117. The CMO endorsed the submission and put it to Ministers on 15 January 1985.[196] Minister for Health, Kenneth Clarke, replied on 22 January 1985:

> "*Thank you for your submission of 15 January. This looks inevitable, I suppose... Will the cost be met from the income now going to the blood transfusion service from the charges introduced for the handling of blood to private hospitals? I never did understand what else that money was to be spent on. Before we all panic further, it is presumably the case that the ending of the collection of blood from homosexuals greatly reduces the risk from blood collected in this country? Also, as only haemophiliacs have died and they may have had Factor VIII from American blood, is it the case that we have not had one AIDS fatality from blood donated in this country yet? Do we need this and heat treatment of the blood?*"[197]

118. Sir Donald Acheson replied on 31 January 1985, addressing the queries raised, and emphasising his previous advice:

> "*While as MS(H) suggests it is hoped that the revised leaflet will substantially reduce the risk, we cannot guarantee that all homosexuals will desist from donating blood even with the additional publicity alerting them of the dangers. There may be considerable social pressure on the individual to continue donation. Additionally, heterosexual contacts of bisexual men and drug abusers, and other risk groups may be unaware that they have been contacts with infected persons. My advice must be that in view of the fact that 2 million units of blood are used annually without a test it will be inevitable that further transmission of the virus will take place as a result of blood transfusion.*

---

[194] Ibid p.2
[195] Ibid p.4
[196] The Inquiry does not have a copy of the final submission but it is referred to at DHSC0002482_012 and HSSG0010076_005; from contextual documents it is understood that the final submission was identical or near-identical to Dr Smithies' draft
[197] DHSC0002482_012

*As far as is known there are no cases of the actual disease AIDS in the UK which have arisen following blood transfusion and the three haemophiliac patients with AIDS had received imported Factor VIII. However, there are three further patients to whom the infection has been transmitted by blood donated in the UK who may yet develop the disease.*

*...*

*The proposed antibody test is not infallible but it is the best at present we can do for whole blood. Blood products are made from pools of many thousands of donations and so the risk of contamination very much increased. It is believed that heat treatment will reduce this risk, and therefore until a specific test is generally available (and this will take time) I advise that the heat treatment for pooled blood products will continue to be necessary and should be provided.*"[198]

119. He further proposed a press release[199] and letter to RHAs[200] announcing that funds would be ear-marked for the introduction of screening tests for blood donations, to be published on 1 February 1985 at the same time as a revised version of the AIDS donor leaflet.[201]

120. The CMO then followed up with a minute to the Minister's Private Office on 1 February 1985:

"*AIDS - THE NEED FOR HEAT TREATMENT AS WELL AS AN ANTIBODY TEST*

*1. MS(H) asked for clarification of the need for heat treatment as well as an antibody test.*

*2. As the Minister knows, blood for transfusion once it has been tested for its blood group and for evidence of infection (currently Hepatitis and Syphilis) is delivered straight to hospital blood banks for use. This is the blood which we wish in addition to screen for AIDS antibody. Heat treatment of blood for transfusion is not possible because of the damage it would do to the cells it contains.*

*3. Some plasma, which is the fluid part of the blood when the cells are removed, is taken from most donations and sent to the Blood Products Laboratory at Elsetree where it is pooled and fractionated to make Factor 8. This is the faction which needs heat*

---

[198] DHSC0002311_051, under cover letter DHSC0002311_050
[199] DHSC0002311_053
[200] DHSC0002311_052
[201] DHSC0002311_050

*treatment because the pools contain contributions from many thousands of donations and the screening tests may not pick up an infection in the latent period before antibodies develop.*"[202]

121. His repeated advice was heeded. Lord Clarke has provided evidence to the Inquiry that "*the process of the introduction of screening tests was a topic which closely concerned the medical advisors. In particular, the CMO advised Mr Patten on the strategy for evaluation of the tests, and his advice was accepted.*"[203] The press release[204] and RHA letters[205] were issued on 20 February 1985.

**Establishment of EAGA**

122. It was at around this time that the CMO established the EAGA. In his autobiography, he recalled:

> "*As far as HIV/Aids was concerned, a few cases of what was already seen as a fatal virus infection associated with infected blood and sexual intercourse had already occurred prior to my appointment. I decided that the implications of the infection were so serious and our knowledge so limited that I should seek expert advice as soon as possible. The expert advisory group on Aids (EAGA) was set up and having met seven times in 1985 and regularly thereafter, it made a series of recommendations which led to more effective control of HIV/Aids within the UK, than in any other country that had links with the African continent.*
>
> *The authoritative advice of EAGA led to a secure understanding of how the retrovirus was and was not spread which stemmed the risk of mass hysteria.*"[206]

123. Lord Fowler has also given evidence that:

> "*The CMO would oversee the arrangements for the provision of the best expert medical advice. In the case of the EAGA, no doubt advice on HIV/AIDS would already have been channelled through other exiting committees, but the EAGA would, I expect, have been designed to provide better focus and co-ordination of the advice.*"[207]

---

[202] DHSC0002327_028
[203] WITN0758001 para 7.82
[204] DHSC0101892
[205] DHSC0002482_045
[206] WITN0771088 p.186-187
[207] WITN0771001 para 6.88

124. The first meeting took place on 29 January 1985. Dr Abrams, DCMO, chaired the meeting and Sir Donald Acheson attended for part of the meeting. The minutes record:

> "*2. The Chairman thanked members for responding so quickly to the CMO's invitation to serve on the Expert Advisory Group. He emphasised the importance of the subject on which they were being asked to provide advice, and drew attention to the fact that papers circulated in connection with the Group were not for publication. Meetings should also be regarded as private and the proceedings of the Group be treated in strict confidence.*
>
> ...
>
> *4. CMO added his personal thanks to those expressed by Dr Abrams. He stressed the potentially serious epidemiological problem posed by AIDS. The terms of reference drawn up for the Group were very wide; specific issues on which advice was sought included measures necessary - in the field of public health - to control the spread of AIDS. Also CMO hoped for unequivocal advice from the Group on the question of the introduction of a screening test into the NBTS.*"[208]

125. The group discussed: the national monitoring system, which was felt to be efficient; the implications of making AIDS a notifiable disease, which was opposed; setting up a working group to develop a monitoring system for blood donors; the need for AIDS counselling; the prospect of a screening test becoming available; guidelines for clinical and laboratory staff; AIDS education; and introducing the same guidance for tissue and semen donation as for blood donation. It is recorded that "*There was general support for the introduction of a blood donor screening test as soon as practicable*."[209]

126. The CMO passed that recommendation on to Kenneth Clarke on 31 January 1985, in the briefing referred to above.[210]

127. The CMO chaired some subsequent meetings while others were attended by DCMOs in his stead, but he had the ongoing benefit of the group's advice. Both Dr Pickles and Dr Walford attended, and their evidence was:

---

[208] PRSE0002734 p.1-2
[209] Ibid p.4
[210] DHSC0002311_050

Dr Pickles: "*The group was set up under Sir Donald Acheson in late 1984/early 1985 (the first meeting was held on 29 January 1985) as a source of expert advice to the UK CMOs and thus the Government on HIV/AIDS, and the response to that pandemic…*

*It was chaired initially by the CMO, and at times by a DCMO. This was primarily a medical and technical group with external experts. EAGA developed various subgroups to deal with specialist topics, reporting back to EAGA. I always attended EAGA when I was in the AIDS Unit and occasionally thereafter.*"[211]

Dr Walford: "*It was usually chaired by the CMO or a Deputy CMO. I first attended its meetings… in the Autumn of 1987, as one of the DHSS observers. Subsequently, I became a member of EAGA when I was Director of the PHLS. The minutes of the meetings record the discussions of the Group, which addressed a broad range of issues arising as a result of HIV infection / AIDS.*"[212]

**Introduction of HLTV-III screening**

128. The CMO's understanding of AIDS, HTLV-III and blood policy is evidenced in a minute dated 17 April 1985, in response to the death of a baby following a blood infusion, which recorded him as saying:

> "*… three people have already been infected with HLTV III as a result of blood transfusion in the United Kingdom. Almost certainly others have as we know that several AIDS patients have donated blood in the months prior to diagnosis. shall be very surprised if "native" cases of AIDS due to blood transfusion do not appear in the next year.*"[213]

129. An inquest was conducted into the child's death. He died in Great Ormond Street Hospital from AIDS-related pneumonia, caused by a blood transfusion he had received in Washington DC. At the conclusion of the inquest, the Coroner wrote to Sir Donald Acheson, stating that the case fell within the rule concerning reporting on prevention of future fatalities.[214] Sir Donald Acheson reviewed the letter, as well as an internal briefing on the case.[215] A note from the CMO's office to DCMO Dr Harris on 17 April 1985 noted Sir Donald Acheson's comment:

---

[211] WITN6965001 paras 15.4 & 53.3
[212] WITN4461001 para 5.2
[213] DHSC0000371
[214] DHSC0000373
[215] DHSC0000375

"*… three people have already been infected with HTLV III as a result of blood transfusion in the United Kingdom. Almost certainly others have as we know that several AIDS patients have donated blood in the months prior to diagnosis. Shall be very surprised if "native" cases of AIDS due to blood transfusion do not appear in the next year.*"[216]

130. The CMO provided the report to the Coroner, which stated:

"*You will be interested to know that we are taking active steps to try to prevent the possible transmission of the AIDS virus via blood and blood products. It is true that in this country we have the advantage that blood is donated voluntarily, unlike the United States where they are paid and where unfortunately their system tends to attract drop-outs, drug addicts and alcoholics. However we cannot rely on this advantage to be sufficient to ensure that the donation of infected blood will <u>never</u> happen here.*

*We have therefore circulated to all Regional Blood Transfusion Centres leaflets for distribution to potential donors requesting that those at high risk from AIDS do not donate. We are also acting as quickly as possible to introduce a screening test for all blood donations. Unfortunately these tests have not been evaluated and we have therefore asked the Public Health Laboratory Service to carry out full evaluation before any test is approved for use.*

*In connection with blood products such as Factor VIII for haemophiliacs the Central Blood Products Authority at Elstree have instituted heat treatment for all new batches. There is evidence to suggest that this treatment will eliminate both the AIDS and hepatitis B viruses.*

*I will be sending out to all doctors in England information on AIDS and advice on how to counsel patients that either have the disease or have a positive antibody test and I will ensure that you receive a copy. Our Expert Advisory Group is constantly reviewing the problem and there is an active programme to influence the most at risk group, homosexuals, to modify their practices*."

131. In the CMO's 'Dear Doctor' letter on AIDS on 15 May 1985, he said:

[216] DHSC0000373

"*Although at the time or writing only 159 cases have been reported, AIDS will undoubtedly become substantially more frequent in the immediate future and cases will occur more widely throughout the country.*"[217]

132. In the enclosed paper 'AIDS – General Information for Doctors', he advised that *"It now seems almost certain that the cause of AIDS is a virus",* namely LAV / HLTV-III.[218] He stated that the majority of those infected were asymptomatic,[219] the risk of infection as a result of blood transfusion was extremely low[220] and that a positive antibody test "*does not imply that the patient concerned will develop AIDS.*"[221] However, it was also noted that *"The incubation period between infection and development of AIDS is prolonged and has been found to vary between 15 and 58 months."* [222]

133. A memo dated 20 May 1985 shows that the CMO had requested *"information about the deployment of tests by Blood Transfusion Services in other countries"*. He was informed that blood donations were being screened already in USA and Australia. Further, Dr Smithies wrote:

"*It has been suggested that donors found positive in the UK might not need to be told the results of their test.*

*The Screening Sub-Group of the Expert Advisory Group on AIDS (EAGA) recommended in a paper to the Expert Group on April 22 that donors found to be positive should be informed of their antibody status. The EAGA endorsed this recommendation....*

*Whilst it would be possible to test and discard positives without, informing donors there is difficulty in sustaining such an approach, because these donors would be recalled for further donations at which time they could present a risk to the donor attendant — taking the blood. It might be possible to eliminate secretly their name from the recall list but regular donors would soon realise they were not being recalled. As it will be*

[217] DHSC0105232 p.2
[218] Ibid, p.2 of enclosed paper
[219] Ibid, p.3 of enclosed paper
[220] Ibid, p.4 of enclosed paper
[221] Ibid, p.9 of enclosed paper
[222] Ibid, p.3 of enclosed paper

*common knowledge that blood donations are being tested there will be public sensitivity about this problem. To keep up the subterfuge would be unacceptable.*"[223]

134. The CMO was personally involved in pushing for the financing for universal screening tests. A minute dated 31 May 1985 from DCMO Dr Harris to Mr M Harris, copied to the CMO, read:

"*RESOURCES FOR HTLV3 ANTIBODY TESTS*

*At CMO's meeting reviewing the AIDS situation yesterday you were able to give assurances that the financial resources needed to cover the PHLS' evaluation of the commercial kits has been made available. CMO was questioned later that evening by PS(H) on the overall position and it is quite clear that Ministers need to know of the timescale for the evaluation of the test and, if satisfactory, for the introduction of the test at every transfusion centre.*

*We have now received from Dr Whitehead, the Director of the Public Health Laboratory Service, an estimate of funds required to provide facilities for testing within the Service, and I have today asked Dr Whitehead for a critical path analysis of the whole exercise. It is essential that if there are any problems on the financial side that these be brought to the attention of Ministers as a matter of urgency.*"[224]

135. Lord Fowler has described this minute as:

"*reporting on CMO's meeting on the AIDS situation, with assurance given that the financial resources required to cover the PHLS's evaluation of the commercial kits had been made available. Mr Patten was in discussion with the CMO making clear that Ministers needed to know the timescale for the evaluation of the test and its introduction if satisfactory*".[225]

136. A submission on 'Screening of Blood Donations for AIDS' dated 7 June 1985 was sent by Mr M Harris to John Patten, Parliamentary Undersecretary for Health. It recommended that a test ought not to be selected until after PHLS evaluation and field trials in BTS, which might take five months to implement (as opposed to proceeding to select a test within the

[223] DHSC0002269_054
[224] WITN0771099
[225] WITN0771001 para 105(7)

next two months).[226] The CMO wrote personally to John Patten in cover to the submission on 10 June 1985:

> "*There is a finely balanced decision here but I am in favour of the suggested line. I think, however, that we must do everything possible to ensure that PHLS is able to keep to its schedule.*
>
> *As far as the option to introduce a partially evaluated ELISA test forthwith is concerned I think the prospect of wasting a relatively small quantity of blood from false positive tests is not the major objection. The major problem is that the scientists concerned at PHLS do not yet have confidence that the suppliers could produce testing kits which are reliable on a large scale and which would continue to be reliable on the shelf. It would be worse to be in the position of having to withdraw a test once introduced than to be in our present position of carefully evaluating the tests. There could also be ethical problems in refusing to tell donors (who are volunteers in this country) the result of a test carried out on their blood if they wish to have it.*
>
> *Ministers should recognise, however, that support for a different view is likely to appear in the medical press (see Professor Bloom's letter attached) and that considerable public pressure would develop if in the meantime a case of AIDS develops in a recipient of UK blood. Such a case or cases is likely to occur sooner or later due to infection one or more years ago prior to our warnings to people at risk not to donate blood.*"[227]

137. This recommendation was made in the knowledge that other countries had already introduced HLTV-III screening.[228] The CMO's recommendation was accepted,[229] and the announcement was made on 27 June 1985 that screening tests would be introduced once the PHLS evaluation programme had been completed.[230]

138. At the EAGA meeting of 30 July 1985, the group concurred with the decision to wait:

> "*Members agreed that the timing of the introduction of the tests was crucial. It would be tragic to expose the BTS to the risk of being the only free access testing point and it was essential to have sufficient counselling arrangements set up by the time the tests*

---

[226] DHSC0002311_019
[227] DHSC0002311_021; the letter he referred to is at DHSC0003828_191
[228] DHSC0002269_054
[229] DHSC0003828_186
[230] DHSC0001501

*were introduced. A synchronised introduction of testing arrangements was therefore required in the BTS, in GUM clinics and elsewhere. The Chairman* [Sir Donald Acheson] *took note of this point and said that a letter had been sent out by the Department that day to Regional General Managers asking them to provide testing facilities outside the BTS and to plan for the counselling of people found to be antibody positive.*"[231]

139. In August, it was announced that screening would be introduced on 14 October 1985[232] and a 'Dear Doctor' letter with guidance on screening was published on 1 October 1985.[233] An internal briefing dated 16 August 1985 shows that DHSS was alive to criticisms of delay.[234]

**Public awareness campaign on AIDS**

140. On 27 June 1985, the CMO circulated a strategic paper titled 'HTLV3 infection, the AIDS epidemic and the control of its spread in the UK'. It was sent to the Secretary of State, Norman Fowler, for his *"urgent attention"* and copied to other DHSS ministers.[235] In the paper, he wrote that:

"*In the absence of effective immunisation of susceptibles, control of the epidemic must depend upon reducing the frequency of transmission of infection. This will require the urgent development of a properly surveyed and evaluated programme of health education and counselling with the assistance of experts and the active cooperation of the groups at risk.*"[236]

141. He also recommended in respect of people with haemophilia: "[*c*]*heck that all Factor VIII and Factor IX used in UK is now heat treated. Provide health education and advice for infected haemophiliacs and their families*"; and in respect of blood transfusions: "[*i*]*ntroduce at the earliest opportunity an effective test for all donated blood simultaneously with a similar service for STD clinic. Introduce counselling and education for donors with HTLV +ve tests. Train an appropriate number of counsellors*".[237]

---

[231] NHBT0097458 para 7.3.2
[232] PRSE0002603, see also WITN0771106
[233] DHSC0000177
[234] DHSC0000501
[235] DHSC0002114
[236] Ibid, p.10 of enclosed paper
[237] Ibid, p.10 of enclosed paper

142. Lord Fowler's evidence was that it was around this time that the CMO sought an urgent meeting with him to discuss prioritising the response to the AIDS crisis.[238] He told the Inquiry, "*…it was the coming together, I think, of Donald and myself that really changed the things.*"[239] He explained in his written statement that:

> "*Sir Donald when seized of the AIDS public education campaign issue in 1985 was very hands on: the decision making benefitted from that and from his public health expertise….*
>
> *… the post of CMO was a critical role. The Department was much better served by a CMO incumbent of Sir Donald's calibre and his background in epidemiology and grasp of public health issues were invaluable. Sir Donald's minute and paper of 27 June 1985 (with his request that it be given urgent attention and his call for an early meeting with me personally) was highly significant. His clear message was the urgent need for a comprehensive campaign to reduce the spread of infection principally by means of education directed at those specially at risk. It was on the back of that advice that I saw the need to become far more directly involved. It seems to me critical, therefore, to have a CMO of the highest calibre, one who is experienced in public health, and who is able to judge when to raise the warning direct to Ministers that there is an urgent need to take action on a medical issue. The Inquiry asks if there are lessons that are applicable today, and that is certainly one.*"[240]

143. Sir Donald wrote a lengthy passage in his autobiography about the 'Don't Die of Ignorance' campaign, which included the following explanation for why the campaign was introduced:

> "*In 1985, it became clear that… what was needed was to take the bull by the horns and with the help of expert advice make available to everyone in the country a frank and full explanation of the facts - how HIV is and is not spread. I was able to advise the public that HIV does not pass from a close contact as occurs in the tube in rush hour or in the cinema nor in food or water but that it did spread or could spread during sexual intercourse with an infected person without a condom or by infected blood during a transfusion. Although this would inevitably involve distributing explicit*

[238] WITN0771088 para 148-149 and transcript of 22 September 2021, at p.54-56
[239] Transcript of 22 September 2021 at p.58
[240] WITN0771001 para 8.25(5)

*information about sex which some people might find offensive, that could not be helped. When I put this proposal to Norman Fowler, whatever concerns he may have had privately about the effect approving such a campaign might have on his future political career, he set these aside and... gave the 'Don't Die of Ignorance' Campaign his enthusiastic support.*"[241]

144. The 'AIDS: Don't Die of Ignorance' leaflet was published in October 1985.[242] In the CMO's introduction to his 1985 Annual Report, he wrote:

"*Public education is essential. Programmes should be aimed at the general public as well as at persons actually or possible at risk. It is essential that everyone receives accurate information and myths are exposed.*"[243]

145. In his autobiography, Sir Donald Acheson described facing disapproval from the Prime Minister, Margaret Thatcher, regarding public sex education. However, with the support of the Deputy Prime Minister William Whitelaw, he was able to obtain approval for a universal leaflet drop, free time on radio and TV, and a set of newspaper and magazine advertisements.[244]

146. At the ninth EAGA meeting on 11 March 1986, the CMO announced a new National Information campaign would be launched shortly.[245] That month, the 'Are You At Risk From AIDS' leaflet was published.[246]

147. The 1986 Annual Report (published in late 1987) recorded that:

"*The public information campaign which began in 1986 has continued to gather momentum and has attracted much international interest. In the first two weeks of January 1987 an AIDS leaflet was delivered to every household in the country. This was accompanied by television and cinema advertising. The broadcasting authorities gave additional 'air time' to AIDS advertising on all channels and by broadcasting 19 hours of television programmes in an 'AIDS Television Week'. In the same month a two-*

---

[241] WITN0771088 p.187, see also to p.193
[242] MRCO0000554_005
[243] DHSC0007007 p.5; the same view was expressed in his article in *The Lancet*, 'AIDS: A challenge for the Public Health', 22 March 1986.
[244] Ibid p.191, see also DHSC0003833_106
[245] DHSC0001499
[246] NHBT0007971

*tier free telephone information and advice service was established to complement the campaign.*"[247]

"*In March 1986 a campaign was launched with the aim of informing the public about AIDS, the ways by which the infection is and is not transmitted and how to protect themselves and others. The initial phase involved advertisements in the national press, the publication of a leaflet from the HEC [Health Education Council] and the establishment of a telephone service, which was run by the College of Health and funded by the DHSS. In addition, the Terrance Higgins Trust and the Standing Conference on Drug Abuse (SCODA) produced posters and leaflets and there were advertisements in the gas press. An interim evaluation of the Department's campaign in July 1986 revealed it had widespread support and further advertisements were placed in the national press.*" [248]

148. Despite these campaigns, Sir Donald Acheson privately expressed frustration that more had not been achieved. In a letter to Sir Kenneth Stowe, the Permanent Secretary at the DHSS, dated 3 October 1986, he emphasised that *"People who are infected with HIV are in many ways more important than patients with AIDS because they usually are unaware they are infected but are infectious..."* He noted the incubation period could be at least six years. He estimated there were at least 50 cases of HIV infection for every case of AIDS, which in the UK would be 25,000 plus infected carriers. At least 25% of them would develop AIDS, *"and it is thought by some that this proportion will continue to be revised upwards as the years pass"*. He warned that many experts believed that most of these people, almost all young, would develop AIDS and die and that unless the spread of infection was curtailed, the cost would be *"calamitous"*. He advised:

"*6. From the medical point of view, the Government's response has been inadequate and is now substantially less to educate the public than some other European countries. It is increasingly difficult to defend in public. Pressure will mount as the numbers of cases increases.*

*7. I have advised Ministers that from the public health point of view the education campaign to reduce the spread of infection should take priority over all other calls on finance. Furthermore, in view of the multiplying effect of the means of spread it is*

[247] DHSC0007008 p.2
[248] Ibid p.57

*desperately urgent that action should be taken immediately. A proper centrally coordinated programme involving all the media and together with the involvement of District Health and Local Authorities and the voluntary sector is urgently required/th and e relatively small amount of money needed should not be spared. There is no time for protracted evaluations."*[249]

149. Sir Kenneth Stowe discussed the matter with the Cabinet Secretary Sir Robert Armstrong.[250] He, in turn, called a meeting of Permanent Secretaries on 8 October 1986, which Sir Donald Acheson attended. A note prepared in advance of the meeting noted barriers to progress, including *"persuading Ministers to introduce those measures which would be effective, but which appear to condone behaviour normally regarded as unacceptable"*. At the meeting, Sir Donald Acheson stated that *"There was a difficult balance to be drawn between complacency and over-reaction."*[251] Consideration was given to establishing a new arms-length body with responsibility for AIDS education.

150. Sir Donald Acheson was successful in securing additional funding for public education. The 1986 Annual Report, published in late 1987, recorded:

*"In November 1986 the campaign was greatly widened and intensified, newspaper advertising was increased and a campaign aimed at young people was started through magazines, cinema and radio advertisements. The DHSS leaflet 'Protect your Health Abroad' was revised to include a section on AIDS. In April 1987 the HEC was reconstituted as a Special Health Authority and was given major executive responsibility for public education about AIDS."*[252]

151. The 1987 Annual Report, published in 1988, stated:

"*In the Autumn of 1986 it was decided to expand the campaign described in my report for 1986 and a further £20 million was allocated for the 12 months from November 1986. Between November 1986 and March 1987 £7.5 million were spent on advertising in all the main media and on the distribution to all house-holds of the leaflet AIDS: DON'T DIE OF IGNORANCE. Advertisements were also placed in youth magazines, in the cinema and on the radio, and street posters were displayed in urban centres. A*

[249] HMTR0000008_045
[250] HMTR0000008_044
[251] SHTM0001041; the Welsh Office also provided a response detailing the public education campaign undertaken there: HSSG0010218
[252] Ibid p.57

*free national AIDS Telephone Helpline was established in January 1987 to complement this campaign. The Helpline had two main components, providing free advice and a free leaflet ordering service. Ministers have agreed to continue support for this Helpline into 1988. Early in 1987 the first phase of the public education campaign was assessed by an independent market research company. This assessment, published in September 1987, concluded that the campaign effectively increased public awareness of AIDS and HIV infection and had increased knowledge about the ways in which infection is spread.*"[253]

152. Minutes of a Home and Social Affairs Committee, Sub-committee on AIDS meeting on 14 January 1987 shows that Sir Donald Acheson personally discussed the detailed specifics of particular adverts at a cross-departmental Ministerial level.[254] (He was a regular attendee at this sub-committee from 11 November 1986[255] to 24 February 1989.)[256] Lord Fowler has told the Inquiry that "*Every advertisement was approved by myself and the CMO.*"[257]

**Introduction of heat treatment**

153. On 2 July 1985, the CMO drafted a letter in response to the BMJ in response to a letter from Professor Bloom and others, in which he set out the DHSS's 'official position' regarding blood safety:

> "*All Factor VIII concentrate produced by the Blood Product Laboratory (BPL) is now heat treated. Variations of licenses for commercial heat treated Factor VIII have been granted early this year by the Committee of Safety of Medicines. The Department is not aware of any difficulty in obtaining the heat treated commercial product when the BPL product is not available. There is not yet sufficient experimental evidence to guarantee that either HTLV III or the agents responsible for non—A non-B hepatitis are inactivated by the various methods of heat treatment used to produce these products.*
>
> *Factor IX produced in the UK at BPL is not heat treated. Work is urgently in hand to introduce a heat treated product. However it is necessary to ensure that heat treatment itself does not cause production of toxic substances which were referred to in a Lancet leader last year. Heat treated commercial Factor IX is however available for prescription on a name patient basis. It is not yet licensed in the UK. As with Factor*

[253] DHSC0007009 p.121
[254] WITN0771115
[255] CABO0100010
[256] CABO0000196
[257] WITN0771001 paras 6.173(2), 6.192 & 6.199

*VIII there is no guarantee that infective agents are inactivated during the heat treatment process.*

*As far as cryoprecipitate is concerned this blood product is produced at Regional Transfusion Centres from individual donations provided by a regular donors [sic]. Since August 1983 all blood and plasma donors have been alerted to the dangers of transmission of AIDS through blood donation and the need for those in high risk groups not to volunteer to donate blood through a leaflet distributed to Regional Transfusion Centres and donor sessions. Updated leaflets about AIDS and blood donation have been distributed individually to all donors since the beginning of this year. Screening all blood donations for antibody to the AIDS virus will detect those donations which react positively to the test and decrease the likelihood of transmission of the AIDS virus even further. Ministers announced last week that screening tests will be introduced into the blood transfusion service in the next few months. In the meantime clinicians responsible for the care of haemophiliac patients to whom they might consider giving cryoprecipitate will need to take account of the possible benefits and risks of using this blood product.*"[258]

154. On 4 July 1985, DCMO Dr Harris provided the CMO with an update titled 'Heat Treated Factor VIII':

"*The position in the United States is that until 1 July only 70% of blood donations were tested for AIDS antibodies. Since July all will be tested. The FDA stated that the American companies were not able to heat treat all Factor VIII but they should be able to do so by July.*

*UK produced Factor VIII has been heat treated at Elstree since April.*

*Haemophilia Centre Directors have been prescribing only heat treated Factor VIII for the past 4 - 5 months. Initially this material was not licensed by Medicines Division but now all companies importing material have been issued with product licences. The heat treated material that has to be imported comes from the Continent (Immuno based in Austria) and from the USA.*

[258] DHSC0000965

*In summary, at the present time haemophilia patients should have no difficulty in obtaining heat treated Factor VIII.*

*Dr Joe Smith of NIBSC has just informed me that since 19 December 1984 all imported Factor VIII cleared by NIBSC has been heat treated. All Elstree material received since April has been heat treated and Scottish supplies have been heat treated since the 23 January 1985.*"[259]

155. Manuscript annotations on the document appear to show that Sir Donald Acheson asked:

"*Dr Harris*

*1. Can you please translate this into an assurance I can give the SoS next week that no haemophiliacs will be infected in UK from now on.*

*2. What about cryoprecipitate?*"[260]

156. He further wrote to Dr Harris on 8 July 1985:

"*FACTOR 8 AND FACTOR 9*

*Could you let me have a note as soon as possible on the current position about the infectivity of these two preparations as administered in the United Kingdom. Also, how we can ensure that no infected Factor 8 and Factor 9 is used here and by what date this can be achieved. I gave the Secretary of State an assurance that I would look into this forthwith and will be seeing him again towards the end of next week.*"[261]

157. Dr Harris replied the following day:

"*The position as from 1 July is that there are adequate supplies of heat treated Factor VIII in this country. All Elstree material has been heat treated since April 1985 and Scottish supplies have been heat treated since January 1985. All imported Factor VIII which has been cleared by the National Institute of Biological Standards and Control has been heat treated since December 1984.*

*It is possible that unused stocks of untreated Factor VII have been used prior to July. A number of haemophiliac patients are also treated with cryoprecipitate which is*

[259] DHSC0002484_063
[260] Ibid
[261] DHSC0002484_061

*produced at the Regional Transfusion Centres. Cryoprecipitate cannot be heat treated but donors from whom it is obtained are normally specially selected.*

*The other bleeding condition known as Christmas disease or haemophilia B is treated with Factor IX. UK manufactured material is at present not yet heat treated but will be available from October 1985. Unlicensed supplies of heat treated commercial Factor IX concentrate can be prescribed under Medicine Act provisions for named patients.*"[262]

158. On 16 July 1985, the CMO sent a submission to the Secretary of State in advance of a meeting regarding AIDS. Lord Fowler described the CMO's approach at this time as follows: "*The CMO was urging that a comprehensive campaign to reduce the spread of infection, principally by means of education directed at those specially at risk, was now urgently needed.*"[263] In his submission, the CMO:

    a. Set out three broad topics for discussion: control of further spread of HLTV-III infection; confidentiality of the results of testing; and provision of counselling for seropositive donors.[264]

    b. In relation to blood donors, he wrote that, "*ACTION is in hand to ensure the introduction of testing of all blood donations as soon as a sensitive and specific test is available. To introduce such a programme nationally, simultaneously with a programme involving sexually transmitted diseases clinics in the district hospitals is a major organisational problem.*"[265]

    c. In relation to haemophilia, he noted that there was sufficient heat-treated factor VIII available and that further infections should not occur providing that non-heat-treated material was not used. Heat-treated factor IX was expected to be generally available from October.[266] One action point was to *"Ask Professor Arthur Bloom, Chairman of the Haemophiliac Centre Directors, to contact all the Directors informing them of the availability of heat treated Factor VIII."*[267]

---

[262] DHSC0002333_040
[263] WITN0771001 para 6.151
[264] DHSC0002327_032
[265] Ibid p.2
[266] Ibid p.2
[267] Ibid p.3

d. In relation to confidentiality, he said, "*There seems no easy way to balance the personal problems of an individual for whom knowledge of a positive test is a tragedy and to whom no medical help can be offered, against the desirability from the public health point of view of such persons having the knowledge on which they may base a change in their habits.*"[268]

159. On 30 July 1985, the CMO attended the fifth meeting of EAGA, at which a paper he had prepared in June for the Secretary of State was circulated.[269] On the same day, he wrote a memo to the Secretary of State:

"*AIDS AND THE TREATMENT OF HAEMOPHILIACS*

*Following our recent conversation I have checked on the position regarding the treatment of haemophiliacs with Factor VIII. I am advised that all Factor VIII produced at the Blood Products Laboratory (BPL) Elstree has been heat treated since April 1985.*

*According to the National Institute of Biological Standards and Control no commercial Factor VIII has been imported into the UK in an unheat-treated form since December 1984. Although it is unlikely that there are any stocks in the country of unheat-treated commercial Factor VIII I am arranging that a letter will go to all haemophilia centre directors in order to draw their attention to the availability of heat treated Factor VIII and the need to avoid using any commercial un heat-treated Factor VIII which may remain from 1984.*

*I am satisfied that it is extremely unlikely that any patients with haemophilia treated in the UK will in future be infected with HTLVIII virus.*

[with manuscript addition] - *but sadly a very high proportion of the haemophiliac population already are infected due to previous use of unheat-treated Factor VIII.*"[270]

160. On 24 October 1985, Sir Donald Acheson gave a speech to PHLS on AIDS. A draft text of the speech shows that he stated: *"[HIV] is prevalent among haemophiliacs, particularly sufferers from Type 'A' haemophilia. Fortunately, however no new cases of infection should now occur in this group."*[271]

---

[268] Ibid p.3-4
[269] PRSE0002628
[270] DHSC0000514
[271] DHSC0000387

161. However, on 28 November 1985, Dr Smithies wrote: "*CMO will wish to know that there is some hearsay evidence that haemophiliac patients are seroconverting to become anti HTLV III positive despite being given heat treated Factor VIII.*"[272] She posited this could be due to late seroconversions from previous use of untreated material, or alternatively that certain products were not being subjected to sufficient inactivation. The PFL in Liberton, Scotland had introduced a quicker inactivation method which may be implicated. The BPL product, on the other hand, was *"the safest product in the world"* and may also be inactivating the NANB agent. She concluded, "*We have scrupulously observed in all our answers to PQs that heat treatment should inactivate HTLV III. This note is just to emphasise the need for continuing to do so.*"[273]

162. Sir Donald Acheson continued to focus on AIDS during 1986. At the eighth meeting of EAGA on 15 January 1986, he "*explained that during a visit to America last year he was made conscious of the need for research into HTLVIII and AIDS. He had drawn his concern to the attention of the MRC and had invited them to consider whether more research could be undertaken, possible epidemiological areas being: 1. the infectivity of HTLVIII seropositive persons, 2. heterosexual transmission, 3. the safety of condoms.*"[274]

**Consent to testing**

163. At the EAGA meeting of 30 July 1985, the issue of consent to testing was discussed:

> "*The question of patient consent to HTLV-III testing was discussed. A positive test result could be serious for an individual patient and the implications of tests taken as an infection control measure for staff and not for the benefit of the individual's diagnosis and treatment should be carefully considered. The BTS would be informing blood donors, who were volunteers, that the test was being done on their blood donation. However, in the context of the diagnosis and treatment of a patient it was agreed that a general clinical approach should be adopted. Patient's permission for hepatitis B testing was not always sought and, with a variety of tests being taken, it should not be necessary to inform the patient in all cases that these included a test for HTLVIII antibody.*"[275]

---

[272] DHSC0002295_047
[273] Ibid
[274] DHSC0000833 para 4
[275] NHBT0097458 para 7.3.3

164. On 11 April 1986, the epidemiologist Sir Richard Doll wrote to the CMO with an ethical query:

> "*The position that many people seem to be taking up is... that you can't take blood for the purpose of testing without an individual's consent to his and his medical attendants being informed if it is positive (with which I think we all agree) but equally that you can't examine blood that has been taken for other purposes without the individual's consent as you would have to tell him if it was positive.*
>
> *One way and another this makes it almost impossible to keep an eye on the rate at which infection is spreading in the general population - something which I regard as vital in the national interest as if it is going to spread like an ordinary venereal disease and have a high fatality, people must be warned persistently and loudly.*
>
> *The RCOG committee (God bless it) said everything would be solved if the DHSS issued an edict that unidentified blood was to be examined, but that seems to me to put a burden on the politician's shoulders which he would be very unlikely to accept.*
>
> *What do you think?*"[276]

165. Sir Donald Acheson forwarded the query to Dr Gunson,[277] who replied on 15 October 1986 setting out the steps which were being taken by NBTS to submit data to the MRC on a monthly basis. Further, all RTCs had been asked to completed a questionnaire regarding prevalence in their area. Without directly addressing Richard Doll's question, he wrote:

> "*I appreciate the importance of this analysis since it is clear that ethical problems are causing difficulties with other studies which might yield valuable information and although blood donors must be a selected group of the population by the fact if nothing else that they volunteer to donate blood and that their age distribution will not be typical for the entire population. I do not think that the exercise will have difficulties that will be insurmountable, and I can assure you that we will progress with this as fast as possible.*"[278]

166. At a meeting of the AIDS Sub-committee of the Home and Social Affairs Committee on 14 January 1987, the issue of anonymised testing was raised. Sir Donald Acheson said he

[276] MRCO0000470_019
[277] MRCO0000548_094
[278] DHSC0002374_058

*"wished the matter that had been raised to be given more thought at the Expert Advisory Group that he chaired".*[279] However, the issue does not appear to have been addressed at the following EAGA meeting.[280] In a letter of 23 January 1987, DCMO Dr Harris wrote that the Department was presently taking a line against anonymised screening.[281]

167. On 4 February 1987, Sir Donald Acheson was asked questions about the ethics of anonymised testing at the Social Services Committee. He stated:

> "*The tests are carried out for epidemiological purposes and the results are not communicated to the patients. Arrangements are made so that the person conducting the test down not know from which patient the blood has come, this there is no way in which it is possible to return to a patient with a positive test, for example, to find out whether or not he or she is in one of the "at risk" groups, or, for that matter, to advise him or her that the test if positive. Studies on blood for HIV antibodies derived in this way from systematic samples on patients throughout the country would provide much better information than is currently available about the prevalence of HIV infection ... Provided the legal and ethical question can be solved, anonymised testing would provide useful information which currently does not exist and it would help very much in planning abd getting a general idea of the prevalence and trend of infection.*"[282]

168. When asked whether it was acceptable that patients would not be told of their test results, he replied, *"that is a matter for ministers".*[283]

169. The issue was the focus of the next AIDS Sub-committee meeting on 9 April 1987.[284] It was decided that an EAGA Working Group on Monitoring and Surveillance should be convened. This group met for the first time on 28 April 1987. Sir Donald Acheson attended and introduced the group as follows:

> "*The Group's objective was to produce a set of recommendations, applicable throughout the UK, for improving the monitoring and surveillance of the epidemic of HIV 1 infection. The Group should not, however, consider the research aspects. That was a matter for the MRC who were represented on the Group so that their attention*

---

[279] WITN0771114 p.8
[280] MRCO0000001_014
[281] DHSCO101033
[282] DHSC0101227
[283] Ibid
[284] WITN0771127, WITN0771126

*could be called readily to research issues. All options should be considered principally from the scientific point of view. It was agreed that the Group might need to call upon the help of those with expertise in particular areas, for example, drug abuse. Recommendations were required quickly but it was accepted that two or more meetings might be needed before the Group was able to reach conclusions.*"[285]

170. It was noted that:

"*The Group felt that there were considerable advantages to schemes for anonymous testing, without consent, of blood samples taken for other purposes, but with the patient's identifying details removed. Age, sex and district would be retained. Such testing could provide a good estimate of the numbers infected and the extent and spread of the epidemic, and provide valuable information for mathematical modelling. It could not be used to identify new risk groups, although the information it provided could indicate what studies were needed to reveal such groups. The ethical problems were well recognised, however, and it was agreed that the advantages and disadvantages should be set out clearly in the report which the Group would produce.*"[286]

171. In the CMO's Annual Report for 1988, published in late 1989, it was reported:

"*On 23 November 1988 the Secretary of State for Health, Mr Kenneth Clarke, announced that the Government saw no legal obstacle and, from the layman's point of view, no ethical objection to anonymous testing for HIV infection. The MRC was invited to prepare proposals on anonymous testing and to extend named testing. Their proposals, submitted in March 1989, are under consideration.*"[287]

172. In the 1989 Annual Report, published in late 1990, the establishment of an anonymous HIV monitoring programme was announced:

"*An innovative, large scale programme, funded by the Department of Health (DH) via the Medical Research Council (MRC), was developed during 1989 following discussions between the Communicable Disease Surveillance Centre (CDSC), MRC, and DH. This programme, designed to provide information about the prevalence and incidence of infection with HIV by age, sex and geographical area, should greatly improve our understanding of the course of the epidemic. The anonymous serosurveys*

[285] WITN0771128
[286] Ibid para 27
[287] DHSC0007009 p.122

*will begin early in 1990, concentrating initially on serosurveillance of pregnant women based on sera taken for rubella testing, and of attenders at genito-urinary medicine clinics. A pilot survey of some patients in general hospitals is planned to commence in 1990. These studies will constitute a valuable adjunct to the voluntary confidential reporting system for AIDS cases and for HIV seropositive people operated from the CDSC at Colindale, which has collected the great majority of United Kingdom (UK) data so far. The CDSC system will continue to collect and collate surveillance data, both for HIV- seropositivity and for AIDS cases, for the whole of England.*"[288]

**HIV litigation**

173. The Inquiry has heard considerable evidence about the litigation brought between 1988 and 1991 by people with haemophilia who had been infected with HIV as a result of the use of blood products. This presentation does not seek to repeat that evidence, but includes for completeness some references to the CMO's role in the Department's response to the litigation.

174. Sir Donald Acheson met with the Minister of State for Health to discuss the HIV litigation on 30 August 1989,[289] but otherwise does not appear to have been heavily personally involved in the Government's response to the proceedings.

175. However, on 20 July 1990, he wrote to Kenneth Clarke, then Secretary of State, to advocate for a settlement of the case, in light of the intervention of the trial judge, Mr Justice Ognall, who had urged all sides to consider compromise. Sir Donald wrote:

"*I hope Secretary of State* [sic] *will take account of my view that the problem of HIV infection in haemophiliacs can in fact be regarded as a unique catastrophe. The key feature... is that HIV infection in addition to almost inevitably causing a very unpleasant progressive illness and death results in a substantial proportion of cases in infection of the female sexual partner and also on average one quarter of the subsequently conceived children. In both wife and children the infection will also prove fatal ...*

*... the tragedy goes beyond anything which has ever been described as a result of a therapeutic accident and is very likely indeed never to occur again.*

[288] DHSC0007011 p.88
[289] WITN0758060, WITN0758061

*I hope therefore, that for humanitarian reasons the Government will find some way to make an ex gratia settlement to the infected haemophiliacs in relation to this unique tragedy. I cannot personally see how this could be regarded as implying any responsibility for other accidents such as benzodiazepine dependence, cerebral palsy following obstetric misadventure etc.*"[290]

176. On 5 December 1990, Dr Pickles wrote to the CMO to express her concern that a justification for settlement based on counsel's advice that the Department was at risk (albeit small) of being found liable might *"damage the reputation of the professionals concerned"*.[291] When asked about this letter in her oral evidence, she said, *"this is very unusual for me to write to a Chief Medical Officer in this format and it's obvious I'd had a discussion with him, and he said put that in writing so he could then put on the record that he felt there'd been no negligence*".[292]

JENNI RICHARDS QC

MATTHEW HILL

RACHEL BARRETT

Inquiry Counsel Team

July 2022

[290] HSOC0017025_004
[291] DHSC0004365_015
[292] Transcript of 12 May 2022 p.101