Witness Name: Norman Fowler

Statement No.: WITN0771001

Exhibits: WITN0771002 – WITN0771219

Dated: 17 July 2021

INFECTED BLOOD INQUIRY

FIRST WRITTEN STATEMENT OF NORMAN FOWLER

Contents

SECTION 0: INTRODUCTION

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006, dated 06 April 2021.

I, PETER NORMAN FOWLER, will say as follows: -

0.1. My name is Lord Peter Norman Fowler. My professional address is The House of Lords, London, SW1A 0PW. I am now 83 years old; my date of birth is known to the Inquiry. I was appointed Secretary of State for Health and Social Security from 14 September 1981 and held that office until 13 June 1987. I have been requested by the Infected Blood Inquiry to provide a statement regarding my involvement in the issues covered by its terms of reference during this time.

The Infected and Affected

0.2. The period when I was Secretary of State saw the emergence of AIDS which took so many lives, and affected so many others, their families and friends. This includes the tragedy of those who were infected with HIV through blood and blood products, many of whom died, and all of whom - with their families - have suffered. They were infected and died as a result of NHS treatment. I appreciate that the infected and affected want answers more than expressions of sympathy. But I would nevertheless first and foremost wish to express my sincere sympathy for all those infected and affected, and my condolences to those bereaved. We should aim now to see what help can be given to those that have survived but suffer sickness as a result, and to relatives who have been affected.

0.3. There was prevarication over many years over the holding of this public inquiry. I support it and its aim of getting to the truth of what occurred and the lessons to be learnt.

0.4. I have done my best in this statement to explain openly my own thinking and rationale. The events happened nearly forty years ago. While I have some

limited direct recollections, I am heavily reliant on the (imperfect) documentary records. For the most part, I have focussed on my direct / personal involvement in the issues raised by the Inquiry. In some areas, however, I am particularly conscious that many of my Ministerial colleagues from the time have since died, a point to which I return below. Where appropriate, therefore, I have tried to use the available records to address Ministerial involvement (rather than just my own involvement as Secretary of State) particularly where the other Ministers have died.

0.5. Any Secretary of State, let alone one in such a large Department as the Department of Health and Social Security ("DHSS", also referred to in this statement as "the Department"), has to devolve decision making. I am not able to speak from personal knowledge or involvement about some of the areas which the Inquiry has raised and, where applicable, I have made that clear. Nevertheless I believe that a Secretary of State is always accountable to Parliament for what happened in their Department while they were in office, regardless of whether the decision making was personal to them or delegated to others.

Further Opening Comments

0.6. Before turning to the issues which the Inquiry has raised, I hope I will be forgiven for making a number of introductory remarks. Some of them are to give context; others are personal or overarching observations which are relevant to the details raised by the Inquiry.

<u>The lessons from the whooping cough epidemic</u>

0.7. The first observation is anecdotal but it illustrates an important early lesson that I took on board as Secretary of State. When I was first appointed Secretary of State for Health and Social Security, I paid a visit to the Birmingham Children's Hospital. This was at the very start of 1982. In one of the wards there were three small babies, desperately ill and fighting for their lives. One of the babies

subsequently died. They were victims of a whooping cough epidemic affecting the whole country.

0.8. Up until then, vaccination had reduced deaths from whooping cough but in the late Seventies the rate of vaccination had fallen drastically. The reason for this catastrophic fall was quite clear. There had been a sustained campaign in the media to cast doubt on vaccination and to give publicity to claims by a very small minority of doctors that it could cause brain damage. So the rate of vaccination went down disastrously. The babies I saw were too young to be inoculated themselves but were infected by older siblings who had not been inoculated.

0.9. Throughout this time, the advice from our medical experts in the Department remained the same, namely that the safest and best course for a parent was to have their children inoculated. My concern is evident from, for example, the press release on 1 September 1982 [WITN0771002]. As it happened my own daughter was coming up to the age for inoculation and my wife and I decided that we would follow that advice. In fact, she was inoculated in front of some television cameras which we hoped might encourage others. The Department and its expert advisers saved lives amidst a media storm. At the same time, the baby deaths suffered were the result of a failure to persuade enough of the public that by far the bigger danger was of children not being inoculated.

0.10. For me, the lesson was this. We had skilled medical advice available from extremely experienced men and women inside the Department, who could call on necessary external advice, and there were overwhelming reasons for politicians who happened to be ministers to follow that advice. It would be unthinkable for politicians to substitute their own personal views.

0.11. An additional lesson was the importance of effective communication. The Department was correct in its assessment of the balance of risks on the whooping cough vaccine, but we were not so effective in transmitting that to the public. We should have been able to counter the propaganda of those making

the charges and the misreporting (especially on television) more effectively than we did.

Judgements made in the face of uncertainty

0.12. My second point is the risk of hindsight when judgements had to be made against challenging uncertainty. AIDS vividly illustrated this. There were rival theories not only on how Government should respond but also on what caused the infection. There were some who denied that HIV led to AIDS. We did not know a tenth of the things we know today. It is an essential point about this Inquiry. In trying to analyse the decision making of the day, it is exceptionally difficult to truly avoid the bias of perception that almost inevitably comes from the considerable knowledge that has been acquired since.

Healthcare resources – difficult choices

0.13. Thirdly, I would wish to highlight the unavoidable difficulty of deciding on the priority of needs against finite resources. Writing in my 1991 biography, I said that:

> *"Every health minister faces the same central problem: it is not just a matter of putting right the deficiencies of the past; you also need to keep up with the ever-increasing demands of the present. Demand is created by medical advance itself. Hip replacements were once a rarity: now they can be carried out easily and the call for them has escalated. Somehow you have to provide for these additional demands, and many more with the annual budget voted each year to the service.*
>
> *It would be nice to believe that the Health Secretary spends all his time understanding the very latest developments in heart-lung transplants. Would that this was the case. Faced with a virtual infinity of demand, your role is to seek new resources and ensure that those resources are spent to the best effect. You battle with the Treasury in public spending negotiations and you battle with the health service to make best use of*

the resources that are available. The health service has genuinely noble ideals: it provides excellent treatment irrespective of income. It also contains some of the most dedicated men and women I have ever met. Yet for all that, health provides just about the bloodiest battleground[1] in British politics today."[2]

0.14. There was a need to help cancer patients, a need to improve mental health, a need to fund treatment of haemophiliacs, and hundreds of other healthcare needs. You need to apportion the resources you have and choose between these priorities. Going back to the Birmingham Children's Hospital whooping cough babies, one of the things that shocked me at the time was that seriously ill children had to be wheeled into the open air to get from one part of the hospital to another. It desperately needed rebuilding and renovation. And later as I travelled around the country, I found other hospitals which were substantially deficient: there was a desperate need for capital resource.

0.15. So all these claims had to be balanced. The health service (as now) had to operate within a fixed budget. The budget was carefully put together trying to balance competing demands. Once it had been settled in the annual public spending talks with the Treasury, the Chancellor of the Exchequer would resist strongly more money being added. As I will address in Section 6 of this statement, from late 1985 into 1987 I was involved in pursuing the public education campaign ("Don't Die of Ignorance") to warn the public of HIV and AIDS. It became the biggest public health campaign that had been mounted since the end of the Second World War and was copied in countries overseas. To my frustration, there was never any subsequent proper assessment of the epidemiological effect of the public education campaign, but it is widely regarded as having saved thousands of lives. The escalation of the campaign in late 1986 only went ahead on one condition. The Treasury laid down that no extra money should come from them for the campaign and that I should find the

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[1] I was here referring to the political battleground.
[2] "Ministers Decide. A memoir of the Thatcher Years", 1991, pg 166.

extra resources from my own budget. This I did but I always remember one Under-Secretary protesting to me that I was taking money away from her budget - and I was. I had to accept the consequences of that. I also add, immediately, that I fully appreciate that the focus of this Inquiry is rightly on the lives lost through contaminated blood products, not the wider public health campaign, though I have addressed the latter where invited to do so by the Inquiry.

The wider context

0.16. Even events as significant as the emergence of AIDS were not occurring in a vacuum. Perhaps I could say something about the organisation of the DHSS. Health and Social Security had been two separate Government departments. They were put together in 1968 to form the DHSS to give a unity to social policy. Twenty years later, in 1988, the DHSS was split back into two Departments. As a single Department while I was Secretary of State, the DHSS was the biggest spender and largest employer in Whitehall, responsible for more than a third of all public spending and employing almost 100,000 staff directly (mainly in social security offices) as well as being responsible for the nearly 1 million staff of the NHS, Europe's largest employer. On the health side, for example, there were constant demands and challenges. As Secretary of State I was responsible for the hospital service, mental health, general practitioners, the nursing profession and all the ancillary staff upon whom the health service depended. I described in my 1991 autobiography my 'baptism of fire' of the NHS pay dispute which lasted for most of 1982.

0.17. I was the political head of the Department – answerable to Parliament on all its activities. The role entailed making frequent statements on the floor of the House, answering questions on both sides of the Department, taking part in frequent debates and acting as the chief spokesman for the Department on both sides of the Department's responsibilities to the outside media. You were the ultimate spokesman for the whole of the Department. I was not there as a manager as such but to ensure that there was an effective management process. This was more of a problem on the health side of the Department than social security who had been used to running a service since the National Assistance Board. In health the policy of both governments had been dominated

by reorganisations. I had become increasingly convinced that the real problem with the health service was the lack of management. That led to the inquiry into NHS Management and subsequent report by Roy Griffiths. The battle was to overcome the opposition to change and secure the necessary decision making and accountability at local level for the service provided, rather than being forever referred upwards to some 'higher authority' (encapsulated in Sir Roy's famous comment, "… *if Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge"*)[3]. Accordingly, for the first time supervisory and management boards were set up during my tenure to oversee the running of the NHS. They remained considerably removed from the boards of industry model but were a substantial improvement.

0.18. On the social security side, I personally headed an inquiry into pensions (announced in November 1983) and set up a wide-ranging review of the social security system as well (announced in April 1984). More broadly, the Department (and I as Secretary of State) was responsible for social security payments, supplementary benefit, child benefit, state pensions and occupational pensions to give only some obvious examples. In addition, there was the rather different work of Social Services (the social work services for which the Department was responsible). Many of these areas are far removed from the Terms of Reference of this Inquiry, but I mention them to illustrate the breadth and depth of policy issues with which we were engaged in both sides of the Department.

[3] Open source reporting of the Griffiths Report.

The DHSS team and our ways of working

0.19. Clearly I had a personal responsibility for the decisions which I directly took as Secretary of State. But more than this, I was accountable to Parliament for the decisions and actions of the entire Department, including the decisions taken by the other Ministers. I have approached this witness statement with that wider accountability to Parliament for the entire Department in mind. As I have indicated, I had to develop new policies particularly to deal with the overarching issues facing the Department such as the management of the NHS. I also took the personal lead in a number of individual areas, such as the pension and social security reforms to which I have briefly referred and, from the second half of 1985, the public health campaign on AIDS (I address this in more detail in Section 6 of this statement).

0.20. Chief amongst the areas with which I dealt personally every year was the particular responsibility to negotiate the budget for the Department. This was crucial. Each autumn there was a public spending round. The policy of the government was to control public spending and the DHSS as the biggest spender was consistently put under close examination – probably closer than any other department. It should be emphasized that in my period of office (indeed throughout the Thatcher years) neither health nor social security were an exception to the general Government policy of seeking to curtail public spending. I always said I gave over three months a year to preparing and negotiating my budget for the good reason that without adequate resources the NHS could not properly function. There were of course disputes about what was adequate: the health bodies rarely thought that that they had enough money although because of careful preparation, I had a reasonably good reputation with the civil service. Equally, I had fierce debates with successive Chief Secretaries to the Treasury. I make no complaint of that. It was their job to achieve what savings were possible. But it was my job not to be forced into indefensible positions and positions which affected some of the most vulnerable people in the country. Some flavour of the negotiations is given by my negotiations in October 1981. The then Chief Secretary argued that as the Department was responsible for over one third of all public spending the overall

target on public spending could only be achieved by radical reductions in the budget for both health and social security. In spite of assurances that had been given by the Prime Minister he wanted pensions to be de-indexed and for there to be new charges for the health service which again had been previously ruled out by Mrs Thatcher. His suggestion was that he and I should go to her directly and say if she wanted the reductions in spending that the Treasury envisaged, she would personally have to drop the pledges. I refused this proposal but in October 1981 the Treasury proposed reductions which were again against pledges made. These included 5% off supplementary benefit and charges for visiting a doctor and charges for the cost of staying in hospital. This gives some idea of the general position on public spending at the time. Continuing with a Department of Health policy (such as funding the redevelopment of BPL) was not just a formality but a positive financial statement of our commitment. The same is true of the years that followed, even though there were cost over-runs.

0.21. The next stage in the negotiations on public spending was a committee of ministers to decide where there was any disagreement between a Cabinet Minister and the Chief Secretary to the Treasury. The so called "hanging jury" was presided over by the Deputy Prime Minister. The whole process took weeks to complete. Ultimately you could take an issue to full Cabinet – although the disadvantage of that was that the other Cabinet members knew perfectly well that if they refused a Treasury bid on your budget the Treasury would ask them to fill in the hole. New bids for money were particularly difficult to achieve. These spending issues were important issues that only the Secretary of State could handle.

0.22. It is important to recall, therefore, the financial constraints within which we had to work.

0.23. Self-evidently it was necessary to devolve responsibility in other areas and to be confident in the people I delegated to. And this meant that the Secretary of State did not, as a matter of course, have meetings to double check what Ministers had decided. There was nothing new in this. It had been done by every Secretary of State in the DHSS since its creation. However, there were clear

exceptions: at any stage, any other Minister could refer issues to me, especially if there was an issue of special concern. And equally, I could call-in Ministers if I had a concern.

0.24. Such was the breadth of the Department that in my time, we always had two Ministers of Minister of State rank, one for Health and one for Social Security.

0.25. At the junior Ministerial level, there was likewise a Parliamentary Under Secretary of State for Health and a Parliamentary Under Secretary of State for Social Security, with a further Parliamentary Under Secretary of State in the Lords.

0.26. As far as blood products were concerned, day to day responsibility was devolved to the Minister in the Lords, answering to the Minister of State for Health. However, in the early stages of my period as Secretary of State, the redevelopment of BPL was principally handled by Gerry Vaughan as Minister of State and then by Geoffrey Finsberg as Parliamentary Under-Secretary of State in the Commons. Devolution of this kind had been followed throughout the 1970s. In the Labour government responsibility went to the Minister of State David Owen but he was not the Secretary of State, Barbara Castle was. When my predecessor Patrick Jenkin was Secretary of State, he devolved to Gerry Vaughan. So, there was nothing new in the way we organised it.

0.27. On appointment as Secretary of State, my Ministerial team was as follows:

(i) Dr Gerard (Gerry) Vaughan was Minister of State for Health. He had held that appointment since the May 1979 election. Gerry Vaughan was succeeded in turn by Kenneth (Ken) Clarke, Barney Hayhoe, and Tony Newton.

(ii) Hugh Rossi was Minister of State for Social Security. He was succeeded in turn by Dr Rhodes Boyson, Tony Newton and John Major.

(iii) Geoffrey Finsberg was Parliamentary Under Secretary of State for Health. He was succeeded in turn by John Patten, Raymond Whitney, and Edwina Currie.

(iv) Lynda Chalker was Parliamentary Under Secretary of State for Social Security. She was succeeded by Tony Newton, Raymond Whitney, John Major and then Nicholas Lyell.

(v) Lord (Rodney) Elton was my first Parliamentary Under Secretary of State in the Lords. He was succeeded in turn by Lord (David) Trefgarne, Lord (Simon) Glenarthur, and Baroness (Jean) Trumpington.

0.28. Having served with so many Ministers, it is perhaps invidious to single out individuals. However, my whole purpose and policy was to build up a Ministerial team I could have total confidence in and I trusted. Over the six years I was at the DHSS, we recruited Ministers a number of whom progressed to Cabinet (of those listed above, Tony Newton, John Patten and of course John Major are notable). However, we had other excellent Ministers in the Commons and in each of the four successive Ministers in the Lords.

0.29. In health, the key position was clearly that of Minister of Health. After some hard weeks of negotiation with the Prime Minister at the beginning of 1982, I managed to get Ken Clarke transferred from Transport where we had worked together to the health department. With the pay strike about to happen and a service surrounded by problems, he was the ideal man to head the health side of the Department at Minister of State level. In short, he was the best man I ever worked with in government with the intellectual range to handle all the many different subjects that the health department produced and certainly with the best temperament.

0.30. In terms of civil servants, the most senior official was the Permanent Secretary, Sir Kenneth (Ken) Stowe. Because of the breadth of department business, there was also a Second Permanent Secretary at Grade 1a level. In my time, this was firstly Geoffrey (later Sir Geoffrey) Otton and then Christopher (later Sir Christopher) France. They would tend to focus on the social security side while

Ken Stowe addressed the health side. Very importantly, there was then the Chief Medical Officer – in effect a third Permanent Secretary, also at what became a Grade 1a position. My Chief Medical Officers were Sir Henry Yellowlees, then Sir Donald Acheson (Sir Donald arrived in October 1983 but he overlapped with Sir Henry for the last three months of 1983). In effect, therefore, I had three Permanent Secretaries and again this reflects the breadth and depth of the Department's responsibilities. 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.

0.31. I wish to say a little about Sir Kenneth Stowe and Sir Donald Acheson.

0.32. Ken Stowe had unrivalled experience. He had started work in the old National Assistance Board. He had been Private Secretary to Jim Callaghan when he was Prime Minister and Permanent Secretary at the Northern Ireland office at the height of the Troubles. He was utterly invaluable.

0.33. For the majority of my time as Secretary of State, the Chief Medical Officer was Donald Acheson who I particularly relied on in handling AIDS. His background was public health. His advice was entirely crucial, and we relied on it.

0.34. These were exceptional public servants.

0.35. Having spoken of some of the key personalities, I am bound to mention that so many of them are now dead. From my period as Secretary of State, these include from within the Department: Ken Stowe, Henry Yellowlees, Donald Acheson, Gerry Vaughan, Tony Newton, Barney Hayhoe, and Baroness Trumpington. They would all have been important witnesses, as would Robert Armstrong and William Whitelaw if the Inquiry was looking at the wider response to AIDS. Moreover, relevant to the development of BPL, all my predecessors

as Secretary of State have died (Barbara Castle, David Ennals and Patrick Jenkin). So too has my immediate successor, John Moore. Self-evidently, if we were to have an inquiry it would have been far, far better had it been done years earlier when more of the main players were still living and recollections were fresher.

Loss of papers and allegations of "cover up"

0.36. I am not an uncritical supporter of the Health Department. The organisation was not perfect and one of those areas was the simple administrative job of storing and keeping papers. I have personal experience of this. In about 2011/2012, I was writing a book on AIDS and travelled to a number of countries overseas to see the effects and the policies. In Britain, I asked to see my own papers on AIDS which I was entitled to do. I turned up at the Department of Health, was taken to a side room and presented with three unsorted bundles of papers in no order. I soon came to the conclusion that the diary I had written at the time was much more informative – I noted that a secretary had been taken away from her duties to watch me at work. That was the first time in my experience of writing three books that this procedure had been decreed: normally it was assumed if an ex-Cabinet minister had been trusted with the secrets of the Falklands, he could be trusted not to make off with what arguably were his own papers.

0.37. The papers that have been provided to me from DHSS records in preparing this statement are helpful to an extent, but the records are not complete. I do however wish to make this clear. In the six years I was at the DHSS I never came across examples of civil servants prepared to destroy documents in an attempt to destroy evidence. I have already commented on the fact that my senior civil service team comprised exceptional public servants. It is inconceivable that they would be party to any "cover up". More generally, my feeling was that in terms of honesty the standards of the civil service were exceptional.

0.38. If papers were destroyed my guess is that it was because of clumsy rules (or their implementation) on thinning out what papers were to be kept, rather than some kind of conspiracy.

The stigma of HIV and AIDS and its impact on the haemophiliac community and transfusion recipients

0.39. I know that this Inquiry has heard moving and distressing evidence of the stigma of HIV infection and AIDS and how it blighted those infected through blood and blood products and affected the haemophiliac community more widely. This evidence has included those who believe that the government public health campaign (including the 'Don't Die of Ignorance' campaign) contributed to that stigmatisation.

0.40. This is a very difficult topic to address. I care passionately about helping those infected by HIV. It has become a major part of my working life. On leaving Government I kept in touch with the progress of the efforts to halt the spread of HIV. I worked with voluntary organisations including the Terrence Higgins Trust, headed and supported Parliamentary work on AIDS, and have served in international and charitable capacities. The central message of my 2014 book "AIDS - Don't Die of Prejudice" was the shocking prejudice against minorities which stands as a massive barrier to necessary improvement in public health when HIV and AIDS remains an international epidemic. I have spent the last 35 years trying to help in the fight against AIDS and will continue to do so for as long as I have life myself.

0.41. I want to make clear that we did not condemn. We asked for understanding. We consistently talked of "gay or straight". That was unusual, if not unique, at the time in government publications. On drug users, again, we did not condemn. When I introduced a policy of clean needles, I was accused of condoning crime both outside and inside government. Obviously, I accept that there were critics but in the main these were critics who were simply against the whole campaign. Our aim, at a time when there were no drugs to control HIV and no treatment

available, was to warn others about their behaviour. No-one seriously doubts that the campaign saved lives. It had also the support of the vast majority of the public.

0.42. The stigma was not created by the campaign. It was the result of the bigotry and prejudice of some sections of the public. This was fuelled by a number of public figures. Some examples:[4]

a) The then Chief Constable of Manchester James Anderton said that homosexuals, drug addicts and prostitutes who had HIV/AIDS were *"swirling in a human cesspit of their own making"*;

b) Lord Monkton argued that those with HIV should be quarantined and kept away from the general public;

c) Woodrow Wyatt, a close political friend of the Prime Minister, told his News of the World readers: "*The start of Aids was homosexual love making. Promiscuous women are vulnerable, making love to promiscuous bisexuals. They then pass on Aids to normal men*";

d) Alfred Sherman, an influential political figure on the right (again close to the Prime Minister), wrote to The Times saying that AIDS was a problem of *"undesirable minorities…mainly sodomites and drug abusers together with numbers of women who voluntarily associate with the sexual underworld"*.

0.43. This was the face of prejudice and stigma with which we were contending. I opposed all this. I hope that my attitude was symbolised in early January 1987 when I was photographed shaking hands with an AIDS patient who a few weeks later died in a San Francisco hospital. This was some months before Princess Diana's famous photograph of the same kind which was much more effective in reaching a global audience.

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[4] All quotations cited in my book, "AIDS – Don't Die of Prejudice", Chapter 1; see also open source reporting.

0.44. We sought to work with faith groups to try to ensure that they would not undermine the public education campaign and (preferably) run a complementary campaign. While they did not undermine our campaign, there were reservations which again reveal what we were contending with. One of the most outspoken was the Chief Rabbi Sir Immanuel Jakobovits who, after coming to see me, left me with an aide-memoire which said amongst other things *"say plainly: AIDS is the consequence of marital infidelity, premarital adventures, sexual deviation and social irresponsibility - putting pleasure before duty and discipline."*[5]

0.45. I address this further in Section 6 of this statement. But I raise it in my introductory remarks both because I feel strongly that it was not the public education campaign that created the stigma, and because I have personally always tried to stand up against the vilification and stigmatisation of those infected with HIV. We were trying to save lives by increasing knowledge of the virus and its risks, without stigmatising.

[5] Cited in my book, "AIDS – Don't Die of Prejudice", Chapter 1.

SECTION 1: PRELIMINARY MATTERS

Overview of Career and Positions held within Government (Inquiry's questions 1 and 2)

1.1. I have been asked to set out a brief overview of my career.

1.2. On leaving school (King Edward VI Grammar School Chelmsford) I did National Service from 1956-1958 with the Essex Regiment. I then read law at Cambridge University from 1958 – 1961. In October 1961, I joined the Times newspaper and I worked there as a journalist for the next nine years becoming the paper's first Home Affairs Correspondent specialising in Home Office subjects like police, prisons and race relations. In 1967, I covered the Middle East War. I was selected as the Conservative candidate for South Nottingham in 1968, and was elected to Parliament in the 1970 election. In the 1974 election, following boundary changes, I was elected the Member of Parliament for Sutton Coldfield, and served that constituency until 2001 when I became a member of the House of Lords.

1.3. I have held the following positions within Government and Opposition:

a) Opposition spokesman for Home Affairs,1974 – February 1975;
b) Shadow Cabinet member for Health and Social Security, February 1975 – January 1976;
c) Shadow Minister of State for Transport, January 1976 – May 1979;
d) Joined Cabinet as Minister, then Secretary of State, for Transport, May 1979 – September 1981;
e) Secretary of State for Health and Social Security, September 1981 – June 1987;
f) Secretary of State for Employment, June 1987 – January 1990;
g) Chairman of the Conservative party, May 1992 – July 1994;
h) Shadow Secretary of State for Environment, Transport and the Regions, June 1997 – June 1998; and

i) Shadow Home Secretary, June 1998 – June 1999.

1.4. I was elected as Lord Speaker, serving from 1 September 2016 to 30 April 2021.

Positions outside Government Relevant to the Inquiry's Terms of Reference, and Membership of Committees, Associations, Societies and Organisations (Inquiry's questions 3 and 4)

1.5. I have previously held the following posts:

a) Board of the National Aids Trust;

b) Board of the Terrence Higgins Trust; and

c) Board of the International Aids Vaccine Initiative (New York).

1.6. I currently hold the following posts:

a) UN Aids Ambassador;

b) President of Mildmay Hospital (dealing with illnesses of HIV patients);

c) President of the British HIV Association; and

d) President of the Kaleidoscope Trust (campaigning against stigmatisation of LGBT+ population).

Business or Private Interests Relevant to the Inquiry's Terms of Reference (Inquiry's question 5)

1.7. I do not have business or private interests that appear relevant to the Inquiry's Terms of Reference. For completeness, I should mention that I am a former Chair of Numark Ltd (essentially an association of community pharmacies).

Involvement in Inquiries and Litigation Relevant to the Inquiry's Terms of Reference (Inquiry's question 6)

1.8. I was Chairman of the House of Lords Select Committee on HIV and AIDS in the United Kingdom (Report, 19 July 2011, 'No vaccine, no cure: HIV and AIDS in the United Kingdom').

1.9. I should mention that this was followed by publication of my 2014 book – 'Aids: Don't Die of Prejudice' (Biteback).

1.10. I have had no involvement in relevant litigation or any public inquiry. I gave brief early written evidence to the BSE Inquiry which mainly just outlined my posts and explained that I had did not have a role in BSE issues (statement S344) [WITN0771003].

Archer Inquiry (Inquiry's question 7)

1.11. The Inquiry had noted that in April 2007, I wrote to the Department of Health about the recently announced Archer Inquiry, asking for access to papers and for a briefing on the chronology of events: [DHSC0041307_119 and DHSC0041307_120]. The Inquiry has asked if my requests were granted and for details if so.

1.12. I have not retained a copy of the response eventually sent to me. However the available papers suggest that a response was approved to be sent to me. I had written to Hugh Taylor, the Permanent Secretary, on 19 April 2007. I have seen that on 2 May 2007, Hugh Taylor put a submission to the Secretary of State Patricia Hewitt with a draft letter of response and chronology and this appears to have been approved: [WITN0771004, WITN0771005 and DHSC0041307_119].

1.13. In the event, I was not asked or approached to give evidence to the Archer Inquiry or asked for a response.

SECTION 2: DECISION-MAKING STRUCTURES

Structure and Organisation of the Department of Health and Social Security 1981-1987

Role as Secretary of State (Inquiry's question 8)

2.1. I am asked to describe my 'role, functions and responsibilities' as Secretary of State for Health and Social Security. I have sought to describe these in my introduction. I would only re-emphasise that my responsibilities covered, in effect, two giant departments running side by side: Health and Social Security (including Pensions). As Secretary of State for the joint DHSS, I therefore had an exceptionally wide responsibility.

Other DHSS Ministers (Inquiry's question 9)

2.2. I have sought to introduce the other DHSS Ministers in my opening comments. They are set out below in tabular form. Although the social security side of the Department should not be overlooked as context to the work of the Department, I have omitted the Social Security Ministers for present purposes.

Secretary of State for Health and Social Security	Norman Fowler	Sept 1981 – June 1987
Minister of State (MS(H))	Gerard Vaughan (deceased)	Sept 1981 – Mar 1982
	Kenneth Clarke	Mar 1982 – Sept 1985
	Barney Hayhoe (deceased)	Sept 1985 – Sept 1986
	Tony Newton (deceased)	Sept 1986 – June 1987
Parliamentary Under Secretary of State for Health in the Commons (PS(H))	Geoffrey Finsberg (deceased)	Sept 1981 – June 1983

	John Patten	June 1983 – Sept 1985
	Raymond Whitney (deceased)	Sept 1985 – Sept 1986
	Edwina Currie	Sept 1986 - June 1987
Parliamentary Under Secretary of State for Health and Social Security in the Lords (PS(L))	Lord Elton	Sept 1981 – Apr 1982
	Lord Trefgarne	Apr 1982 – June 1983
	Lord Glenarthur	June 1983 – Mar 1985
	Baroness Trumpington (deceased)	Mar 1985 – June 1987

2.3. I have already commented in general terms in the Introduction Section, above, on which Ministers dealt with blood, blood products and blood transfusion issues. I address this further in the sections below in relation to the specific topics raised by the Inquiry.

Decision - Making Process (Inquiry's question 10)

2.4. There was always a judgement to be exercised by the civil servants on when it was necessary to submit to Ministers. In broad terms, a ministerial submission would be expected on significant policy issues, and if an issue had either significant novel spending implications or political implications. Some submissions would in effect be 'for information', alerting a Minister to a particular development or giving a briefing if an issue had gained publicity, or was about to do so. Others would expressly be seeking a Ministerial decision, in which case it was conventional for the submission to set out realistic options, the key arguments and a recommendation. Such submissions would normally be addressed principally to the Private Secretary of the Minister expected to take the decision. However, the Private Office of other Ministers would often be copied into such submissions. A submission going, for example, to the Minister

of State for a decision might therefore be copied to the Private Office of both the relevant Parliamentary Under-Secretaries of State and to my Private Office.

2.5. Clearly the Minister expected to make the decision would actually see the submission. However, that Minister's Private Office would consider the urgency and priority in deciding when it went before the Minister. Sometimes the Minister would be able to make a decision immediately, in which case the Minister's views would conventionally be reported back in a minute from the Minister's Private Secretary. On more complex matters, the Minister might want further information or explanation, which would again typically be actioned by a minute from the Minister's Private Secretary. Alternatively, the decision might require a meeting in person with the relevant officials and the Minister, or – more rarely – more than one Minister.

2.6. Where a submission has been copied to the Private Office of other Ministers, it means just that: a copy would have gone to the Private Office of that Minister as well. However, this does not necessarily mean that the Minister would have seen it. A large number of such submissions were created daily and part of the art of the Private Secretaries was to assess what their Minister needed – or would want – to see. The Private Office effectively acts as a funnel for information between Ministers and the Department and this inevitably calls for the exercise of judgement in terms of what wider submissions are put into the Minister's Red Box to read.

2.7. The Red Boxes would nightly contain a full and complex mixture of letters to sign, submissions for decision (often in double figures), submissions containing briefings, draft replies to Parliamentary Questions, diary issues for decision, draft press releases, press cuttings, correspondence from Cabinet colleagues, letters from MPs and from members of the Lords, briefings for Parliamentary business, and further papers related to the next day's business and meetings.

2.8. Given the above, the Principal Private Secretary to the Secretary of State was an important position and led the Private Office. The role was staffed accordingly. The role was typically undertaken by someone at Assistant

Secretary (later Grade 5 / Deputy Director level). My Principal Private Secretaries were Mr David Clark, Mr Steve Godber, and Mr Anthony Laurance. The records show that my Assistant Private Secretaries included Ms McVerry, Ms Mothersill and Ms McKessack. Some care should be taken with Ms McKessack's name where listed in documents as she had earlier served as a Private Secretary to the PS(H). The lead Private Secretaries for other Ministers were more junior but would typically be talented young civil servants on the track of fast promotion, gaining experience of working directly with Ministers.

2.9. Throughout my time as Secretary of State, the health side of the Department had a parallel hierarchy system with administrative staff and medical officers. The administrative side was led by the Permanent Secretary (Sir Ken Stowe), and in broad terms was responsible for policy and finance. Given the breadth of issues covered by the Department, the administrative side of the DHSS was also allocated a Second Permanent Secretary (Geoffrey Otton then Sir Christopher France). The medical advisers were led by the CMO, originally Sir Henry Yellowlees but for most of my time, Sir Donald Acheson, and were responsible for medical advice and input. I have already referred to the qualities of both Sir Ken and Sir Donald.

2.10. In broad terms, therefore, for each policy area there would be a hierarchy of administrative civil servants and a parallel hierarchy of medical officers. I have addressed Medicines Division in Section 3 of this statement, below.

2.11. In addition, there was obviously an array of advisory committees who would bring greater specialist expertise to particular areas, as well as offering a greater degree of independence of Government. Such committees would normally have a Departmental Secretariat. Some would be chaired by high-ranking DHSS medical officers, while others had an outside chair. Depending on the nature and level of the committee, Ministers might be involved in approving appointments or structural changes to such committees, but they would not report direct to Ministers rather their advice fed into the Department through the parallel hierarchy.

2.12. While Ministers did have to make (often difficult) decisions on funding, we were not responsible for clinical treatment decision-making which remained a matter for the practising clinicians.

Senior Civil Servants (Inquiry's question 11)

2.13. As I have indicated, my key advisers on the health side of the Department were the Permanent Secretary and the Chief Medical Officer. A great deal rested on the Chief Medical Officer who was in charge of the Medical Division and was responsible for a crucial professional part of the Department. Ministers would not intervene in medical judgements.

2.14. Beyond this, it is difficult at this remove to pick out individual civil servants and the written records will be a better guide to those who were most involved. Given the breadth of the Inquiry's Terms of Reference, it is perhaps not surprising that the issues engaged different Divisions of the Department. By way of example only, looking at the position when I became Secretary of State in 1981, the records reflect that:

(1) On the administrative side, blood transfusion services were part of the remit of Health Services Branch 1 (Assistant Secretary, Mr Harley), one of the branches in the Health Services Division headed by Mr Wormald and then Mr Cashman, which in turn was part of the Service Development Group headed by Mr Nodder (Deputy Secretary). Communicable diseases and vaccinations were within the remit of Children's Division Branch D (Assistant Secretary, Ms M Stuart), one of the branches of the Children's Division (Under Secretary, Mrs J Firth) which was a separate Division within the Service Development Group.

(2) Similarly, on the medical officer side, Blood Transfusion Services fell within the remit of the Medical SEB Division (Principal Medical Officer Dr Diana Walford and Senior Principal Medical Officer Dr Oliver, this being one of the Medical Divisions under the Command of Deputy Chief Medical Officer Dr E. L. Harris). Communicable diseases were part of the remit of the

Medical IMCD Division, (Senior Medical Officer Dr Sibellas, Senior Principal Medical Officer Dr T Geffen).

While these would have been the branches and divisions most heavily involved, others would be involved too such as on the financial side, and issues arising under the remit of the Medicines Division. Inevitably, the officials involved changed over time from a combination of the usual Civil Service policy of job rotation, promotions, retirements and restructuring.

Devolved administrations in the 1980s (Inquiry's questions 12-15)

Scotland, Wales and Northern Ireland

2.15. The Inquiry has asked me a series of questions about Scotland, Wales and Northern Ireland and my role as Secretary of State for Health and Social Security. I have little recollection now of the detail of these arrangements, and the available papers do not assist very much on this issue.

2.16. Constitutionally, my recollection is that the responsibility for healthcare in Scotland, Wales and Northern Ireland (including in relation to blood and blood products) rested with the respective Secretaries of State of the 'Territorial Departments'. The three Secretaries of State were, of course, Cabinet members in their own right. One major difference from the current devolved administrations, however, was that we were all Ministers in the same Government and as such, had the usual collective responsibility for all Government policies. However, I do not consider it would be right to say that as Secretary of State of the DHSS I retained an oversight responsibility for health policy in Wales, Scotland and Northern Ireland.

2.17. In practice, what I recall on health issues generally was that Scotland tended to be the most independent, whereas Wales and Northern Ireland more closely followed the DHSS. This meant that on some issues Scotland followed a path of its own.

2.18. In general terms, however, it would be desirable in many contexts to adopt a common or similar approach to health issues across the four nations, and DHSS officials would have liaised with their counterparts in the Territorial Departments to that end. Membership of advisory committees also had to take this into account. Depending on the issue under consideration, there might be justification for different approaches being taken in Scotland, Wales, or Northern Ireland but I would have expected officials to alert us as Ministers if liaison with the Territorial Departments indicated a difficulty of which we needed to be aware.

2.19. Based on the available documents (rather than any independent recollection), I have referred to some examples of dealings between DHSS and the Territorial Departments in later sections of this statement including:

(1) Liaison between DHSS officials and Scottish Home and Health Department officials, ahead of submissions to Mr Finsberg on BPL: see paragraph 4.8, below.
(2) My exchange of correspondence with Welsh Secretary Nick Edwards in late 1985 over HIV antibody screening of blood donations: see paragraph 6.89 *ff*, below.
(3) Discrepancy in the lesser funding of Haemophilia reference centres in Scotland than the rest of the UK: see paragraph 6.141, below.
(4) Agreement by DHSS and the Scottish and Welsh Offices to contribute funding towards MRC research: see paragraph 6.209, below.

2.20. Where I had dealings with the Scottish, Welsh and Northern Ireland Offices, it would normally have been at Secretary of State to Secretary of State level - that is to say with George Younger and later Malcolm Rifkind (Scotland); Nick Edwards (Wales); and Jim Prior, then Douglas Hurd and later Tom King (Northern Ireland). I recall in particular that Nick Edwards would talk with me frequently on health issues.

2.21. The issue that stands out for me on AIDS in relation to the Territorial Departments is not one directly relevant to the issues involved in this Inquiry. It

related to the trial of needle exchanges. I recall Scottish ministers were not initially supportive of our moves towards needle exchanges, believing it condoned crime i.e., drug taking. This was despite the then acute problems of HIV infection from shared needles in some Scottish cities, particularly Edinburgh.

SECTION 3: SAFETY OF BLOOD AND BLOOD PRODUCTS

Advice or briefing on taking office and development of knowledge (incorporating Inquiry's questions 16-17)

3.1. When I took over as Secretary of State for Health and Social Security in 1981, it was as part of a significant political reshuffle, rather than at an election. In addition, the Ministers of State in the Department (Gerry Vaughan for Health, and Hugh Rossi for Social Security) were unaffected by the September 1981 reshuffle. As a result, I doubt that there would have been the same sort of pre-prepared written briefings that the Civil Service produce in advance of an election when a change of Government and Ministers is readily foreseeable. I am informed that keyword searches of the relevant files disclosed to the Inquiry have not revealed any incoming written briefings to me on blood safety issues.

3.2. In practice, as a new Secretary of State coming in following a reshuffle, you would get up to speed with the briefings when first considering particular issues. I know that Ken Stowe happened to be on holiday when I was first appointed, so I would not have received a briefing from him on first arriving in the Department. I do recall that I received a briefing on the social security side of the Department's work from Geoffrey Otton and there may have been some other initial briefings. I should stress however that these briefings would have covered key strategic areas and policy matters of immediate concern at a broad level. I think it is relatively unlikely that I would have received any specific briefing on blood safety or the blood transfusion service.

3.3. As an incoming Secretary of State, the substantive work starts immediately; there is no 'reading-in' period. That is why, for the most part, you would get up to speed by the background being explained when an issue first came up for a decision or consideration.

Knowledge of assessment, and communication, of risk of blood products, their licensing and steps taken to reduce risk over time (incorporating Inquiry's questions 18-20)

3.4. The Inquiry requests a chronological account of my involvement in, and knowledge of, the steps taken by or at the request of the Department during the c. 6 years I was Secretary of State to assess and reduce the risk of people contracting hepatitis through blood and blood products. I have sought to address the relevant Ministerial submissions in the course of the later sections of this statement, and after such a long time these are the most reliable guide to the information that was being conveyed to us as Ministers. In Section 4, I have given a detailed chronology (ranging somewhat more widely than my own personal involvement as Secretary of State) in what appears to have been the Ministerial involvement in the redevelopment of BPL. In Section 5, I have addressed issues concerning Hepatitis B vaccination, although I had no direct involvement in that issue. To the extent that the hepatitis risks from blood products were being raised at Ministerial level it is, I expect, principally in those areas that this would have happened.

3.5. The licensing and regulation of blood and blood products, as with other medical products, was a technical regulatory area. The senior officials in the Medicines Division and the members of the Medicines Commission and its Committees are better placed than me to give a full explanation of the practical day to day application of the regulation and licensing system.

3.6. As Secretary of State I was the Licensing Authority, but decisions were taken under delegated powers so I would not normally be personally involved (nor would the other Ministers). To explain this slightly more fully, it is perhaps useful to draw on the account given in the BSE Report, Volume 7, Chapter 2. Although this was describing the position in 1988/1989, I have no reason to doubt that it will be a generally fair and accurate summary of the position earlier in the 1980s as well. Vol 7, Chapter 2 of the BSE Report includes the following points on the structure of, and roles within, the medicines regime:

(1) The licensing regime was established by the Medicines Act 1968.

(2) In essence, a medicinal product could not be sold unless it had been granted a 'product licence' by the Licensing Authority. The Licensing Authority was in principle the relevant Minister, although in practice his or her functions were delegated to officials in the Medicines Division of DH (medicines for human use). They received advice from a number of committees of experts, set up under Section 4 of the Medicines Act, known as 'Section 4 committees'.

(3) Responsibility for the granting, renewal, variation, suspension and revocation of licences was given by the Medicines Act to the 'Licensing Authority'. Under the Act 'the Health Ministers' and 'the Agriculture Ministers', i.e., the Secretary of State for Health, the Minister of Agriculture, Fisheries and Food and the corresponding Ministers in Northern Ireland, Scotland and Wales, comprised the Licensing Authority, although any one of them acting alone was permitted to perform its functions. In practice, the functions of the Licensing Authority in relation to medicines for human use in the UK were, throughout the period 1985–96, performed by the Secretary of State for Health.

(4) Although formally the Secretary of State for Health acted as the Licensing Authority for human medicines, in practice his or her functions were delegated to officials working in the Medicines Division of DH (and, after April 1989, officials working for the Medicines Control Agency (MCA)), subject to the normal legal principles relating to the extent to which ministerial functions may be delegated.

(5) The arrangements meant that product licences were physically granted by officials, not by the Minister, although I remained accountable for them.

(6) The Medicines Act 1968 required that Ministers establish a Medicines Commission, made up of professionals with 'wide and recent experience' in the practice of medicine and pharmacy. The Commission was required to advise the Ministers making up the Licensing Authority on matters relating to the execution of the Act and on medicines generally where the Commission considered it expedient or when requested by Ministers. It also acted as an appeal body in respect of advice given to the Licensing Authority by the Section 4 committees.

(7) The Committee on the Review of Medicines (CRM) was established to review the safety, quality and efficacy of medicines that had been on the market before the Medicines Act introduced licensing requirements. At that time these products were granted licences of right.

(8) The Committee on Dental and Surgical Materials (CDSM) advised on questions of the safety, quality and efficacy of dental and surgical materials.

(9) The Committee on Safety of Medicines (CSM) advised on questions of the safety, quality and efficacy of human medicines that fell outside the remit of the CDSM and the CRM. The Biologicals Sub-Committee was one of the Sub-Committees reporting to the CSM.

(10) The Licensing Authority was required to consult the relevant section committee (or if there was none, the Medicines Commission) in certain circumstances, for example, where it was minded to refuse an application for a product licence or to suspend, vary or revoke a licence. Otherwise, officials had a discretion whether to seek advice from Section 4 committees in relation to any particular product.

(11) The licensing regime for human medicinal products was operated by officials in Medicines Division in DHSS. This Division was organised in three parallel structures: medical staff, pharmaceutical staff and administrative staff. Responsibility for staff in these structures was

essentially divided along professional/administrative lines. The professional staff reported to the Senior Principal Medical Officer (SPMO) or the Chief Pharmaceutical Officer and the administrative staff reported to the Under Secretary.

(12) The National Institute for Biological Standards and Control (NIBSC) was established under the Biological Standards Act 1975 in order to secure high standards of quality, safety, efficacy and consistency of biological substances used in medicines. In fulfilling this role it devised standards for the quality, purity and potency of biological substances, tested batches of biological products on behalf of DHSS, carried out research and advised a number of bodies, including Medicines Division of DHSS and its Section 4 committees. NIBSC staff were members of the BSC/CSM.

(13) EC regulation of human medicinal products was introduced with the adoption of Council Directive 65/65/EEC. Its framework was similar to that of the Medicines Act: it was based on the grant of a 'marketing authorisation' by the competent authority of the Member State in question (i.e., a decentralised system). No product within the scope of the Directive could be placed on the market in a Member State unless an authorisation had been issued by the competent authority of that Member State. No new legislation was introduced to implement Directive 65/65/EEC. The competent authority of the UK for the purposes of the Directive was the Licensing Authority. Additional measures were introduced in 1975 including mechanisms for the recognition by all Member States of product licences granted by any individual state. The Committee for Proprietary Medicinal Products (CPMP), a scientific committee, was also established; this advised the Commission on issues of safety, quality and efficacy in much the same way as the CSM advised the Licensing Authority in the UK.

(14) This Chapter of the BSE report goes on to refer to the Evans-Cunliffe report commissioned in 1987 [WITN0771006] and details the various

findings of that report commenting on the strengths and weaknesses as at 1987.

3.7. As the BSE Report made clear, the officials in Medicines Division acted on the advice of the relevant committee to make decisions under delegated powers. Against that background my general recollection is that it was very unlikely that individual issues on licensing decisions would come to me or indeed other Ministers. I do not recall any licensing decisions relevant to blood products coming to me for a decision.

SECTION 4: SELF-SUFFICIENCY AND THE REDEVELOPMENT OF THE BLOOD PRODUCTS LABORATORY AT ELSTREE

4.1. I am asked about the drive towards self-sufficiency in blood products, the redevelopment of BPL, Elstree and the creation of the Central Blood Laboratory Authority (CBLA).

4.2. One of the matters that does stand out in my recollection about my own personal involvement in these events is Sir Ken Stowe raising with me a pressing need for substantial extra funds to complete the BPL project and I will address this within this section. I do not recall otherwise having much personal involvement in the redevelopment of BPL which was principally handled at Parliamentary Under Secretary of State and Minister of State level. Since Gerry Vaughan, Geoffrey Finsberg, Tony Newton and Baroness Trumpington are no longer alive, I have sought to offer assistance and comment where I can on the topics raised by the Inquiry. I must stress, however, that in doing so I cover some submissions and other documents that do not appear to have been copied to my own Private Office at the time.

BPL redevelopment issues in 1981 and 1982

4.3. Before my appointment as Secretary of State, submissions on BPL and the management of the Central Blood Laboratories were being handled mainly by Gerry Vaughan as Minister of State and Sir George Young as Parliamentary Under-Secretary of State. However, Patrick Jenkin as Secretary of State had agreed that RHA allocations would, if necessary, be 'top-sliced' to pay for the redevelopment of BPL. This can be seen in the exchanges of 27, 28, and 29 May 1981 [DHSC0002309_002, WITN0771007, DHSC0002309_095] and responses of 2 and 4 June 1981 [WITN0771008 and WITN0771009]; and Mr P J Wormald's minute of 18 June 1981 (just three months before my appointment) [DHSC0002309_004] and response of 1 July 1981 [DHSC0002309_005]. Thus, the policy direction had been set down by Patrick Jenkin's team, but the in-principle agreement to funding had only very recently been given.

4.4. Following my appointment, the same pattern initially continued with Gerry Vaughan remaining active in this area at Minister of State level and with Geoffrey Finsberg increasingly involved as Sir George Young's successor as Parliamentary Under-Secretary of State. As Patrick Jenkin's Minister of State for these issues, it was sensible that Gerry Vaughan should continue to give the policy continuity. Geoffrey Finsberg took on day to day responsibility as successor to Sir George Young. George Young was moved to another Department, not I stress because of any deficiencies, but because he was perceived to be over-zealous in tackling smoking.

4.5. Gerry Vaughan's involvement can be seen from the briefing he received for a meeting with the Haemophilia Society on 21 October 1981 [WITN0771010, DHSC0002211_062], and Gerry Vaughan's subsequent letter of 30 October 1981 [WITN0771011]. See also his letter of 19 January 1982 [CBLA0001536].

4.6. On 17 November 1981, Geoffrey Finsberg received a submission on redevelopment of BPL and Plasma supply [WITN4461055], see also the follow-up minute of 25 November 1981 [DHSC0002327_086] and response of 26 November 1981 [DHSC0002327_163]. See also: the officials' note of his meeting with Dr Lane on 17 December 1981 [WITN0771012]; reference to his planned visit to BPL on 22 January 1982 [DHSC0002215_024], which was deferred until 12 February 1982; related correspondence from Dr Lane to Geoffrey Finsberg [WITN0771013 and advice [WITN0771014].

4.7. There is no indication from these documents that I was being involved at Secretary of State level. It is very hard to piece together so long after the events what I would have known about this issue at this time. I would, however, have known that £17 million had already been agreed as the cost of redevelopment of BPL and the support for the aim of self-sufficiency. The detail (including how the money would be spent) would – where Ministerial input was required – be handled at PS(H) and, to an extent, MS(H) level. At this time, I was heavily engaged in the tough first spending round since my appointment, to which I have referred at paragraph 0.20, above – but I had to confirm the figure in the public spending talks.

4.8. The issues the Inquiry has asked me to consider include whether I had any knowledge of proposals for Scottish facilities to be used to produce blood products from plasma supplied from England and Wales. I do not recall this being raised with me specifically, nor have I seen reference in the documents to it being raised at my level. The documents suggest that there was liaison between officials in DHSS and the Scottish Home and Health Department (SHHD) before these matters were raised with the Health Minister dealing with the issue, which is what I would have expected. See by way of example:

(a) Mr Macpherson's letter to Mr Harley of 11 January 1982 in the context of a meeting with Geoffrey Finsberg [CBLA0001532]; and

(b) Mr Cashman's letter to Mr Walker of 2 September 1982 ahead of a further submission to Geoffrey Finsberg [WITN0771015 and WITN0771016].

4.9. The documents also show that Geoffrey Finsberg sought and received advice about the possibility of putting the English Central Blood Laboratories and PFC under single management. At the same time, Geoffrey Finsberg was considering the best management structure going forwards, with the pros and cons of the different management structures being set out in a submission dated 18 February 1982 to him, with a Special Health Authority being the preferred option: [WITN0771017]. I was not involved in those issues at this stage, nor would I have expected to have been unless there were aspects that Geoffrey Finsberg was concerned about which could not be addressed or resolved by Gerry Vaughan at Minister of State level.

4.10. I became more directly involved in March 1982, in the context of concern at the misuse of blood and plasma at the National Heart Hospital: see the Parliamentary Answer I gave on 3 March 1982, [DHSC0101561_003]. This dates back to allegations in the press in October 1980 concerning the misuse of blood and blood products. This episode was later to lead to criminal convictions of a number of individuals. I received a brief submission on this from Sir Ken Stowe on 12 March 1982 [DHSC0002309_009]. One part of the proposed response recommended by Sir Ken was to decide upon and announce the setting up of a new direct management structure for the three

central blood laboratories with the status of a Special Health Authority, which was the solution to the management structure already proposed by Geoffrey Finsberg. At the same time, action was already in hand to review the standards of operation of the Regional Blood Transfusion Service, with a review being conducted by the Deputy Chief Medical Officer Dr Harris.

4.11. Against this background, by 19 March 1982 we had agreed that a Special Health Authority should be set up for the central blood laboratories: see Mr Harley's minute of 19 March 1982, [DHSC0002215_059]. Ken Clarke had now taken over as Minister of State and on 5 April 1982, my Private Office indicated my agreement with the joint recommendation made by Ken Clarke and Geoffrey Finsberg [WITN0771018] that David Smart should be the Chairman of the new SHA [WITN0771019]. I announced the setting up of the new SHA on 18 May 1982 [WITN0771020, CBLA0001581_003]. Later in the year, the Central Blood Laboratories Authority (Establishment and Constitution) Order 1982 was enacted to bring the CBLA into existence.

4.12. The documents show that on 18 June 1982, Mr Nodder (Deputy Secretary, Service Development Group) minuted Sir Ken Stowe and a number of other officials [DHSC0002217_036]. This was not a Ministerial submission and I would not have seen it at the time. The issue that Mr Nodder was raising was membership of the CBLA. The Chairman wanted a DHSS member on the Authority, but it was noted that Geoffrey Finsberg had queried the reappointment of a DCMO to a different body (the Public Health Laboratory Service Board). Mr Nodder said that, as regards the CBLA, "RL's advice" (this likely refers to Regional Liaison, the Division that dealt with liaising with NHS bodies) was against there being a DHSS member of the Authority. This was said to be on the grounds of "… *conflict of interest and problems should the Authority seriously cut across DHSS policy, or require to be disciplined or, as a last resort, dismissed*"). However, Mr Nodder noted that as the CBLA would be managing a substantial capital project, it was important for the Department to have strong influence and full information which he considered would be assisted by having a DHSS member. As I shall come to below, the available records show that Geoffrey Finsberg ended up agreeing to there being a DHSS

member on the CBLA but was against a DHSS member being on the BPL redevelopment steering group.

4.13. On 6 July 1982, Mr Nodder then put a submission to Geoffrey Finsberg on this issue [WITN0771021]. Amongst other things, the submission set out the pros and cons of a DHSS official being a member of the CBLA. Mr Nodder noted that a decision on this was not required straightaway and that he would take Sir Kenneth Stowe's view as the Accounting Officer.

4.14. On 22 September 1982, Mr Godfrey put a submission to Geoffrey Finsberg on the redevelopment of BPL: [DHSC0002309_017, WITN0771016]. My Private Office does not appear to have been copied into this submission and nor would I have expected it to be. While significant sums were involved, the submission was looking at the detail of the size, scale of production and cost. These were matters for Geoffrey Finsberg to address and escalate if required. In the context of the Inquiry's interest in the consideration given to the use of the PFC Liberton, I note that this was addressed in paragraph 6 of the covering note and in the submission itself. The recommendation was for approval for redevelopment of BPL at the largest and most expensive option, namely redevelopment to a size capable of making England and Wales self-sufficient in blood products. This would have a planning cost of £21.03 million with a contingency of £1.5 million, spread over the financial years from 1982/3 to 1985/6, with approval from the Treasury that the project should be 'fast-tracked'.

4.15. The records show that Geoffrey Finsberg then held a meeting on 7 October 1982 with the relevant officials at which Mr Godfrey's submission and the redevelopment options were discussed [DHSC0002309_019]. The points of note from this were that Geoffrey Finsberg:

(a) Agreed the overall approach, namely redevelopment at a size (i) capable of making England and Wales self-sufficient in blood products; and (ii) capable of extracting all therapeutic materials from the plasma it would receive and selling the surplus materials to industry;

(b) Wanted the cost limit to be set at £21.1 million, to exclude the £1.5 million contingency;

(c) Wanted the investment appraisal to be amended to reflect a lower expected production level in the Laboratory's first year of operation, given the complexity of commissioning a plant of this size. A copy of the investment appraisal revised along these lines was to be put to the Minister of State for information; and

(d) Approved the necessary pre-emption of health authorities' capital in 1985-86.

Further, in response to the indication that the CBLA was likely to ask for DHSS to be represented on its project steering committee, Geoffrey Finsberg felt that *"… the project should be left entirely to the Authority (on which DHSS would be represented through Dr Harris, DCMO), but he wished to seek Sir Kenneth Stowe's view on the need for such representation to protect the Accounting Officer's responsibilities, given the size of the project*".

4.16. A slightly revised investment appraisal was produced as requested: [WITN0771023]. On 20 October 1982, Geoffrey Finsberg minuted Sir Ken Stowe, noting that he had authorised the investment appraisal to go to the Treasury [DHSC0002321_065]. He went on to say:

> *"Management of the BPL will be taken over by an SHA, the Central Blood Laboratories Authority, on 1 December 1982. The new Authority, to be chaired by David Smart, will no doubt set up its own project steering group. It is likely, however, that the Authority will ask a DHSS official to serve on the group. My initial reaction would be to discourage this. We are after all establishing a statutory health authority to manage these laboratories and it should be left to get on with that task. The Department will be represented on the Authority itself - I have appointed Dr Ed Harris (DCMO) for a 2-year term. In addition the Department will see plans for the new BPL at the pre-tender estimate stage in the normal way.*

I would welcome your views as Accounting Officer on whether representation on the project steering group is desirable."

This was seen and noted by Ken Clarke on 8 November 1982: [DHSC0002321_059].

4.17. On 3 November 1982, Sir Ken Stowe replied to Geoffrey Finsberg in the following terms [WITN0771024]:

"*As Accounting Officer, my aim would be to pin responsibility for the project on the Special Health Authority itself, and minimal Departmental involvement.*

As against that, I can see some advantage in going along with the Special Health Authority, if it does ask that a DHSS official serve on the project steering group. Even if there is no formal DHSS representation on the steering committee, the Chairman will look to us for informal help and advice: formal membership would carry more weight with other members and strengthens the Department's hand where that is necessary.

The Blood Products Laboratory is rather different from the general run of health authority capital projects, whatever their size since the new BPL will be a national facility, having the whole of the NHS in England and Wales as its customer. I am inclined not to see our involvement as a point of principle but to go along with David Smart's request. But let us discuss when we meet next week."

Geoffrey Finsberg's office received other responses: see for example those from Mr Hulme (Deputy Secretary for Finance and Accountant General) [WITN0771025]; Mr Cashman (Under Secretary, Health Services Division) [WITN0771025]; and Mr Bolton [DHSC0002321_054].

4.18. On 25 November 1982, Sir Ken Stowe's Private Secretary minuted Mr Cashman confirming the discussion which had taken place between Geoffrey Finsberg and Sir Ken as Permanent Secretary [WITN0771026]:

> *"Mr Finsberg discussed with Sir Kenneth yesterday his minute of 3 November, about the possibility of a DHSS official serving on the project steering group. Mr Finsberg said he would prefer there to be no Departmental member of the steering group. He asked that if Mr Smart approaches the Department to suggest this, he and Sir Kenneth are alerted; one of them would then see Mr Smart to discuss why he wished an official to join the steering group."*

The result was that DHSS was represented on the CBLA itself, and had observers at CBLA meetings, but DHSS was not directly represented on the BPL redevelopment group.

4.19. This decision was later subject to internal criticism to which I shall return later in this section. I can see from the files now available that at the time Dr Harris questioned the decision in a minute to Sir Ken Stowe dated 29 November 1982 [WITN0771027]. The records show that Sir Ken Stowe then asked Mr Hulme for his views and that on 24 December 1982, Mr Hulme replied to Sir Ken's Private Secretary in the following terms:

> *"There is clearly substance in Mr Finsberg's concern that the responsibility of blood products laboratories should not be diluted through sharing it with the Department and that it should be wholly accountable for the project.*
>
> *On the other hand, we would expect them as the accountable body to obtain and apply the necessary expert advice and, if that is to be found within the Department, to get it from the Department. If it is the case that such advice can most efficiently be provided by having a Departmental member associated with the project team, it should be possible to arrange that without going against the principle to which Mr Finsberg*

rightly attaches importance. This could be done by making quite clear the responsibility of the BPL and its project team and the role of the DHSS adviser. Alternatively, there may be other ways in which BPL could get the necessary advice, including bringing officials in for consultation and advice ad hoc.

Like Sir Kenneth, I don't see any strict Accounting Officer point here.

The best course might be to wait and see if Mr Smart does raise the question of DHSS participation and, if he does, explore the above points with him." [WITN0771028]

4.20. On 26 November 1982, Mr Godfrey advised Geoffrey Finsberg's office that Treasury approval had been granted for the BPL redevelopment [DHSC0002309_020].

4.21. In December 1982, formal administrative directions were given to the CBLA in my name. They included the need for maintaining efficiency and exercising financial supervision and control: [CBLA0001645].

BPL redevelopment issues in 1983

4.22. In 1983, Geoffrey Finsberg remained the Minister dealing with the BPL redevelopment until John Patten took over as Parliamentary Under-Secretary of State for Health in the Commons following the June 1983 election. See, for example, the correspondence and submissions dated 15 April 1983 (Mr Smart to Geoffrey Finsberg, [DHSC0002321_010]); and 4 May 1983 (minute from Mr Winstanley to Geoffrey Finsberg's Office, [WITN0771029]). On 11 May 1983, Mr Parker (Assistant Secretary, Health Services Division 1) minuted my Private Secretary directly [DHSC0002227_037] regarding an article by Andrew Veitch in the Guardian [DHSC0002227_037] concerning the CBLA funding allocation. It is likely that this was addressed to my Private Office directly because of the personal nature of the attack on me in Mr Veitch's article, timed just before the election. It was a highly political piece. It was common for civil service divisions

and the departmental Press Officers to alert Ministers to hostile articles carrying direct attacks (and on occasions, the more positive articles praising action by a Minister). Geoffrey Finsberg provided written answers to PQs from Alfred Morris MP on BPL production on 12 May 1983: [DHSC0002227_045].

4.23. Following the June 1983 election, Lord Glenarthur took day to day responsibility at Ministerial level for issues concerning blood and blood products including responsibility for the Blood Transfusion Service. On 5 July 1983, in answering a PQ in the Commons about taking steps to ensure self-sufficiency because of the risk of hepatitis, Ken Clarke stated that over the next three years BPL would be redeveloped at a cost of £21 million and that, when completed, the laboratory would be of a size capable of making England and Wales self-sufficient in blood products: [WITN0771031]. (See also his answer to a further PQ on 11 July 1983 at [DHSC0006401_005].) Lord Glenarthur could not, of course, field PQs in the Commons.

4.24. Lord Glenarthur continued to address BPL's redevelopment and associated CBLA issues in the second half of 1983, for example:

(1) Lord Glenarthur visited BPL on 21 July 1983 [CBLA0001732].

(2) He met with the Haemophilia Society on 8 September 1983 [DHSC0002337_050]. The Haemophilia Society were pressing the case for self-sufficiency within two years or less if possible. The redevelopment was scheduled for completion at the end of 1985 and Lord Glenarthur made clear that the aim was to have a facility of a size capable of achieving self-sufficiency, coupled with the necessary build up in plasma supply: see his letter to The Rev'd. Tanner, dated 28 September 1983, following their meeting [DHSC0002071].

(3) David Owen wrote to Ken Clarke on 19 October 1983, noting that in his time the Department had set in train a capital investment programme to achieve self-sufficiency and asking what stage this had now reached [WITN0771032]. Lord Glenarthur replied to David Owen on 10

November 1983 [DHSC0000208] referring to the £2 million already spent on improvements and the major redevelopment programme.

(4) Lord Glenarthur also met with members of the CBLA on 22 November 1983 (see the briefing for this meeting [DHSC0046951_042] and note of the meeting itself [DHSC0001669] copied to the Minister of State's and Permanent Secretary's offices).

(5) Lord Glenarthur was also in correspondence with Clive Jenkins, General Secretary of the Association of Scientific Technical and Managerial Staffs, including in relation to the steps being taken towards self-sufficiency. See the letters of 26 August 1983 [DHSC0002231_036] and 27 October 1983 [DHSC0002235_041]. This correspondence continued into 1984: see the further letters of 5 January 1984 [PRSE0001727], 14 February 1984 [DHSC0001672] and 2 April 1984 [DHSC0001674].

4.25. A discrete issue raised by the Inquiry is my announcements on 7 and 8 November 1983 concerning the introduction of handling charges for supplying private hospitals with blood and blood derivatives: [ROTH0000001, WITN07711033]. I do not now have any specific recollection of this issue. Resources were under strain and my general policy was that if supplementary resources could be raised without harming the service provided by the NHS or the NHS generally then the opportunity should be taken. 'Handling charges' would have seemed an obvious opportunity. There seemed to be no sensible reason why we should be subsidising the private sector in health. This did not in any way interfere with the collection of blood for the NHS. I do not have any information on how much revenue was raised and there was a reluctance in the NHS to charge. We would have been under criticism from outside had we refused to take the opportunity. I have seen some documents which give some of the earlier background to developments in this area:

(a) Minutes from Mr Godfrey (dated 22 and 23 December 1981 [WITN0771034, WITN0771035] and 29 January 1982 [WITN0771036]) reflect that Gerry Vaughan had heard rumours that

a private hospital group in London was considering setting up its own paid donor panel in order to guarantee supplies of blood to its hospitals. Gerry Vaughan asked for a note on the legal position: see the related minutes at [WITN0771036]. This was against the background of proposals from the Department for the introduction of handling charges for supplying private hospitals with blood.

(b) Ahead of a working dinner in May 1982, I received briefing on the issue of private hospital blood banks [WITN0771037]. Following the issue at the National Heart Hospital and the potential for handling charges to be introduced, I was advised that there was a risk that the AMI group might set up its own private donor panel or import blood. I was further informed that the supply of blood to private hospitals was on the agenda for Ken Clarke's formal meeting with the Joint Liaison Committee for Independent Health Care on 27 May 1982 and that no announcement on charges was going to be made until after that meeting. While a product licence would be required for collecting, selling or supplying blood, there was otherwise no legal bar to private blood services. I was told that in August 1980, in response to a written PQ, Gerry Vaughan had made it clear that if necessary he would be prepared to take action to discourage private companies from offering payments to blood donors given the wish to preserve the voluntary blood donor system.

4.26. Given the commitment to the principle of freely donated blood in the UK, I think at the time it would have seemed to me to be correct that there should not be a charge for blood itself, but reasonable that private patients should face a charge for the associated handling and processing expenses. It was equally correct to seek to require that these fees should be used to further the efforts towards self-sufficiency. Lord Glenarthur wrote to the Telegraph in response to a leading

article alleging that the Government was seeking to make a profit [WITN0771038]. In this letter, Lord Glenarthur stated:

> *"The Government welcomes the growth of the independent sector in medicine and is keen to encourage co-operation with the NHS. Indeed the right of patients and doctors to choose private treatment can only add to the country's health care resources and reduce pressure on State services. However, it also believes that the independent sector should be self-supporting. The NHS should not be out of pocket in providing services to the independent sector on an agency basis and we have decided that it would be equitable and logical to make an economic charge to re-imburse regional health authorities for the cost of collecting processing, handling and transporting blood and blood derivatives…*
>
> *We are rightly proud of our voluntary blood donation system in this country and have no desire to see it undermined. Nor do we intend to change the principle on which the National Blood Transfusion Service is based: blood should be available to all who need it."*

I entirely agree with the points that Lord Glenarthur was making here. Lord Glenarthur made similar points in answering an oral PQ in the Lords on 5 December 1983: [WITN0771039].

4.27. I am not personally aware (from the documents that came to me at Ministerial level) how sizeable the contribution from this source was, as the income ought to have come in at RHA level. However, I do not take from the contemporaneous documents any suggestion that this would have been expected to be a major element of the financing of self-sufficiency. For example, it does not appear to have been used to offset or reduce the £21 million cost of redevelopment. But that does not mean that it was wrong to introduce the charges or wrong to ask RHAs to channel the income towards the efforts towards self-sufficiency.

4.28. The Inquiry has directed my attention to a minute from Mr Parker dated 3 November 1983 [SCGV0000133_053] in which my Private Secretary was

advised that there were a number of reasons for not referring to the way in which income derived from the handling charges should be used, in the statement announcing the charges. It was said that these would be explained in a meeting that afternoon. Unfortunately, the electronic searches have not revealed any minute of that meeting. I can only assume that this objection was not pressed by officials, that as Ministers we overruled the advice on this occasion, or that the eventual phrasing of the Press Release (which spoke of *asking* RHAs to ensure that the income was used to help self-sufficiency) sufficiently addressed officials' concerns. I am afraid that after all these years I simply cannot assist on the precise reasons – I do not know. The only reason I can think of is that there may have been a fear that Regional Health Authorities would not be happy about collecting charges that then went "elsewhere", but I cannot actually recall the reason.

4.29. I would note, however, that by December 1983, the briefing for supplementary questions to the PQ answered by Lord Glenarthur was referring to the fact that RHAs would be asked to ensure that income from handling charges was used for the purpose of furthering the drive for self-sufficiency by ensuring that there was an adequate supply of plasma: [WITN0771039 at p. 11]. Lord Glenarthur, with some input from Ken Clarke, handled a subsequent submission dealing with both record-keeping and stock control and the consultation on the detail of the handling charges: see the submission of 27 February 1984 [WITN0771040] and responses of 5 March 1984 [WITN0771041], 7 March [WITN0771042], 8 March 1984 [WITN0771043], and 5 April 1984 [WITN0771044]. I received briefing on this on 20 March 1984 in case it was raised at a meeting with RHA Chairmen: [WITN0771045, WITN0771046].

BPL redevelopment issues in 1984

4.30. Turning back to the redevelopment of BPL, I laid the foundation stone on 23 March 1984 and the associated Press Release [DHSC0002239_088] quoted me in the following terms:

"The decision to invest an estimated £24 million over the period of construction of this new unit reaffirms this Government's commitment to safeguard and develop this vital part of the country's health service. We believe moreover that this is a sound economic proposition in that the NHS will save annually many millions of pounds by not having to buy in vital products from abroad. This scheme is likely to pay for itself within perhaps five or six years of reaching full production.

"The United Kingdom is justly proud of its voluntary blood donation scheme run by the National Blood Transfusion Service, and this project will ensure that the best use is made of the precious donations. The blood provided by voluntary donors has immediate uses in straightforward transfusions, but increasingly it is possible to separate it into different components with specific properties used to treat different conditions which makes much more efficient and economic use of blood donations. The most significant of these products is Factor VIII which is needed for the treatment of haemophilia. Over the past ten years the demand for Factor VIII has increased dramatically.

"When the redevelopment is complete, BPL will have the capacity to satisfy the needs of England and Wales for blood products. However, as with any production process, the unit cannot function without the basic raw material - in this case blood plasma. Efficient operation of the new unit will require three times as much plasma as is currently processed. For this we shall look to Regional Health Authorities through their Regional Transfusion Centres.

"The urgency in getting this new unit on stream has been appreciated, and the project has been organised in a special "fast streaming" way. This means that design and construction take place together – the construction of the building shell can start before the details of the plant it contains have been finalised.

I am pleased to say that the project is on time and completion is due by the end of 1985."

Lord Glenarthur came with me on this visit. I have no memories of the occasion, except perhaps the feeling that we were now making progress.

4.31. From the records available to me, there does not then appear to have been any issue raised with us as Ministers on the BPL redevelopment until September 1984. A submission went to Ministers sometime around 20 September, a late version circulated on 19 September 1984 is at [DHSC0002309_047]. The submission sought Ministerial approval for a substantial increase (from £25.3m to £35.3m at 1984-5 prices) in the capital cost of the redevelopment project. The background to how this had come to pass was set out. The options in outline were to abandon the project, redesign it to meet the original budget updated for inflation, or accept the revised design solution at a cost of £38.8m. We were told that the latter option had been subject to Treasury guideline economic appraisal and was economically the best option and the recommendation was to approve this course and seek Treasury sanction for it. I would wish to emphasise here that we agreed at this stage to find this substantial increase in costs (as we were to do again later), and we did so from DHSS budgets not from any Treasure grant.

4.32. On 25 September 1984, Ken Clarke responded to the submission with a minute to the Permanent Secretary copied to the Private Office of Lord Glenarthur [DHSC0002309_114]. My Private Office was not copied in, but the thrust of Ken Clarke's response was that there was little practical alternative to seeking Treasury approval for the further sum, but that the situation suggested, at first sight *"… a fairly woeful lack of cost control somewhere in the Department"*. Ken

Clarke pressed to be kept informed of what was going to be done and from where the money was going to be found. Although I was not copied into this minute I would have agreed with the sentiments.

4.33. Sir Ken Stowe's response was to note that this was *"all news to me – which perhaps reveals a lot"* and to ask Mr France (then I think a Deputy Secretary) to investigate the matter with Mr Hulme and report back to him: 26 September 1984, [DHSC0002309_113]. This is a very unusual response from the Permanent Secretary and appears to indicate that the Department had stepped back. It fully justifies the setting up of the Griffiths Inquiry into management which regrettably was too late to catch this failure.

4.34. There was a press release on 27 September 1984 [DHSC0004764_103] quoting Lord Glenarthur's comments at a meeting of the newly formed British Blood Transfusion Society. He said that:

> *"The other major change has been the great increase in the volume of blood and blood products demanded by the Health Service. Developments such as open heart surgery have demanded much larger supplies of whole blood. Other new treatments have increased the needs for specific blood components - Factor VIII for the treatment of haemophilia, platelet transfusion in the treatment of leukaemia and other disorders.*
>
> *"The Government has accepted the World Health Organisation's recommendation that countries should become self-sufficient in blood and blood products. Our commitment to the importance of self-sufficiency is shown by our current investment of over £24 million in the redevelopment of the Blood Products Laboratory at Elstree. My Department is asking Regional Health Authorities to ensure that the Blood Transfusion Service is provided with the resources to increase their collection of blood plasma - this is essential to the success of the Elstree project because obviously it can't be run properly without enough raw material."*

4.35. The Treasury were alarmed at the substantial cost overrun: see their letter of 25 October 1984 to Mr Harris [DHSC0002247_105]. Mr France reported to Sir Ken Stowe on the matter on 7 November 1984: covering note at [DHSC0003964_029], report at [WITN0771047]. The report included a section on the responsibilities within DHSS in respect of project control. This included that the Works Group had imposed a cost limit of £21.1m, but also noted Geoffrey Finsberg's earlier opposition to direct participation in the Project Committee, which was said to have been interpreted by the Works Group as an indication that they should 'stand back' from the project and had monitored it less closely than would have been the case had direction participation not been an issue. Mr France's covering note to Sir Ken Stowe commented:

> *"On the facts, the project has not been subject to adequate financial control at any level. The Project Team ignored a plainly stated cost limit. The Authority was not informed of design changes and their cost implications and, despite the fast track approach, did not apparently enquire about these inevitable features. The Department was uncertain about its role but did not insist on the observation of those controls which it decided formally to impose. It is possible to conclude that the original cost limit of £21.1m was widely regarded, certainly by the Project Team, as being so unrealistic that it could not be taken seriously. Certainly it was neither challenged nor enforced, and so the keystone of the intended control proved useless."*

Noting how tight finance was, Mr France's inclination was to go for a cost limit below the suggested £38.8m. However, Dr Harris, the DCMO, pressed the concern at any delay to the project and that there was little alternative but to press for the factory to be completed as planned, though he supported pushing back on the additional £3.5m sought for a new quality control facility: [DHSC0003964_028].

4.36. My view based on the papers was that (as Mr France said at the time) the original cost limit of £21 million was regarded as unrealistic by the project team – which with the benefit of hindsight, it clearly was. The suspicion is that the

construction project (like many other projects of its kind) was "sold" low to get acceptance and, once accepted, higher costs could be achieved. There is always some truth, however, in the claim that you cannot know the future cost of many projects until you get onto site. The Griffiths proposals meant an improvement but were not automatically popular with the senior civil service. Moving forwards from the stage that had been reached, the important decision was that Mr France's proposal to go for a lower cost limit was rejected and the building project went ahead. I was not involved in the detailed planning.

4.37. There was a further press release on 19 November 1984 [WITN0771048] reporting on the statement of John Patten which partly addressed AIDS research but also commented on the BPL project. John Patten said that the redevelopment of the Laboratory was on target for completion early in 1986, which should enable the UK to become self-sufficient in blood products by the end of that year. As I will address in Section 6, below, I received briefing on the current AIDS situation on the same day, 19 November 1984: comprising a covering memo and note [DHSC0002309_053]. On self-sufficiency, this noted that: *"Secretary of State will be aware of the increasing costs of the blood products BPL project currently under consideration. This is the subject of separate consideration"*. (P. 3 of DHSC0002309_053)

4.38. The records show that Mr France was to meet CBLA Vice-Chairman Mr Jerwood on 23 November 1984 [DHSC0002323_015] as part of calling CBLA to account for the overspend. Mr France reported on this meeting to Sir Ken Stowe the same day [WITN0771217]. Mr France also wrote to Mr Jerwood on 30 November 1984, copied to Mr Clarke's Private Office [DHSC0002323_098]. Mr France summarised the Department's concerns. It was noted that there would be a meeting with Ken Clarke then planned for mid-December. I have no reason to think that I would have seen these exchanges at the time, but they appear all to be part of officials' response to the concerns raised by Ken Clarke regarding the overspend and lack of costs control.

4.39. On 27 November 1984, I referred to the drive towards self-sufficiency in response to a supplementary question from David Sumberg MP [DHSC0002251_012]:

> *"Mr Sumberg: …Is he aware that there is increasing public concern that the NHS does not have sufficient funds and resources to combat and publicise the danger of patients contracting AIDS as a result of blood transfusions? If that is so, will he assure the House that sufficient funds and resources will be made available to the NHS?*
>
> *Mr. Fowler: Yes, I think that I can give that assurance. The Government are taking a number of actions. We are seeking to become self-sufficient in Factor 8 so that imports are no longer required. I very much hope that that will be done by 1986. My right hon. and learned Friend the Minister for Health has issued leaflets. Perhaps, most important of all, we are seeking ways to test blood donations. No screening test has yet been developed, but a pilot trial will be started in London in the next few weeks."*

On 28 November 1984, Ken Clarke also answered PQs on self-sufficiency from Nicholas Brown MP and Chris Smith MP: [DHSC0002251_014].

4.40. Lord Glenarthur met the Haemophilia Society again on 7 December 1984. Lord Glenarthur's subsequent letter to the Rev'd. Tanner of 12 December 1984 [DHSC0002249_015] noted:

> *"You asked me to confirm the Government's commitment to attaining self-sufficiency in blood products. The new production unit at the Blood Products Laboratory, Elstree, is still on target for completion in January 1986. The Department is aware of projected shortfalls in plasma procurement in certain Regions, and is discussing the matter with the Regional Health Authorities concerned".*

BPL redevelopment issues in 1985

4.41. On 18 January 1985, Alun Williams (of HS1A) provided briefing to Mr France and Ken Clarke's Private Office ahead of the planned meeting between Ken Clarke and the CBLA on 21 January 1985: [WITN0771049]. The briefing was copied to Lord Glenarthur's Private Office and that of the Permanent Secretary, but not to my Private Office. There was nothing exceptional in that. Ken Clarke had already intervened forcefully and was seeking to ensure that the need for better costs control was understood and CBLA were called to account, while the reality was that the additional funding (at least to a compromise level of £35.35m) was going to have to be found from central reserves. A letter from Mr France to Mr Jerwood dated 28 February 1985 set out the expectations going forwards following this meeting [DHSC0002323_027]. The sum of £35.3 million was agreed; it was made clear that it must be CBLA's determined aim to deliver the main production unit with that cash limit, maintaining firm management control over the project and alerting the Department to any development that could put the cash limit or timescale for completion in jeopardy. Mr France's letter was copied to the Minister of State's and Permanent Secretary's Private Offices.

4.42. Lord Glenarthur wrote to Tony Benn MP on self-sufficiency on 22 January 1985 in response to a letter from a constituent [WITN0771050]. Ken Clarke answered further PQs in February 1985: see [CBLA0002020, PRSE0003968, [DHSC0002261_043] and DHSC0002261_065]. On 23 May 1985, my Private Office was copied into a minute from our Press Office to Ken Clarke's Private Office concerning a request for Ken Clarke to appear on the World in Action programme in relation to haemophiliacs and AIDS [DHSC0002337_034]. It stated that: *"MS(H) can emphasise the Government's £35m investment, the fact that the building project is on target and that the Laboratory should be commissioned at the beginning of 1986. Although there can be no guarantee that we will achieve self-sufficiency by the end of that year, HS say that the problems over plasma supply have largely been overcome and Elstree are hopeful about meeting the demand*".

4.43. I can see from the available records that on 21 June 1985, Mr Harris of HS1 alerted Mr France to the further problems on the project costings from CBLA [DHSC0002333_033]. I can see that a draft brief for Ken Clarke for a lunch meeting with MHN (the design and build contractor) on 25 June 1985 raised concern at any delay which may occur in the completion date when expenditure had been accelerated on the project, at the expense of other projects in the NHS, in order to obtain as swift a result as possible [DHSC0002333_033].

4.44. This was followed by a submission to Ken Clarke on 10 July 1985 from Mr Harris: [DHSC0002311_024]. That submission sought approval for a revised cash limit of £38m and authority for officials to discuss further unavoidable expenditure on a quality control facility and warehousing. The estimated main building cost was now £31m with fees of £6.5m and heat treatment costs of £0.4m. It was said that a revised cash limit of £38m was probably a realistic basis for future control, and CBLA suggestions for reductions were thought to be mainly illusory. Mr France's covering note to Ken Clarke's Private Secretary [DHSC0002311_026] warned that the new figure remained an estimate and that the Department's Work Group put the outer limit at about £42m, excluding warehousing and quality control costs of up to £3m. He noted further that:

> *"2. There are some brighter spots. The CBLA is now properly organised, under Mr Jerwood, to control this project, and membership of the Authority has been strengthened on lines required by MS(H). Works Group have been able to bring the Authority's procedures under effective scrutiny. Most of the extra £2.7m on the cash limit is expected to arise in the current financial year, and Finance Division advise that the money can be found. No further Treasury approval is needed. The project itself is technically on course, and although expected completion has slipped from the end of 1985 to the first quarter of next year there are no major anxieties about it.*
>
> *3. At this stage in the project - 8 or 9 months from completion - I see no realistic alternative to approving the cash limit at £38m. MS(H)'s intervention earlier this year helped to bring the CBLA under control and to*

make them take the management of the project seriously. Its benefits, economic and for health, remain, and have been enhanced by the AIDS crisis. So I endorse the recommendation in Mr Harris' para 15."

Neither the submission nor Mr France's note appear to have been copied to my Private Office, which I do not find surprising for the reasons I have already indicated. Reflecting on matters now, and notwithstanding the justified concerns about overspend and cost control, it seems to me that Mr France's suggestion that that the CBLA had not been taking the management of the project seriously was a considerable overstatement of the position.

4.45. The records show that there then followed a series of exchanges about the revised cash limit of £38 million, including:

(1) Letter from Mr Harris to Mr Peet (Treasury), 23 July 1985 [DHSC0002273_011];
(2) Letter from Mr France to Mr Smart, CBLA Chairman, 23 July 1985 [WITN0771051];
(3) Minute from Mr Clarke's Private Secretary to Mr Cashman, 25 July 1985 [DHSC0002311_061];
(4) Response from Mr Harris to Ken Clarke's Private Secretary, 2 August 1985 [DHSC0002333_045];
(5) Further minute giving Ken Clarke's views, 8 August 1985 [DHSC0002311_059];
(6) Further submission from Mr Harris to Ken Clarke, 9 August 1985 [DHSC0002311_058]; and
(7) Response from Mr Peet to Mr Harris, 20 August 1985 [DHSC0002275_081].

Although I have not seen, in the records that are available, the final response to this series, it is apparent from later documents (see below), that the revised cost budget of £38m was endorsed in accordance with Mr Harris's submissions at around the time that Ken Clarke left the Department to become Paymaster

General. Later submissions show that the authorisation was given to CBLA on 17 September 1985.

4.46. I note that on 22 October 1985, Baroness Trumpington, who had succeeded Lord Glenarthur as PS(L) wrote to Baroness Masham to clarify and provide further information on the production of plasma by RHAs: [WITN0771052].

4.47. On 5 November 1985, Barney Hayhoe – who of course had succeeded Ken Clarke as Minister of State for Health – wrote to John Selwyn Gummer MP to address issues raised by GRO-A who was his constituent and who had recently been made a CBLA member: [WITN0771053]. He noted that a consequence of the fast-track design and build approach for BPL had been that the costs estimates at the start were much less firm, but that because of the importance of the project, the Government had authorised increased resource to enable it to be completed. On 12 November 1985, Barney Hayhoe also answered a PQ on self-sufficiency from Michael Shersby MP [WITN0771054]. His answer referred to the fact that the Government was already committed to achieving self-sufficiency in blood products and that "*when the new plant at Elstree is fully commissioned by the end of 1986, the Department will ensure that regions collect enough plasma to achieve this*". I see that the notes for supplementary questions indicated that:

> *"On the redevelopment of BPL's factory, previous PQ replies quoted completion "in January 1986"; this referred to building completion, which would be followed by lengthy process commissioning. This target date has now slipped three months, but it is still hoped to complete commissioning up to full production levels by the end of 1986"* [WITN0771055].

BPL redevelopment issues in 1986

4.48. Baroness Trumpington dealt with further appointments to the CBLA, see for example Mr Harris's submission to her of 14 January 1986 [WITN0771056]. Baroness Trumpington also agreed to a visit to Elstree planned for 12 June 1986 [WITN0771057].

4.49. A Departmental "position paper" dated 12 June 1986 from Dr Moore (HS1A) indicated further problems with the completion of the redevelopment: [DHSC0002303_018]. His review of the history included that:

> *"During 1985 it became apparent that although no further expansion of the scheme was taking place, the cost was apparently still rising and slippage of the completion date was occurring. At the Department's suggestion CBLA took on, in August 1985, a firm of project management consultants (BDP) to help in controlling the project. In September 1985 officials approved a revision to the cost limit from £35.2m to £38m which at that time appeared to be a realistic estimate of the final cost.*
>
> *The completion date slipped from an original prospect in November 1982 of July 1985, to an estimate in July 1985 of June 1986."*

Looking at the current position, Dr Moore stated:

> *"In May 1986 CBLA made a formal submission for the cost limit to be raised from £38m to £50m to take account of all known and projected requirements essential to completion. It is considered that this cost represents the present estimate of most likely outcome. There is still some design work to be completed so precise costing of some detail cannot yet be done. However the delay in completion has previously led to labour problems with critical sub-contractors. Allowance for possible disruption to the programme by this and other unknowns gives a £55m pessimistic forecast.*

Since November 1985 BDP have submitted detailed monthly cost reports and have itemised the expenditure. The project has become considerably more controlled. The continuing increase in estimated costs has been due to:-

a. *Essential modifications by the contractor to designs in order to meet the original specification. (A feature of design and build contracts).*
b. *Inaccuracies by the contractor in the previous estimates of amount, and cost of materials and equipment.*
c. *Previous omission of equipment essential to the functioning of the factory eg packaging equipment and standby generators.*
d. *Delays in actual construction because of the complexity of the plant and difficulties with special building techniques (covering walls with vinyl).*

Based on the latest report by BDP, CBLA now have a high degree of confidence in a completion date of mid-January 1987. Process commissioning is expected to lead to production in mid 1987 and production levels consistent with self-sufficiency during 1988.

Officials are preparing a submission to Ministers regarding the increase in cost limits."

4.50. The submission to Ministers was not in fact raised until 7 August 1986: covering minute at [WITN0771058], submission at [HSOC0003411]. On that date, Strachan Heppell put a submission ultimately addressed to Barney Hayhoe as Minister of State, but first inviting comment from Len Peach (of the NHS Management Board and by now the Accounting Officer) and from Baroness Trumpington. Barney Hayhoe was asked to approve a revised cost limit of £52m and indicate whether he wished to see the Chairman of CBLA personally, or for Mr Heppell to meet him, to emphasise the importance which Ministers attached to the management of the CBLA and to the problems created by the failings on the BPL project. I note here the involvement of Len Peach (appearing in the

post-Griffiths report management board who had taken over as Accounting Officer). Strachan Heppell was a civil service 'heavy weight' at Deputy Secretary level, who later appeared with Tony Newton, the CMO and I before the Select Committee in 1987 (see Section 6, below). My recollection is that Strachan Heppell had previously worked on the social security side of the Department and was brought over to the health side to strengthen its management; he was a very strong manager.

4.51. The submission [HSOC0003411] included the following explanation of recent developments:

> *"During 1985 it became apparent that although no further expansion of the scheme was taking place, the cost was still rising and slippage of the completion date was occurring. The inability of the management of CBLA to control all aspects of such a complex project was becoming a matter of increasing concern. At the Department's prompting they took on, in August 1985 a firm of project management consultants (BDP), to coordinate all management aspects of the scheme. In September 1985 officials approved a revision to the cost limit from £35.5m to £38m which at the time appeared to be a realistic estimate of the final cost. The subsequent investigations by BDP have revealed for the first time the extent of the cost escalation and the slippage in completion date: details which CBLA had not been able to fully extract from MHN themselves. Detailed monthly cost reports during 1986 have shown continuing increases in estimated costs due to:*
>
> a. *Essential modification by the contractor to designs in order to meet the specification and the reintroduction of essential equipment previously omitted to make immediate savings. Appendix 1 gives examples.*
>
> b. *Revision by the contractor of previous estimates of quantity and cost of materials and equipment.*

c. *Delays in actual construction because of the complexity of the plant and difficulties with special building techniques. These delays give rise to claims by sub contractors for extra payment for their work. Special measures such as weekend working may be needed to contain the programme slippage.*

d. *Additional MHN fees.*

As the inability of CBLA to control costs has emerged, the Department has been forced to diverge from the remit envisaged by Ministers and become increasingly involved with details of the project. CBLA have been put under considerable pressure from the Department to increase the effectiveness of their project management and to limit the escalation of costs."

4.52. On 12 August 1986, Sir Ken Stowe commented on Mr Heppell's submission to Len Peach's Office, stating:

"As the former Accounting Officer, I have no hesitation in saying that it was wrong (but in accordance with the Ministers policies at that time) for the De[p]artment to hand over total responsibility for this project: effectively, it had no "owner". That is not to say we would have spotted all the errors. But at least we should have been looking. This is, with hindsight, a simple failure to apply the principle of accountability." [WITN0771059]

4.53. On 13 August 1986, Baroness Trumpington's observation on the submission was that:

"My view is that this has been badly handled - no commercial enterprise would have got into this situation, neither could they have afforded to. Management must be tightened up and a very tough line taken. I cannot see why the delay is so long. I have seen the buildings which seem almost complete. I think that MS(H) should see the Chairman." [WITN0771060]

4.54. The next day, Barney Hayhoe's response to Mr Heppell was no less forthright. He said:

> *"What a shambles – the NAO and PAC should have a field day. Len Peach's detailed comments are awaited. Secretary of State should be kept fully in the picture."* [WITN0771061]

Barney Hayhoe wanted an early meeting to discuss the issue with officials.

4.55. One point which does not appear to be explained in the available records is what transpired between this response from Barney Hayhoe on 14 August 1986 and 29 December 1986 when – as I set out below – an updated version of the same Ministerial submission was prepared ready to be put to Ministers.

4.56. However, as I have mentioned at paragraph 4.2 above, one of the abiding recollections I have is of Ken Stowe coming to see me about the BPL overspend. He came to see me for an informal one to one discussion; I remember it because it was very unusual for him to ask to see me on that basis. My recollection is that he was no happier than anybody else at the cost increase but pointed out that the decision now was how to respond. From memory he said he was under some pressure to reduce the increase. Ken Stowe's view was that this would be wrong – a reduction in the cost limit could only put back the project and disadvantage haemophiliacs. I agreed with this argument and said that the cost increase should go ahead. The priority was to finish the factory and bring it into operation. Alarming though the very substantial cost increase was, I saw no viable alternative to it; it was important to see the project through. I think this discussion with Ken Stowe was around the time (following the 7 August 1986 submission) when the issue was an increase from £38m to £52m. However, I cannot rule out that it may have been around the time of the 29 December 1986 submission when the increase had escalated further to £56.5 million, and the submission was for £60 million.

4.57. In a submission dated 11 November 1986, Edwina Currie (who had succeeded John Patten as Parliamentary Under Secretary of State) and Baroness

Trumpington were asked if they were content with the proposed membership appointments and re-appointments to the CBLA, and I was asked if I was content to reappoint Mr Smart as the Chairman for 2 years [WITN07711062]. Baroness Trumpington was also asked to consider the appointment to a new Chief Executive post for the CBLA [WITN0771063]; it was noted that this role was one of the agreed outcomes of the CBLA Accountability review for that year, which Baroness Trumpington had endorsed. On 15 December 1986, I can see that my Private Office was being chased for confirmation that I was content with the re-appointment of Mr Smart [WITN0771064]; it seems that in the event re-appointment of Mr Smart was delegated to Baroness Trumpington, see the later minute from her Private Office of 23 January 1987 [WITN0771065].

4.58. On 29 December 1986, Mr Harris provided an updated version of the submission that had been raised on 7 August 1986 (this may be a late draft of the submission, it was later referred to as a submission of 30 December): [WITN07711066]. It was addressed to Mr Heppell and Mr Peach (as Accounting Officer), and then to Baroness Trumpington and Tony Newton (who was by now Minister of State for Health).

4.59. It is perhaps convenient to set the text of this submission out in full:

"1. This submission seeks Ministers approval for an increase (from £38.8 to £60m) in the capital cost limit for the new Blood Products Laboratory, Elstree. It updates the submission of 7 August 1986 which is attached as Appendix A. The laboratory is scheduled for completion in the first part of 1987.

Background

2. The history of the project and the factors which have contributed to the escalation in costs have been detailed in paragraphs 2 to 6 of the submission to Ministers of 7th August (Appendix A). Costs have increased further since that submission.

Current Cost Estimate

3. The cost limit now needs to be raised from £38m to £56.5m. This cost represents the estimate of most likely outcome. It shows an increase of £4.5m over the final cost estimated in the August submission. The latest increase is almost entirely due to reassessments which have been made of the necessary work required to enable the sub-contractors to meet their specifications. There have been no significant changes to the scope of the work.

It remains possible that other essential costs will emerge as the sub-contracts near completion. Although the estimate of final cost should be more accurate as completion approaches, a pessimistic forecast of £60m has been made to allow for unknowns.

CBLA have separately submitted a draft Approval in Principle request for a warehouse, quality assurance, and engineering building costing £7m. These are essential to the full functioning of the factory. Thus the cost of bringing the new production centre fully on-stream amounts to some £63.5m to £67m Appendix B summarises the financial history of the project.

Current Completion Date

4. Completion takes place in stages so that CBLA can start commissioning those areas which have been scheduled to be finished first. Commissioning of some parts of the factory has already started and it is anticipated that limited production will begin in the summer of 1987. The build-up to production levels consistent with self-sufficiency will be achieved during 1989. Appendix C summarises the delays in completion of the project: Despite these problems the building will still have been completed 2/3 years earlier than conventional methods would have allowed.

Recent steps taken by DHSS to improve control of the project

5. As the problem of increasing cost has emerged, the Department has had to diverge from the "hands off" remit envisaged by Ministers (see para

4 of Appendix A) and become increasingly involved with the details of the project in order to ensure that all possible steps were taken to control costs.

6. Most recently this involvement has included a meeting between senior officials, the CBLA chairman and the chairman of the contractor company (Matthew Hall). The meeting was constructive and agreement was reached on a range of procedures for ensuring that the final stage of the factory could be finished as soon as possible. Matthew Hall made out a strong case that the increase in costs was largely due to the complexity of the project which was underestimated at the tendering stage.

7. In addition officials now meet regularly with CBLA to ensure that no design amendments are made other than those essential for safe and effective production. Less critical work outside this category will be postponed until the main contract has been completed.

8. The fixed fee agreement negotiated with Matthew Hall was based on a completion date in early July. They are now losing money on the scheme. It would be inequitable for them not to get fair remuneration for their work. CBLA are in negotiation with Matthew Hall to agree additional fees. Officials will ensure any settlement has due regard for economy. Allowance for additional fees has been made in the costs at paragraph 3 above.

Benefit of the Factory and its Early Completion
9. The financial and other benefits of early completion set out in paragraphs 9 and 10 of the August 1986 submission remain valid.

10. The submission of 7 August (paragraph 12) set out a number of options but concluded that the only viable option was to complete the project as quickly as possible. The subsequent passage of time has made any option even less viable.

Cash Limit for 1986/87

12. Expenditure incurred on this project by the end of 1986/7 will be £10 million above the authorised cash limit. Ways have been found to accommodate this extra pressure. The cash limit needs to be formally adjusted to reflect this reality.

Cash Limit for 1987/88

13. Sums have been provisionally earmarked within the deposition of HCHS capital to meet the anticipated cost of completing this project. If Ministers approve a formal cash limit will be agreed with CBLA.

Improvements to CBLA management

14. The complexity of the project is the most important cause of the cost escalation. However the Authority could have exercised its role more effectively. During critical stages it was under resourced managerially. Only at the Department's instigation were consultants brought in to strengthen the client team. Steps have been taken to strengthen general management at the CBLA - a new chief executive takes up post on 12 January. Steps are also being taken to strengthen the Authority itself by bringing in new members of hopefully higher calibre.

Audit Interest

15. The National Audit Office have stated that they are likely to examine the project on completion. Public Accounts Committee scrutiny in 1987 or 1988 is therefore a possibility.

Recommendation

16. Officials recommend that the Revised Cost Estimate of £60m should be accepted. This option has demonstrable economic benefits for the NHS and maintains Ministers' intent to achieve self-sufficiency as soon as possible.

Decision Required

17. Are Ministers content that:

a) the cash limit for 1986/87 be adjusted; and

b) the necessary funds are allocated in 87/88."

BPL redevelopment issues in 1987

4.60. There appears to have been some delay in the updated submission being presented to Ministers. This was explained by Mr Peach in a minute of 4 February 1987 to the Private Offices of Baroness Trumpington and Tony Newton [WITN0771067]. The submission had been inadvertently filed by Mr Peach's office after he had cleared it on 12 January 1987. Mr Peach noted that it had already been necessary to authorise officials to make additional payments to CBLA *"... in order to safeguard Ministers' objective of achieving self-sufficiency as soon as possible (the building work would otherwise have had to stop)*". Mr Peach's note shows just how near we were to stopping building work and provides an obvious justification for going ahead in spite of the cost overrun.

4.61. On 20 February 1987, Baroness Trumpington minuted Tony Newton regarding this submission having discussed it with the officials concerned [WITN0771068]. She noted the following points:

"1. Since the submission was prepared costs have continued to increase. It is very likely that the main production facility will cost £60 million. In view of the complexity of this project it would be prudent to add an extra 5 per cent (£3 million) contingency allowance in case of problems emerging during the commissioning of the plant.

2. Thus taking account of the necessary ancillary projects listed in paragraph 3 of the submission the total cost could be in the order of £70 million. The ancillary projects will be built using conventional design and contractual procedures which give control over costs.

3. By the end of the current year, 1986/7, the total spent should be around £51 million. The amount needed in 1987/88 has already been pre-empted from HCHS capital allocations. Whilst the money has been found, the price

will be paid in terms of the projects which RHAs would otherwise have undertaken.

4. I am told that there are no clearly identifiable reasons for this escalation in cost. It is largely a result of the project being much more complex than a 'scaling up' exercise based on the old plant would have suggested. It is some small comfort that the new Chief Executive of the CBLA (who is not implicated in the project's history) has told officials that on the basis of a life time of experience in the pharmaceutical industry he would say that the building represents value for money.

5. The project is unlikely to be completed in the sense of placing the last nut and bolt before the end of May. However commissioning of major areas of the plant is expected to start in March and the Laboratory will be opened by the Duchess of Gloucester on 29 April. The start of production itself will depend on the extent of the teething troubles which I fear can be expected on a project of this complexity.

6. Given that there is no lessening of concern over AIDS and the particular plight of haemophiliacs I see no alternative to authorising the additional expenditure so that the scheme can be brought to completion as early as possible."

4.62. On 4 March 1987, Mr Harris sent a brief submission to Tony Newton's Private Office noting that the December submission was with the Minister of State but that it was urgent to regularise the position as the CBLA had overspent their present cash limit for 1986/1987 by some £8.6 million: [WITN0771069]. He sought Tony Newton's approval to increase the capital cash limit by this amount for 1986/87 pending his decision on the BPL project as a whole.

4.63. On 25 March 1987, Tony Newton's Private Office communicated his agreement to the increase in CBLA's cash limit, and that he would be meeting with Baroness Trumpington to discuss her minute of 20 February [WITN0771070]. I have not seen, within the documents available to me, a specific record of Tony

Newton's response to the December submission but it is apparent that by 3 April 1987 the submission had been agreed. A minute of that date refers to the fact that the submission had now been agreed: [WITN0771071].

4.64. The new production unit was officially opened on 29 April 1987 by HRH The Duchess of Gloucester. I made a statement at the time that:

> *"The Government has attached great importance to the goal of self-sufficiency and has used a fast-track contracting method to ensure that this complex pharmaceutical facility was completed as quickly as possible. It is only three years since I laid the Foundation Stone at the start of construction in March 1984.*
>
> *Over £55 million has been committed to the project and it has been estimated that once the new laboratory is fully operational it will be able to make products worth up to £60 million a year for the National Health Service.*
>
> *The complicated process of starting up the plant has already begun. Limited production will start later this year and next year should provide England and Wales with 75 per cent of their needs as the new plant begins to come fully on stream. Self-sufficiency will be completely achieved in 1989 and we will no longer need to rely on costly imported blood products.*
>
> *This new manufacturing unit at the Blood Products Laboratory represents a significant improvement to the Health Service. The people who have worked so hard to bring it to fruition and those who will work in it can be justifiably proud. The tremendously important role of our voluntary blood donors in the goal of achieving self-sufficiency in blood products should also not go unacknowledged. They have responded magnificently to the call from the National Blood Transfusion Service for more donations to ensure that the new plant will have sufficient supplies of the essential*

plasma to meet its demands." (Press Release of 28 April 1987 [DHSC0101068]).

4.65. So far as I can tell from the records available, the formal opening of the new production facility was the last significant element of the redevelopment chronology during my time as Secretary of State.

Particular issues raised by the Inquiry on BPL redevelopment and the CBLA

4.66. I have tried to set out the above chronology addressing matters wider than my own direct involvement not least because so many of the Ministers and senior officials who were involved have since died. Having set out the chronology in this way with the comments I have made above, I can deal more briefly with some of the particular questions raised by the Inquiry.

Knowledge of Self-Sufficiency Policy (Inquiry's questions 21- 24)

4.67. I strongly suspect that I did know about the self-sufficiency policy at least in general terms from my period as Opposition spokesman. However, I cannot recall exactly what level of detail I was aware of when I became Secretary of State taking over from Patrick Jenkin. What I do remember is that I certainly knew about the redevelopment of BPL and the need for self-sufficiency shortly after becoming Secretary of State when the Cabinet got down to reviewing public spending following the 1981 reshuffle. Every piece of spending was reviewed at that time and that would have included the £17 million planned for the redevelopment of BPL. In this spending review, there was fierce pressure for cuts in health spending. Although I do not have any direct recollection now, I must have agreed with the redevelopment of BPL and self-sufficiency because it was not given up as a saving at this time. It would be easy for the Inquiry to overlook the fact that, against the intense pressures to make cuts, the mere act of protecting existing spending plans was a significant positive decision at this stage.

4.68. I am asked whether I was aware of earlier statements made by David Owen. It should be remembered that ministers of one party do not have access to the papers of the party they are replacing. I cannot recall specific statements on the floor of the House although I have some recollection of Roland Moyle, one of his successors, coming under criticism for not putting the words into a definite policy. I do not have any knowledge of the extent to which substantial funds were devoted to bringing self-sufficiency into practice before the approval of funds that had been agreed shortly before I became Secretary of State.

Scottish facilities (Inquiry's question 25)

4.69. I do not believe that I was personally involved in consideration of the use of the Scottish fractionation facilities. Geoffrey Finsberg considered this in the submissions to which I have referred at 4.9 and 4.14, above.

CBLA (Inquiry's questions 26 – 27)

4.70. I have set out my involvement in the creation of the CBLA as a Special Health Authority in the chronology set out above. In effect I inherited the commitment to a Special Health Authority, which I supported on the grounds that it brought better coordination of policy and a proper concentration on the work of the authority.

4.71. The Inquiry asks me about Dr Lane's criticisms of proposed terms of reference for CBLA/BPL contained in a document dated 18 September 1981 [CBLA0001451]. I have no recollection of concerns of that kind being brought to my attention and the surviving records which I have seen do not suggest that this was raised at Ministerial level. Dr Lane's comments are broad in nature and I do not think it is realistic for me to seek to comment on whether *any* of these problems transpired following the CBLA's establishment. However, there was no "political interference" in CBLA activities during my time as Secretary of

State. Nor is it at all clear what Dr Lane means. It appears that Dr Lane was referring to the following part of the description of BPL's role:

> "*The main tasks of the Blood Products Laboratory and the Plasma Fractionation Laboratory are:*
>
> *i. to prepare plasma fractions for therapeutic, diagnostic and other use in accordance with the requirements of Good Manufacturing Practice and in the quantities that management shall from time to time determine;*
>
> *ii. to undertake research and development in plasma protein fractionation and related fields, production technology and plant design;*
>
> *iii. to undertake such other activities, including collaboration with industry, as can in the Secretary of State's opinion conveniently be carried on in conjunction with the foregoing."* [CBLA0001639]

From my general experience, I would not see sub-paragraph (iii) in the above quotation as opening the door to political inference as Dr Lane appears to have apprehended. Rather, the wording at (iii) is the typical type of language used to ensure that an Authority's area of competence was not too narrowly prescribed, so that that its activities could be adapted to meet future changes.

NHS Reforms (Inquiry's questions 28 – 30)

4.72. I have touched on the wider NHS reforms which we implemented in my introductory comments.

4.73. I am asked to what extent these reforms affected the objective of achieving self-sufficiency in blood products; a letter from Mr Smart of 3 January 1984 is referred to in this regard [NHBT0000467].

4.74. The management reforms of Roy Griffiths proposed in 1983 were basic to my period of office. Rather than having yet another reorganisation of the NHS, I came to the view that we should concentrate upon better management of the resources that were available to us. This affected every part of the health service. For example, had we had this priority earlier then it is possible that we might have forecast spending on the BPL more accurately and also avoided some of the cost overrun. Cost overruns in other areas could have the effect of forcing economies elsewhere in the health service. However, Ministers maintained the construction of the factory in spite of the cost overrun because of its priority for the benefit of haemophiliacs. Good management is basic to every part of the NHS.

Redevelopment of BPL (Inquiry's questions 31-33)

4.75. I have set out a chronology of events above, which refers where possible to the contemporaneous documents which in turn explain the oversight that we had at Ministerial level. Surviving members of CBLA and DHSS officials will be able to expand upon the committees and meetings that lay behind the matters being raised at Ministerial level.

4.76. The Inquiry invites me to reflect on the BPL redevelopment and asks whether, using my wider experience of government, I can identify reasons why the policy objective of self-sufficiency was not achieved sooner.

4.77. As events in fact transpired, the key dates in reducing HIV transmission through blood products (and also HCV infection) were the introduction of heat treatment in imported blood products (by December 1984) and in domestic blood product production (by April 1985). I take those dates from what was subsequently conveyed to me by the CMO (see paragraph 6.75, below). It follows that in order to impact materially on the transmission of HIV through blood products, self-sufficiency would have to have been achieved (or significantly achieved) earlier than April 1985.

4.78. Realistically, the only way that the redevelopment of BPL could have been completed before April 1985 was if the decision to fund its redevelopment had been taken much earlier, that is to say in the 1970s, instead of in the months just before I became Secretary of State. As I have noted in paragraph 4.3. above, it was only on 18 June 1981 (about 3 months before I became Secretary of State) that Patrick Jenkin had agreed that, if necessary, RHA capital allocations could be top-sliced to pay for the redevelopment of BPL (cost then estimated at £17 million) and that detailed planning could now proceed.

4.79. In my tenure, we put that decision into effect and got on with the redevelopment of BPL. Even with the fast-track building approach that was taken, the original completion date was expected to be in the summer of 1985. Even if this had been met, it would have been too late to affect the levels of HIV transmission. So, again, what would have been needed was for the 'green light' to the full redevelopment of BPL to have been given much earlier than the summer of 1981.

4.80. I cannot comment on why this had not occurred as it relates to the earlier administrations of the mid to late 1970s[6], and Patrick Jenkin's period in office.

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[6] In this context, I note in passing the frustration that Baroness Trumpington may have felt when replying to Lord Ennals in the Lords' debate on 24 July 1985, when she said *"My Lords, I really think I have answered the noble Lord, Lord Ennals. As a past Minister for the DHSS, he should know that perhaps in his day more could have been done to bring up the amount of blood products."* Lord Ennals replied: *"My Lords, neither the Noble Baroness nor I had heard of AIDS when I was Secretary of State"*: [DHSC0002273_013].

4.81. The problems encountered in the redevelopment of BPL during my own tenure as Secretary of State principally manifested themselves in the very marked overspends on the project. However, at every point, we put the goal of achieving self-sufficiency ahead of financial concerns (despite all the Treasury pressures). In short, we continually found the extra funding to keep the redevelopment project live. The £60 million to which the cost limit was amended in 1987 equates to about £180 million in today's money. I would wish to emphasise the very considerable level of investment that this represents, particularly given the financial pressures on health spending. As I have indicated, it was my personal decision to continue with the work after the particularly big increase was raised with me in the discussion with Ken Stowe.

4.82. Notwithstanding that we kept finding additional funds, the considerable overspend reflects poorly on the Department; the accounting officer had his own responsibilities for this but, as with other areas, it was I who was ultimately accountable to Parliament. From the various reports and minutes to which I have referred above, it is likely that the original cost estimates for the project were significantly unrealistic. Other aspects of the increase will have related to changing specifications as the project developed; it is an almost inevitable feature of complex construction projects that the final cost is genuinely difficult to estimate until you are well into the project itself, because some aspects are only discovered part way through (I have more recent experience of this in Westminster). But in other respects, the overspend undoubtedly reflected poor project management and a lack of adequate financial control, as Chris France's report to Ken Stowe acknowledged.

4.83. I note that by August 1986, Ken Stowe was putting the blame for the marked overspend/lack of financial control on Geoffrey Finsberg's much earlier decision, in November 1982, not to have a DHSS member on the BPL redevelopment steering body (see paragraphs 4.18 and 4.52, above). As I have made clear, I have the very highest regard for Sir Ken Stowe. However, as I look at it now, I am somewhat sceptical about his attribution of fault on this point. Not having a DHSS member on the redevelopment steering body should not have prevented adequate monitoring of the project costs by DHSS. It should

not have meant the Department adopting a "hands off" approach as it was characterised in later submissions. We after all influenced all kinds of spending in the NHS without having an official on the body involved. Moreover, in 1982, Sir Ken did not appear to view this as a point of principle even if his own inclination, on balance, was to go along with having a DHSS member on the redevelopment project steering group (see paragraph 4.17, above). Ken Stowe did not think the issue was of sufficient concern to raise it with me in November 1982. I think it would have stood out in my recollection if he had done so. Instead the issue seems to have been determined in the meeting Sir Ken had with Geoffrey Finsberg on 24 November 1982. The point remains that the costs were poorly controlled, but the (considerable) extra funds were found. This means the redevelopment was prioritised over other pressing needs. As Chris France had made clear, *"…finance is tight; something else must give to accommodate the excess on the BPL"*: [DHSC0003964_029, para 3].

4.84. In addition to the cost overspend, the completion date for the redevelopment of BPL did slip quite considerably. This slippage was tabulated in the December 1986 submission at Appendix 4: [WITN07711066]. From the summer of 1985 as originally projected for the building completion, the formal opening ended up being in very late April 1987, although the build up to full self-sufficiency was projected to take longer still (into 1989). As to this slippage of completion dates:

(1) As I have noted above, even if the redevelopment project had run to time with completion in the summer of 1985, this would still have occurred only after heat treatment had been introduced. What would have been required was the whole redevelopment project getting the green light years earlier.

(2) As reported, the delays in actual construction were said to be *"… because of the complexity of the plant and difficulties with special building techniques"*: [HSOC0003411, para 6c].

(3) The 29 December 1986 submission to Ministers, while outlining the delayed completion date, made the point at §4 that *"despite these*

problems the building will still have been completed 2/3 years earlier than conventional methods would have allowed": [WITN0771066].

4.85. The Inquiry asks about my knowledge of, and involvement in, the DHSS steps to increase plasma supply. The submissions to which I have referred in the chronology are the best guide to this. Clearly it was going to be necessary to increase plasma supply as well as the capacity to fractionate the plasma. In setting out the chronology I have referred to the emphasis given to the need to increase plasma production. Ministerial statements – including mine on the laying of the foundation stone – did refer to the importance of ensuring adequate supply of plasma and, for example, Lord Glenarthur referred in December 1984 to the discussion the Department was having with some RHAs where there were projected shortfalls in particular areas. However, I would not have been involved in the detail of this. While plasma supply had to be increased, I am not aware of inability to meet the projected plasma requirements being raised as a significant concern with the other Ministers, still less escalated to me as Secretary of State.

RTCs and RHAs (Inquiry's questions 34 – 35)

4.86. I am asked about my experience of how much influence I and the Department had on RHAs' and RTCs' allocation of resources. In general terms, my recollection is that the Department did have quite substantial influence on how RHAs allocated their resources. I had regular meetings with the RHA chairmen. They were to an extent my "cabinet" where any issue of concern could be raised. Early on, I tried to change the emphasis of their recruitment towards men and women with business experience, not as a reward for past political service. They also of course needed a knowledge of their region and we wanted to avoid them being be too London-centred. However, to the best of my memory I do not remember policy on blood issues being raised – or at least not extensively raised – at these meetings. Spending would have been inside regional allocations. That would have been the usual policy leaving a certain amount of discretion to individual authorities – otherwise we would have been making all the decisions for them at the centre.

4.87. From my own direct involvement and recollection, I am not able to assist the Inquiry on whether at any time special funding was made available outside of the RHAs' allocation for the purchase of commercial factor products.

Summary

4.88. Reflecting on this part of the Inquiry's request, in summary I would wish to stress the following:

(1) What would have made the difference to achieving self-sufficiency significantly earlier (before heat treatment was in fact introduced) would have been for government to have given the funding green light to BPL's redevelopment much earlier i.e., in the late 1970s not in the three months just before I became Secretary of State;

(2) During my tenure as Secretary of State, we kept finding further funds to keep the redevelopment project going. The cost of so doing was very considerable (in the order of £180 million on today's money) but we found those funds from the DHSS budget, necessarily at the expense of other priorities;

(3) The overspend on the project reflects poorly on the Department's management of the project, although the costs were probably underestimated from the outset;

(4) I am sceptical about Sir Ken Stowe attributing blame for the overspend to Geoffrey's Finsberg's decision not to have a DHSS member on the redevelopment steering group. It should have been better monitored whether or not there was DHSS membership on that group.

SECTION 5: HEPATITIS B VACCINATIONS

HBV vaccinations (incorporating the Inquiry's questions 36 – 37)

5.1. I am asked about Hepatitis B ("HBV") vaccinations in the period 1982 to 1983. Based on the available records and to give context, I am going to start with a chronological account of the papers at Ministerial level, before moving to address the Inquiry's questions about my own personal involvement. Once again, nearly 40 years after the events, it is impossible for me to construct accurately what I did or did not know at a given time. I do not now recall having

any personal involvement in the issue of HBV vaccines, and the documents show that this was principally handled at Minister of State level. The documents do not suggest that I saw reason to intervene on this issue. I have sought to offer assistance and comment where I can on the specific questions raised by the Inquiry. I must stress, however, that in doing so I cover some submissions and other documents that do not appear to have been copied to my own Private Office at the time.

Consideration in 1982 of Merck Sharpe and Dohme's HBV vaccine

5.2. On 21 April 1982, the American drug company, Merck Sharpe and Dohme ("MSD"), wrote to Ken Clarke about their new HBV vaccine [DHSC0001728]. The letter refers to the company producing a briefing for me. I do not know if the letter is referring to a face-to-face meeting or some sort of written document. I have not been shown any documents that relate to this briefing and cannot now recall anything about it. The letter formalised an offer to supply the UK with 300,000 vaccine doses.

5.3. I am asked about a planned visit by me to MSD's HBV vaccine manufacturing plant as part of my planned visit to the USA, which the letter says did not go ahead. I have a diary entry from 19 April 1982 which reads, *"Lunch at Number Ten*[7] [WITN0771072]. *I was due to be in the United States this week to try to bring some internal investment from American pharmaceutical companies but we have obviously cancelled the trip..."*. The reason my trip to the USA was cancelled was because of the Falklands war; Cabinet Ministers were obviously expected to be available in the UK. The USA visit was intended to promote inward investment in the UK by US pharmaceutical companies. The idea had been to persuade US companies to base more of their activities in the UK to the advantage of employment - a crucial issue at this time and obviously since. The skills of British professionals, researchers and other staff in this area were widely recognised throughout the world. DHSS was the sponsor department of

[7] The Prime Minister had regular Monday lunches with Cabinet Ministers; this was one of them.

the UK pharmaceutical industry which had its problems later on (see section 8, below) but on inward investment there was general agreement.

5.4. On 26 May 1982, Dr Geffen sent a minute to Ken Clarke's Private Secretary, Robert Venning [DHSC0001724]. The minute was copied to Mr Clark, my own Principal Private Secretary. The minute started by referring to the attached submission and the need for decisions from Ministers on the use of "*...a new and expensive American vaccine against hepatitis B infection*". Dr Geffen noted that the Joint Committee on Vaccination and Immunisation ("JCVI") had in the previous month recommended that the vaccine should be given to certain defined groups. He said implementation of JCVI recommendations would involve considerable resource implications.

5.5. Dr Geffen 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. However the vaccine has been licensed for use and will be available on prescription if the manufacturer decides to make it generally available in this country. 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 to ensure that it is used only for the high priority groups*".

5.6. The minute attached a ministerial submission [DHSC0001726] and a summary of the JCVI's recommendations [DHSC0001726, pp. 6-8]. The latter set out which groups of people fell in the "higher priority group" and which in the "lower priority group". Patients receiving regular therapy with blood products or other products capable of transmitting hepatitis B infection were one group in the Category 1 (higher priority) group.

5.7. The submission's opening summary noted that the vaccine would be "... *very expensive, in short supply for at least a few years, and subject to competing*

claims from groups of individuals considering that they should have priority": [DHSC0001726, para 1].

5.8. The submission flagged that an urgent decision was required on MSD's offer to supply 300,000 doses. It also noted that I was due to meet John Horam, President of MSD, on 9 June 1982 when the issue would be likely to be raised.

5.9. The Inquiry has asked me specifically about this planned meeting with Mr Horam. I have no independent, personal recollection of this matter. I expect that a meeting in the UK with Mr Horam may have been arranged because my earlier trip to the US (in which a visit to the MSD manufacturing plant was one planned part) had been cancelled. I have seen a minute of 8 June 1982 stating that the meeting in the UK with Mr Horam had been cancelled [WITN0771073] and a later minute of 10 June 1982 which noted that, "*the Secretary of State did not see Mr Horam on 9 June, and no plans for a meeting have been made*": [DHSC0001718]. Based on these records, therefore, it seems clear that I did not meet Mr Horam. I do not know why the UK meeting did not go ahead.

5.10. I understand from the papers that MSD was the only HBV vaccine available at the time. Dr Geffen's submission made reference to research, in the UK and abroad, into new methods of producing the vaccine, commenting:

> "*5 …It is too early to say whether this research will succeed in producing a much cheaper vaccine, but there is some possibility of success within the next three to five years. The Department has given considerable financial support to research into hepatitis B vaccines, and has recently given some money towards developmental work on a new British vaccine*": [DHSC0001726, p. 2].

5.11. The submission set out four groups at increased risk of contracting hepatitis B, which included health care workers and patients who receive regular treatment with blood or blood products. It was said that views as to which categories should be given priority were likely to vary. Reference was made to the fact that

health service staff and unions were particularly concerned by HBV and would make strong demands for staff vaccination.

5.12. Under the heading costs and benefits, the submission noted that:

> *"13. The vaccine is highly effective in preventing hepatitis B infection, but its use in the two priority groups would only prevent a small fraction of all cases of hepatitis B. Although individuals in the priority groups have an increased risk of contracting hepatitis B, the great majority of reported cases do not occur in the two priority groups. Because of this, and because the vaccine is so expensive, the cost of prevention is very high; possibly £25,000 to prevent each case of hepatitis, £500,000 to prevent each case of chronic liver disease and £3 million to prevent each death*": [DHSC0001726, p. 4].

5.13. Four policy options were set out: (i) discourage the manufacturer from supplying to the UK; (ii) discourage use of vaccine as a poor use of scarce NHS resources; (iii) ask the manufacturer to supply hospitals on an equitable geographical basis and to limit distribution to a pre-determined number of doses and then leave health authorities to decide local policy on use, with assistance from the JCVI advice ('attempted limitation and control'); and (iv) publish JCVI advice with or without a Government recommendation that the vaccine be used for one or both groups.

5.14. Dr Gefffen's recommendation was as follows:

> "*15. In view of the high cost of the vaccine, the lack of unanimity over the medical indications for its use, and the widespread concern about hepatitis B infection among health service staff and unions, it is inevitable that any of the policy options outlined will give rise to criticism and difficulties. Option (iii) – attempted limitation and control – would seem the most attractive option but would be dependent on the cooperation of the manufacturer and the health authorities*": [DHSC0001726, p. 5].

5.15. On 7 June 1982, Mr Venning replied to Dr Geffen with Ken Clarke's response to the submission [DHSC0001723]. This was copied to my Private Office. Ken Clarke's response was as follows:

> "*The whole thing strikes me as far too expensive. I am impressed by a cost of £3.3 million in the first year only to cover a limited number of high priority cases. Even then we will not prevent the majority of hepatitis B cases apparently. £3 million to prevent each death is given as the cost of full use of the vaccine. No PESC or other financial provision appears to have been made for the use of the vaccine.*
>
> *I would like to say "no sale" in the friendliest possible way to the Company marketing the product. We should do everything possible to discourage its use in this country. The positive policy must be to press on to produce a British product at a more realistic price."*

5.16. I have been shown various minutes which circulated amongst officials on 8 June 1982: see [WITN0771073]. The minutes were concerned with how to communicate the Minister of State's decision to MSD and the JCVI. There was a further minute on 10 June 1982 [DHSC0001718, p. 2], which expressed concern about one of the policy options in Dr Geffen's submission, namely discouraging MSD from marketing the vaccine in the UK at all. The minute's author, B W Taylor, considered this was an unwarranted limitation on the freedom of health authorities. None of these minutes appear to have gone to my Private Office.

5.17. On 29 June 1982, Ken Clarke wrote to MSD saying:

> "*Whilst the disease can in some instances be a very serious one, it has a low overall incidence in this country and, though several groups with increased risk can be identified, there is no group with an exceptionally high risk. In order to stand a good chance of reducing the number of cases contracted in this country we would therefore need to vaccinate extremely*

large numbers of people and the cost of preventing a small number of cases would be very considerable.

We are grateful to you for offering a supply of the vaccine and for being helpful in explaining what quantity we might expect to be made available in the near future. I am afraid however that we must decline since we do not feel that the purchase of the vaccine could rank highly amongst the many claims on limited NHS resources at present": [DHSC0001715].

5.18. On 12 July 1982, Mr Collier minuted Ms Stuart about a conversation with MSD [DHSC0001712]. The minute does not appear to have been copied to my Private Office. Mr Collier reported that in response to the rejection of the offer MSD had cut their supply from 300,000 to 50,000 doses. MSD were reported to have agreed not to advertise the vaccine to GPs or hold a press conference, which I understand to have been in response to the Department's request for the vaccine to be given a low profile. On 13 July 1982, MSD replied to Ken Clarke's letter, expressing regret at the decision and hoping to be able to discuss it in future. They noted that the greater part of the UK allocation had been released to other European countries. They noted that other than normal communication to the medical profession, "*...our professional information activities with respect to the vaccine will be limited*" since they did not wish to prejudice their excellent relationships with successive Governments: [DHSC0001711].

5.19. On 16 July 1982, Miss Stuart minuted Mr Venning (PS/Ken Clarke) and attached Mr Collier's minute of 12 July 1982 (with a copy sent to my Private Office): [DHSC0001710]. Ms Stuart noted the Minister of State's wish to discourage use of the vaccine. This would need to involve taking positive steps, such as issuing a Health Notice to GPs and health authorities. Ms Stuart advised that because of the smaller quantity of supply and MSD taking a low profile it no longer seemed necessary to take such action.

5.20. The minute went on to note that:

> "*MS(H) also said that he thought 'the positive policy must be to press on to produce a British product at a more realistic price'. He may like to know that Professor Zuckerman's research has recently suffered a potential set back when British Technology Group withdrew funding at short notice. The Department has agreed to make up the small sums involved - less than £15,000 this year and £30,000 next year - so that the work can continue. There is however no guarantee that the resultant British vaccine would be any cheaper than the MSD one*".

5.21. By a minute dated 22 July 1982, Ken Clarke's Private Office confirmed to Ms Stuart he was content to take no further specific action but wished to be involved straight away if there was any sign of press or political interest [DHSC0001708]. This response was copied to my Private Office.

5.22. On 27 July 1982, Ms Stuart minuted Dr Geffen and Ken Clarke's Private Office with a draft reply to MSD's letter to Ken Clarke of 13 July [DHSC0001707]. The minute does not appear to have been copied to my Private Office. Ms Stuart explained that the Department had received queries from practitioners about availability of the vaccine, in particular for healthcare staff. She suggested general guidance could be given by way of an article in the Prescriber's Journal and attached a draft paper headed "*Suggested line to be taken in guidance for RMOs*": [DHSC0001707, p. 3].

5.23. On 4 August 1982, Lord Trefgarne wrote to MSD on Ken Clarke's behalf in line with the draft response that had been prepared. He expressed thanks to MSD for informing the Department of how they intended to manage supply to the UK and for not adopting an aggressive approach to marketing the vaccine in the UK: [DHSC0001704].

5.24. On 20 August 1982, Ms Stuart put a further submission to Ken Clarke's Private Office on the HBV vaccine, addressing an article in the Nursing Standard: [DHSC0002309_071]. Ms Stuart advised that although the article did not call for

a reply, there was a risk a future article might criticise the Department's stance. She suggested the issue of guidance to health authorities needed to be resolved and asked if the Minister was content with the line suggested in the paper attached to her minute of 27 July 1982. Ken Clarke responded to this via his Private Office on 23 August 1982 [DHSC0002309_015].

5.25. On 8 October 1982, Dr Ian Field sent a minute to Dr Harris and Ken Clarke's Private Office regarding guidance to the NHS concerning priority groups for receipt of the vaccine [DHSC0002221_030]. This was copied to my own Private Office. MSD would shortly be releasing the vaccine in very limited quantity, enough for 15,000 people. Dr Field noted that in September, Ken Clarke had agreed the proposed line for disseminating JCVI guidance to RMOs and individual enquirers. The submission referred to the previous policy decision not to include the HBV vaccine in the UK's schedule of public policy vaccinations because of its high cost. Dr Field went on to say:

> *"It is clear now that wider distribution of the JCVI guidance, which is based on recommendations from the Advisory Group on Hepatitis, is necessary. The Advisory Group at its meeting this week recommended most strongly that the guidance be circulated within the NHS. With the assistance of the Advisory Group those meriting highest priority have been defined and are set out in the Appendix of the attached draft CMO/CNO letter. Because of the low incidence of the disease even in the high risk groups, advice is given that the vaccine should be limited to specific individuals at special risk within these groups. The text has been drafted with a view to avoiding Trade Union criticism, especially from the ASTMS, that the vaccine will not be liberally available to all their members who might be at risk.*
>
> *As pressure is mounting for early guidance, we should like to issue the CMO/CNO letter next week. It is not intended that its issue be publicised by the Department."*

5.26. The letter from the CMO (Sir Henry Yellowlees) and Chief Nursing Officer (Mrs Poole) was circulated on 15 October 1982 [WITN0771074]. The CMO/CNO

letter attached a summary of the latest JCVI's recommendations [WITN0771074, p. 2] and said:

> "*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 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.*"

HBV Vaccine issues in 1983 and early 1984

5.27. The Inquiry has referred me to correspondence between DHSS and the Association of Scientific Technical and Managerial Staffs ("ASTMS") trade union. On 12 May 1983, Clive Jenkins, General Secretary of ASTMS, wrote to me with questions about the safety of MSD's HBV vaccine and – against the background of public concern about AIDS – asked for a guarantee the vaccine was without risk [DHSC0001657]. Mr Jenkins referenced an earlier exchange between ASTMS and Dr Harris.

5.28. On 31 May 1983, Dr Harris provided a draft reply to this letter to Lord Trefgarne's Private Office. Dr Harris noted that he had discussed it with Lord Trefgarne. The draft reply repeated the point made previously about the CSM having carefully assessed the vaccine and it continued to be monitored for safety by the CSM [DHSC0001656]. It also pointed out it was unrealistic to ask for a guarantee the vaccine was without any risk.

5.29. In April 1983, Geoffrey Finsberg wrote to Richard Page MP in reply to a letter sent to me on behalf of his constituent [DHSC0002225_026] (this may be a late draft of the reply). The reply noted that the development of a British HBV vaccine was being given high priority and supported by the Department's research budget. Research was being carried out at the London School of Hygiene and Tropical Medicine ("LSHTM"), by Professor Zuckerman. The letter noted "*there is no prospect of producing a fully licensed British vaccine in 12 months*".

5.30. On 8 June 1983, Lord Trefgarne wrote to Sir Brandon Rhys-Williams again in reply to a letter sent to me on behalf of a constituent [MACK0002663_067]. Lord Trefgarne's reply explained that the Department's advice on use of the HBV vaccine was formulated against a background of limited supply of an expensive vaccine and where the overall incidence of disease was low. He further explained that the decision to prescribe was essentially for the individual doctor, but the JCVI recommendations had defined very carefully the categories of people who should receive priority. He noted that "*the distribution of limited resources presents formidable difficulties and, where medical considerations are involved, Ministers must look to their expert medical advisers to provide guidance on the best way of using the resources available*."

5.31. On 31 August 1983, Dr Field minuted Dr Harris, the DCMO, on the subject of a British plasma derived vaccine against HBV [WITN0771075]. Ministerial Private Offices were not copied in. The minute was concerned with whether to reconsider the Department's continued financial involvement in the London School of Hygiene and Tropical Medicine research. The reasons were: (i) doubts about the efficacy of the underlying technology and (ii) concern about possible risk of transmission of AIDS by plasma derived vaccines.

5.32. As to Ministerial involvement, the minute said:

> *"Because of Ministers earlier expectations of this project, expressed at the time when we were considering the introduction of the US vaccine, it is clear that we shall have to update them on the matter and seek their agreement to the proposed scientific review."*

5.33. Dr Field's minute attached a draft submission to John Patten: [WITN0771076]. The Department had contributed £167,000 to date. The draft summary of the present situation included the following:

> "*In June 1982, in considering the importation of the US vaccine which is priced at £72 per individual course – expensive enough to warrant Departmental guidance on the high risk groups to which it might be offered*

– the Minister for Health stressed that our positive policy must be to press on to produce a British product at a more realistic price. This has guided officials in their discussions with those working on the product, and with the British Technology Group.

11. However, in recent weeks it has become increasingly clear that the inactivation operations (explained earlier), which had not been perfected fully before starting the transfer of the technology from the London School to the Centre for Applied Microbiology & Research, was giving more trouble than had been anticipated. It is estimated now that the perfection of these operations may take at least a further year": [WITN0771076, p. 5].

5.34. The draft submission also referred to problems transferring the technology from LSHTM to PHLS (who were to be involved in preparing the research for commercial exploitation); British Technology Group could find no commercial entity that was willing to embark on commercial exploitation of a plasma derived vaccine (due to concern over AIDS transmission); and, very recent reports from abroad that a recombinant vaccine might be available commercially in 1985. An independent review of LSHTM's work on an HBV vaccine was recommended.

5.35. Dr Harris replied to Dr Field by minute dated 1 September 1983 (again, not copied to Ministerial Private Offices): [WITN0771077]. He considered a Ministerial submission to be premature. He proposed a meeting to decide whether to continue support of the LSTHM/Professor Zuckerman research, in light of concern about AIDS and the new research into a recombinant vaccine.

5.36. The Advisory Group on Hepatitis ("AGH") met on 18 October 1983: [BPLL0008168]. Ministers would not have routinely seen minutes of this kind. Professor Zuckerman provided an update and the AGH discussed progress on manufacture of a British HBV vaccine. The minutes record:

"*There was discussion on the desirability of producing a British hepatitis B vaccine and it was agreed that it was desirable that a hepatitis B vaccine*

should be produced in Britain but that the vaccine should be produced using the most up-to-date technology available.

After discussion of the problems of, and likely time-scale for the bulk production of the plasma-derived vaccine developed at the LSHTM; the lack of interest expressed by British vaccine manufacturers; other developments in the field of vaccine technology, as well as the fears consequent on the appearance of AIDS, it was agreed that support by the Department would be better directed to the development of hepatitis B vaccines utilising the newer biotechnology rather than to continue further work on the plasma-derived product."

5.37. From the available papers it seems an update to Ministers on progress of a British vaccine came on 2 December 1983: [WITN0771078]. Ms Edwards put a submission to Dr Harris and Ken Clarke's Private Secretary, which was not copied to my Private Office. The submission recommended withdrawal of funding from Professor Zuckerman's vaccine research:

"5. *Officials have concluded that the Department should no longer support the development of a plasma-derived Hepatitis B vaccine for routine use and that no further encouragement or finances should be directed to this end. Professor Zuckerman's basic research in hepatitis generally and in micelling will continue to be encouraged and considered for further research funding. While no guarantee can be given that there will be a British Hepatitis B vaccine in the foreseeable future, it is a distinct possibility. But the pace of such a development will be governed by the interest of the British Pharmaceutical Industry.*"

5.38. A subsequent minute from Ms Edwards dated 13 January 1984 (copied to Ken Clarke's Private Office though not mine) attached a note which referenced the fact that Ken Clarke had agreed to discontinue this funding. This was a decision taken *"… in the light of advice from an external group of scientific experts who were unanimous in their view that the project had been overtaken by events…"*: [DHSC0002237_086, DHSC0002237_087].

5.39. I should add that in a further correspondence with the ASTMS dated 18 January 1984 [HSOC0001419], Lord Glenarthur stated:

> *"Concerning the MSD plasma derived hepatitis B Vaccine, the Department accepts that the standards of safety in the manufacture of the vaccine should ensure that there is no transmission of any putative agent causative of AIDS; yet acknowledges, with you and the medical research community in general the substantial scientific problems of conclusively proving this in the absence of a definite identified causative agent.*
>
> *The Department also shares your view that we should not expect plasma derived hepatitis B vaccines to provide a long-term solution but rather should expect this to be provided by biotechnologically manufactured alternatives eg genetically engineered or synthetic oligopeptide products. We have reached this view not just because of the AIDS problems, but have taken note of the world-wide developments in biotechnology generally. To this end the Department is encouraging (under the auspices of the British Technology Group) a collaborative project involving a DHSS funded research group and the University of Uppsala, Sweden into synthetic vaccine production in general and including Hepatitis B work in particular"*: [HSOC0001419, para. 7]

5.40. Against this chronology, I turn to specific further questions raised by the Inquiry on HBV vaccines in this period.

Ken Clarke's minute of 7 June 1982 (Inquiry's question 38)

5.41. I am asked about Ken Clarke's policy decision, communicated by Mr Venning's minute of 7 June 1982 [DHSC0001723], not to accept MSD's vaccine offer. I do not have any independent, personal recollection of how policy on this issue developed and am reliant on the documents made available. As I noted above, my Private Office was copied into the key ministerial submission of 26 May 1982 [DHSC0001724] and also into Ken Clarke's decision.

5.42. As to the reasons for the policy, in particular the desire to discourage use of the vaccine in the UK and instead pursue a British vaccine I would note as follows:

(1) The JCVI's recommendations were that any available vaccine should be prioritised for two priority groups. The supply MSD proposed to make available would not have been sufficient to cover both categories.

(2) Dr Geffen's advice was that use of the American vaccine in the two priority groups would prevent "*only a small fraction of all cases of hepatitis B*" [DHSC0001726, para. 13]. Purchase of MSD's full offering was not considered, as a matter of health economics, to be a good use of scarce NHS resources.

(3) I cannot speak for other Ministers, but it seems to me that (in line with the advice of officials) the decision was taken that if the vaccine was made widely available and prescribed in the UK without restraint, then the NHS would inevitably have been required to meet the cost. Even if restricted to the priority groups, the cost of this was assessed as being disproportionately high. It is always difficult – seen in isolation – to justify a refusal to fund new treatment. The process for making cost-benefit judgements has significantly changed since the 1980s and was then still being made within the Department. The fact remains that this was a situation where the treatment costs would be exceptionally high, and would still only prevent a limited number of the cases of Hepatitis B.

(4) As to pursuit of a British vaccine, this was a matter to which the Department had already given financial support. It was not unreasonable to anticipate that a vaccine produced in the UK would likely be cheaper. As to what was my understanding of the timeframe for development of a British product, I do not have any independent, personal recollection of this. The submission referred to a possibility of success within three to five years. From the available papers it appears that following the 16 July 1982 minute the next update I received on expectations for the British vaccine project was in December 1983.

5.43. The Inquiry raises the wider question of what consideration was given to safeguarding those at risk while a British product was developed. The medical officers advising on this would have been aware of the wider framework of precautions against HBV transmission through blood products and the licensing requirements. I cannot see that they were expressly set out in the submission into which I was copied. These are matters of patient safety that Ministers would expect to have been considered by the Department's medical officials, upon whose advice we relied, when formulating the policy advice.

Developments in July and August 1982 (Inquiry's question 39)

5.44. As set out above, the minute of 16 July 1982 was copied to my Private Office: [DHSC0001710]. I am unable to say whether it would have been included in my Red Box. I would have thought that this is the kind of submission which my Private Secretary may have decided I did not need to see, in part because it was suggesting to Ken Clarke that no further action now needed to be taken, and in part because this was a detailed policy point which the Minister of State was handling. The Inquiry asks about the setback to the British product in the withdrawal of the British Technology Group funding and the fact that there was no guarantee that the British vaccine would be any cheaper than the MSD one. Within the minute itself, it was noted that the Department had agreed to make up any shortfall caused by the withdrawal of the British Technology Group. As to the cost differential between a potential British vaccine and the MSD vaccine, the expectation, not unreasonably, was that a domestic vaccine would be cheaper, but that of course could not have been known for sure until such time as the product came to market.

5.45. The Inquiry has asked me if I was aware of and agreed with the DHSS position taken in the 22 July 1982 minute [DHSC0001708] and Lord Trefgarne's letter of 4 August 1982 [DHSC0001704].

5.46. The 22 July 1982 minute concerned Ken Clarke's decision, on advice from officials, not to take any further specific action to discourage use of the vaccine in the UK (for example, by way of a Health Notice). Lord Trefgarne's letter expressed appreciation to MSD for not marketing their vaccine aggressively in the UK. The minute from Ken Clarke's Private Secretary was copied to my office, but it may not have been drawn to my attention for the same reason as I have set out in relation to the submission to him (see paragraph 5.44, above). I would not necessarily have been aware of the content of Lord Trefgarne's letter (which I see was sent on behalf of Ken Clarke).

5.47. As I understand the question, I am being asked if I agreed with the policy of discouraging the use of the vaccine in the UK. While I again make the point that

I do not appear to have been directly involved in formulating policy on this issue, I would not have disagreed with the stance Ken Clarke had taken. As I have explained above, the assessment and concern raised at the time was that this vaccine, at its then cost, did not have a strong case for use of scarce NHS resources. I would refer to the comments I have made in the introductory section and the difficult choices that had to be made on the use of resources.

SECTION 6: HIV AND ACQUIRED IMMUNE DEFICIENCY SYNDROME ("AIDS")

HIV and AIDS: General (incorporating Inquiry's questions 40-42)

6.1. The Inquiry has asked me to provide, so far as I am able from the documents and my recollection, a chronological account of my involvement in the decisions and actions taken by DHSS to consider, assess, respond to and/or reduce the risk of people being infected with blood or blood products. As I have already indicated, I am heavily reliant on the written records which are imperfect. I have done my best to provide a chronological account below and, as invited by the Inquiry, I have tried to group this by reference to the main themes raised by the Inquiry. Where they are not otherwise addressed in this chronological account, I will return to individual issues at the end of the chronology. As I have indicated, blood products were mainly handled by the Parliamentary Under-Secretaries in the Lords and the Ministers of State for Health. In very broad terms, my main personal intervention was on the broader risks that AIDS posed, and the need for a radical approach to public health information to make the public understand that anyone could be infected with HIV. In saying this, I do not seek to abrogate responsibility for the decisions taken in the Department in relation to blood products for which I remained accountable to Parliament.

HTLV-III/HIV and AIDS to July 1983 (incorporating Inquiry's questions 43-56)

6.2. I am not able now to pinpoint exactly when I first became aware of AIDS as a newly identified disease. I had some knowledge of the "new threat" prior to the 1983 general election but it should be remembered that in the early 1980s there were no certainties – and indeed there were different theories on what the cause of the disease was. My general recollection is that, learning from the experience of the United States, it steadily became evident that (what became known as) HIV could be spread in a number of ways the most common being unprotected homosexual sex while another was by injecting drug users sharing needles.

There was a reported incidence of AIDS amongst haemophiliacs, although the early case numbers were low in absolute terms.

6.3. I have been asked when and how I first became aware of the American Food and Drug Administration ("FDA") March 1983 regulations regarding the collection of plasma from donors at increased risk of AIDS: [DHSC0001203]. From the available records, I have not seen any indication that the making of the American FDA regulations was reported to Ministers at the time they were made. Therefore, I think it is more likely that I became aware of them when they were later referred to in Ministerial submissions (rather than being reported at the time to Ministers), but I am not able to pinpoint exactly when this occurred.

6.4. I can confirm that on Tuesday 3 May 1983, Mr Parker (Assistant Secretary, Health Services Division 1) provided Geoffrey Finsberg's Private Secretary with the minute entitled 'Acquired Immune Deficiency Syndrome (AIDS)': [DHSC0001651]. It appears to be endorsed with a comment from Geoffrey Finsberg's Private Secretary, *"Mr Finsberg. To see above. Do you wish to meet the Haemophilia Society urgently (I would suggest early next week? J 3/5"*, and Geoffrey Finsberg noting *"OK"* in response. It was copied to my Principal Private Secretary (by this stage Mr Godber) and to the Private Secretaries to Ken Clarke and Sir Ken Stowe, as well as a number of officials. The associated documents with this minute were the line to take [DHSC0001651], together with the background brief in Q&A form [HSSG0010056_035]. There was also the reply from Geoffrey Finsberg's Private Secretary to Mr Parker dated 4 May 1983 (confirming Mr Finsberg's willingness to meet the Haemophilia Society) [WITN0771079] but also endorsed by her in hand on 5 May and again on 10 May *("Mr Parker – with pps I understand that the Haemophilia Society would prefer to wait until after the election"*).

6.5. I gather that the documents do not cast light on which of these documents I personally saw. Given that this related to a line to take which had gone to Number 10 in relation to Prime Minister's Questions, I think it more likely than not that my Private Secretary would have included Mr Parker's minute in my Red Box for my information, together with the line to take and briefing Q&A. I

cannot however be certain of this. A briefing note sent to Number 10 *ahead of* PMQs is the sort of document which my Private Secretary would normally include in my Red Box. I am somewhat less confident in this case (and consequently cannot be sure after the event) because the date of the minute is Tuesday 3 May 1983 and by the time that Tuesday evening's Red Box was being assembled, PMQs would already have happened. Accordingly, I still think it is likely that I would have seen this, but assuming I did so, it looks as though this would have been seen by me only after PMQs had already taken place.

6.6. I do not now recall seeing Mr Harris's minute, the line to take or the questions and answers. Reviewing the Q&A brief today I note that the answer to a question on whether AIDS is caused by a virus is *"the cause of AIDS is unknown"*. This gives an indication of the state of medical knowledge in May 1983. I also note the advice that *"as far as can be established, there are no proven case of AIDS in UK haemophiliacs"* and particularly the answer to the next question *"should a ban be placed on the imports of US Factor 8 concentrate",* namely:

> *"At present, haemophilia experts in this country take the view that to ban the imports of US FVIII would be to place haemophiliacs at greater risk from bleeding than they would be from acquiring AIDS"*: GRO-D p. 2].

6.7. A previous question in the brief asks whether AIDS is transmitted by blood or blood products. It was in that section that the wording was included which stated:

> *"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"* [HSSG0010056_035, p. 2]

I note that the evidence for this was stated to relate to 11 haemophiliacs in the United States and three in Spain, for whom the most likely explanation for the development of AIDS was their exposure to American FVIII concentrates, and that there was some evidence that AIDS had been transmitted to babies in blood

transfusions. As above, the indication in the same Q&A briefing was that the view of UK haemophilia experts was that to ban US imports would be to place haemophiliacs at greater risk from bleeding than they would be from acquiring AIDS.

6.8. I am not able to say with certainty or from direct knowledge whether the briefing note in Q&A form would have gone to Number 10 with the line to take. However, from general experience, I think it would be relatively unusual to provide a brief line to take for Prime Minister's Questions without including further background. The further background would be for the benefit first of the Number 10 staff directly advising the Prime Minister. On that basis, I think it more likely than not that the background Q&A would have gone to Number 10 with the line to take. If there were any questions arising from it then they would probably be settled by telephone. Thus, the initial background briefing from the Department would not necessarily be the final considered response.

6.9. From the documents available to me and from my recollection, I am not aware of any specific earlier use of the phrase *"no conclusive proof"*.

6.10. It is not apparent from the documents who had actually drafted the line to take for Number 10 which Mr Parker sent to Geoffrey Finsberg's Private Office, including the use of the phrase *"no conclusive proof"*.

6.11. The Inquiry has drawn my attention to what is described as the tension between the line to take and the background note. I set them out below:

Line to take	Background Note
"I was very concerned to read this weekend's Press Reports and can well understand the anxiety which some sensational reports may have caused. It is important to put this in perspective: there is as	"Is it [AIDS] transmitted in blood or blood products? 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

yet no conclusive proof that AIDS has been transmitted from American blood products. The risk that these products may transmit the disease must be balanced against the obvious risks to haemophiliacs of withdrawing a major source of supplies".	this is likely to be the case. The evidence relates to some 11 haemophiliacs in the USA and 3 in Spain in whom the most likely explanation for the development of AIDS was their exposure to America FVIII concentrates. There is also some evidence that AIDS has been transmitted to babies in blood transfusions."

6.12. I am asked whether any concerns were raised about this tension at the time; whether I myself had any such concerns at the time; why the line to take did not contain the qualification in the background briefing; and whether with reflection I now have concerns about the content of the line to take.

6.13. I have thought carefully about this issue and reflected not just on this briefing to Number 10 but also the later use of the 'no conclusive proof formulation'. My views are these:

(i) First, I should make clear that I have no recollection of any concerns being raised *at the time* about the tension which the Inquiry identifies.

(ii) Second, Ministers did not draft the lines to take and I cannot with authority comment upon who actually drafted this line to take or upon the choice of language. One can speculate that it may have related to a wish to give reassurance, retain perspective, or avoid panic or a crisis of blood supply.

(iii) Third, it should be noted that the line to take did implicitly accept there was some risk (*"The risk that these products may transmit the*

disease…"). The line to take was not denying the existence of a risk of transmission by this route.

(iv) Fourth, the likelihood of blood products being a route of transmission was also expressly recognised elsewhere. For example, as addressed later in this section, in the blood donor leaflet (*"Can AIDS be transmitted by transfusion of blood and blood products?", "Almost certainly, yes…"*), and Lord Glenarthur's letter to the ASTMS *("It remains the case that there is no conclusive evidence of the transmission of AIDS through blood products, although the circumstantial evidence is strong"*). However, we in the Department should have been more consistent in the use of that kind of language so as to reflect more precisely the balance of the background briefing (see below).

(v) Fifth, and consistent with the above, I accept that we in the Department should have spotted this need to reflect the balance of the background note more precisely in the line to take. In other words, if the *"no conclusive proof"* line was to be used in the line to take, it would have been better also to have included a reference to the fact that the evidence was suggestive that it was likely that AIDS could be transmitted by blood.

(vi) Sixth, 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, and our senior non-medical officials, could ourselves have spotted the tension to which the Inquiry refers.

(vii) Reviewing and reflecting on this now, I can see that getting *exactly* the right balance of risk information consistently into all public announcements would have better served the openness of Government and would have provided better information to those affected.

(viii) I would not wish to speculate on what difference this may ultimately have made given that the advice was stressing that the risk that these products may transmit the disease must be balanced against the obvious risks to haemophiliacs of withdrawing a major source of supplies; this was specifically referenced in the line to take. Furthermore, the background briefing noted that the view of UK haemophilia experts was that to ban US imports would be to place haemophiliacs at greater risk from bleeding than they would be from acquiring AIDS.

6.14. I am asked whether I recall seeing the section of the background briefing that addressed whether there were any cases of AIDS in UK haemophiliacs, and whether a ban should be placed on US factor VIII concentrates. On the assumption that I did see the background briefing, I would have seen these sections. I am asked what my thinking was at the time about a ban on US factor VIII concentrates and whether I recall discussing this question with others at this time. I have no specific recollection of this so, inevitably, any comment of mine now will be based on my general experience. Assuming that I did read this briefing, I would have noted that it was giving a clear indication that UK haemophilia experts took the view that to ban the imports of US FVIII would be to place haemophiliacs at greater risk from bleeding than they would be from acquiring AIDS. That being the assessment that had been made, I do not consider that it would have immediately caused me to question whether US imports should be banned, nor do I recall this being raised for discussion with Ministers at this time.

6.15. I am also referred to what the Prime Minister said at PMQs that day, 3 May 1983: [RLIT0000255]. In answer to the Inquiry's queries on this, unless specifically called to do so, I would not normally have been involved in personally briefing the PM ahead of PMQs in relation to an issue such as this. I have no recollection of doing so on this occasion and I have no reason to think that I had any role in formulating the answer that the Prime Minister gave. In my experience it was very rare for the Secretary of State to attend a briefing of the Prime Minister ahead of PMQs and almost never on any other occasion during my 10 years in Cabinet. As the Hansard extract makes clear, PMQs can vary

enormously from the state of the economy to the contribution being made by the video and tape industry to employment. It would be simply impractical to have all the affected Secretaries of State in the drafting session and would have brought government to a halt every Tuesday and Thursday.

6.16. The Inquiry invites me to comment on the Prime Minister's actual reply. I have no personal knowledge of why the Prime Minister did not use either the line to take or wording drawn from the background briefing. She instead stated *"we first need to find out a good deal more about the incident and the causes that have been reported before coming to any conclusion"*. The line to take is the first suggestion of an official of what might be said in Parliament. But at No. 10, the suggested line would then have undergone consideration by the Prime Minister's officials and advisers in terms of what they think would be the most appropriate answer. The final decision rests with the Prime Minister. The only other observation I think I can make is one based on practical political experience. In my experience, a short answer to the effect that we needed to know a great deal more before coming to a conclusion would likely have been seen (by the Prime Minister and/or her advisers) as a more appropriate line for the cut and thrust of PMQs than either the DHSS-suggested line to take or the more detailed information contained in the background briefing. In Parliamentary terms, both the line to take and the background briefing were too long as an answer for PMQs. The Prime Minister's response – to the effect that we first need to find out a good deal more about the infection and the causes that had been reported – was not an unfair statement of the position.

6.17. I am asked whether I was made aware of the Observer article of 1 May 1983 [MDIA0000016]; the Communicable Disease Surveillance Centre (CDSC) report for the week ending 6 May 1983 [DHSC0002227_020]; or the 6 May 1983 minute from Dr Sibellas to Dr Oliver [DHSC0002227_021]. These three documents each report on the first reported case of AIDS in a UK haemophilia patient treated with factor concentrates. I may have seen the Observer article as part of the many press cuttings provided to my Private Office (along with the other AIDS-related stories that weekend) but I am not able to confirm determinatively whether or not this was the case. I have not seen any indication

that the CDSC report of 6 May 1983 or Dr Sibellas' minute were provided to Ministers at the time. I am asked whether these should have been brought to my attention. While it is easy, with hindsight, to suggest that this development should have been immediately raised with Ministers, it would not be at all unreasonable for officials to have gathered information and considered views before reporting to Ministers.

6.18. The Inquiry has also referred me to the letter dated 9 May 1983 from Dr Galbraith, Director of the CDC to Dr Ian Field, DHSS: [CBLA0000043_040].

6.19. I have seen no evidence that Dr Galbraith's letter was raised with Lord Trefgarne, the Minister of Health or myself. The Inquiry asks if it should have been drawn to my attention as Secretary of State. I think this is unrealistic. The question of whether the licences for the US products should be withdrawn would have to be considered by the relevant Medicines Committee, which I understand here would have been CSM(B) and then the CSM itself. It is reasonable to expect that Dr Galbraith's views should have been part of that consideration by those committees of experts. I do not think anything further would have been achieved by putting Dr Galbraith's views to Ministers immediately, particularly given that they would in any event have had to go through the same process of medical review by the relevant Committee in any event. I would however add this. If, following the consideration of the relevant committees, a senior medical adviser felt seriously unhappy about the outcome, I would have expected that they would have felt able to raise that concern (probably initially through the CMO). In broad terms, I would expect Ministers to be alerted if the Committee was unable to decide or was seriously split, or senior medical advisers had serious reservations which they felt Ministers should be aware of following the relevant expert discussions.

6.20. The Inquiry draws my attention to Dr Walford's response of 13 May 1983 [DHSC0002227_047]. Like Dr Galbraith's own letter, this does not appear to have been copied to Ministers, nor would I have expected it to have been. My only comment would be that Dr Walford's view that Dr Galbraith's suggestion was "*…premature in relation to the evidence and unbalanced in that it does not*

take into account the risks to haemophiliacs of withdrawing a major source of their Factor VIII supplies" and the cited views of the Centre Directors both fortify the suggestion that there were views other than Dr Galbraith's that needed to be considered. However, the Inquiry is inviting me here to comment on documents which I do not believe I saw at the time. The Inquiry also invites me to note that Dr Galbraith attended the relevant discussion of the Biologicals Sub-Committee of the Committee on the Safety of Medicines on 13 July 1983. Again, my only comment would be that – in general terms – I would expect the relevant committees to consider the relevant evidence, the range of views, and the necessary action, rather than individual views being forwarded to Ministers. I would have expected Dr Galbraith to be able to give input into the sub-committee's considerations.

6.21. The Inquiry raises the issue of the 1983 General Election which was announced on 8 May 1983 and took place on 9 June 1983. It would be idle to pretend that an election does not have a disruptive effect. Not only are there the demands of the constituency (in my case 120 miles from the Department) but in addition there were daily calls to appear on radio and television, make visits to different parts of the country, and give newspaper interviews etc. However, there is one point here that should be noted. While there is the rule of purdah on initiating new policies (like announcing a new Order), arrangements are made that the Department itself is under day-to-day control of a Minister from the House of Lords who is obviously not due for election and is available at the Department for any immediate questions that may come up, for example on safety. In this case the junior Minister in charge was Lord Trefgarne. The 'purdah' conventions do not act to restrict decisions which must be taken promptly on safety or other important urgent grounds. As it happens, the Lords Minister on duty (Lord Trefgarne) was also the Minister in charge of blood products. So the calling of the election would not have prevented officials raising Dr Galbraith's concerns at Ministerial level, had that been seen as appropriate.

6.22. I note that on 22 June 1983, Dr Oliver forwarded information on AIDS from the CMO Sir Henry Yellowlees to Lord Glenarthur: [DHSC0002309_123]. This does not appear to have been copied to my Private Office. I note that the attached

briefing information referred to 12 UK case of AIDS, of which one was the suspected case of AIDS in a haemophiliac: [DHSC0002309_124]. It also referred to the FDA regulations of March that year.

6.23. The Inquiry has referred me to the Council of Europe's Recommendation R(83) 8 of 23 June 1983 [PRSE0000372]. The recommendations included that the governments of member states should take all necessary steps and measures with respects to AIDS and in particular, *"... to avoid wherever possible the use of coagulation factor products prepared from large plasma pools; this is especially important for those countries where self-sufficiency in the production of such products has not yet been achieved..."*. The recommendation was circulated to Ministers. Mr Cumming referred to it in a minute dated only July 1983 [DHSC0002309_086]. This was addressed primarily to Mr Lupton (who I am told was an Assistant Secretary in the Branch responsible for EC medical directives) and Mr Patten's Private Office. However, it was also copied to my Private Office, and copied on to the Private Offices of Lord Glenarthur and Ken Clarke. The minute noted, amongst other things, that the Recommendation did not prevent the UK from continuing to import factor VIII concentrate from the USA on whom we relied for about 50% of our supply. The operative phrase was 'wherever possible' – it was clearly not possible with the UK's heavy dependence upon imported blood.

6.24. I note that on 22 July 1983, Lord Glenarthur's Private Office gave his views on the recommendation to Ken Clarke, principally in the context of the blood donors leaflet which was in preparation: [DHSC0002309_029], see also the reply from Ken Clarke's Private Office of 26 July 1983 at [DHSC0002309_031]. The Inquiry asks if I was aware of any discussion or alternatives to using products prepared from large plasma pools, or reverting to the use of cryoprecipitate, at or around this time. I do not recall this. I have seen no indication from the papers that this was raised at Ministerial level at around this time.

6.25. I am asked about the World Federation of Hemophilia, and about its resolution dated 29 June 1983: [PRSE0001351]. I do not have any recollection of seeing this resolution. I am informed that the electronic searches of the DHSS materials

disclosed to the Inquiry include copies of the resolution, but not as apparent attachments to Ministerial submissions from the time. I am not able to comment on what contact officials in the Department may have had with this Federation.

The Initial Blood Donor Leaflet (incorporating Inquiry's questions 57-60)

6.26. Lord Glenarthur and Ken Clarke were the Ministers principally involved at Ministerial level in the first version of the Blood Donor leaflet.

6.27. The submission raising this was dated 1 July 1983 and sent from Mr Parker to Lord Glenarthur's Private Office, copied to the Private Offices of Ken Clarke, John Patten and Sir Ken Stowe as Permanent Secretary: [DHSC0002309_024]. It attached a short paper by Dr Walford [DHSC0002309_121], and the draft leaflet which had been prepared by the Regional Blood Transfusion Directors: [DHSC0002309_122]. The submission was copied quite widely including to the Scottish Home and Health Department (SHHD), as to which see further below.

6.28. Under the heading, "Sensitive Issues", Dr Walford's paper noted as follows:

> *"It is possible that a request to homosexual donors to refrain from donating could be interpreted by homosexuals rights groups as a discriminatory move which would infringe their rights as individuals to donate their blood. Such a reaction would be more likely to arise if there were widespread misunderstanding of the nature of the problem posed by AIDS and the Transfusion Directors are anxious to pre-empt such misunderstandings by publishing their information leaflet as quickly as possible. The Directors have secured the full cooperation of the Gay Medical Association – a society of homosexual doctors – who have undertaken to disseminate information on AIDS and to draw attention to the need for homosexuals who suspect they may be at risk from AIDS to refrain from donation. It would also be possible for officials to meet with leaders of the various homosexual groups to ensure that they were fully informed of the medical background to this request, if such a meeting were felt to be desirable.*

Recommendation

In spite of the potential sensitivity of the issue, officials are of the view that early publication of the information leaflet is in the best interests of the public health".

6.29. Lord Glenarthur's Private Secretary informed Mr Parker on 4 July 1983 that he was content with the proposed leaflet and the suggested cost: [WITN0771080].

6.30. On 6 July 1983, Mr Patten responded to Ken Clarke's Private Office concerning the same submission stating:

> *"In my view, public concern on this issue is mounting, and rightly.*
>
> *The earliest possible publication seems desirable, and the Gay Medical Association could take the strain should more fringe-like gay bodies raise the flag of discrimination"*: [DHSC0002309_027], see also acknowledgement from Mr Clarke's Private Office on 8 July 1983 at [WITN0771081].

6.31. Also on 6 July 1983, there was a meeting between Ken Clarke and Lord Glenarthur to discuss the leaflet and likely attendant publicity: [DHSC0001511]. In addition to those present, the minute of this meeting was copied to my Private Office and that of John Patten, as well as two further officials. The note was relatively brief and it is perhaps convenient to set it out in full:

1. *"MS(H) had two main concerns – to establish the necessity of a leaflet and to agree how the inevitable publicity surrounding it should be handled.*

2. *Officials felt that Ministers did not have the option of doing nothing. The main objective of the leaflet was to discourage those who were most at risk from AIDS from giving blood and thereby spreading the infection to patients who needed large amounts of blood, principally haemophiliacs. Similar guidance had been issued by the American Blood Transfusion Service and the Council of Europe had recommended that its Member States should*

put out a warning. Moreover, one of the Regional Transfusion Directors had let slip to the Press that a leaflet was in the offing and if nothing was now done, speculation would be rife.

3. *MS(H) accepted the strength of these arguments. He thought the leaflet, as drafted, read well although he would like it to emphasise more strongly how few cases of AIDS there had been in the UK, perhaps by quoting numbers. It should also emphasise unequivocally that donors would not be questioned about sexual matters when giving blood. It was inevitable that the leaflet would attract wide publicity and a carefully drafted Press Notice and full question and answer briefing would be needed. To minimise the scaremongering, the PN should emphasise how relatively few cases of AIDS had been reported and repeat that there was no question of donors being quizzed about their sexual habits. The main objective was to minimise any damage to the transfusion service. The announcement should be made at the same time as the leaflets were released.*

4. *Lord Glenarthur would be answering an oral PQ about AIDS from Baroness Dudley on 14 July. If she asked about the Blood Transfusion Service, Lord Glenarthur should emphasise that the risk to haemophiliacs was very small".*

6.32. The Inquiry notes that an SSHD minute of the same date, 6 July 1983, from Dr Albert Bell contained the comment that *"…we are informed that Mr Fowler's first reaction is that the terms of this leaflet are too strong, and that DHSS may therefore be making further amendments"*: [PRSE0000049]. I note this observation was not based on a direct conversation or meeting with me.

6.33. The Inquiry asks whether Dr Bell's minute accurately recorded my reaction to the draft I was shown and if so, why I considered it to be *"too strong"* and if not, what my reaction was. I have considered the documents available on this and I cannot see anything which really assists as to whether I had a view that something in the first draft was *"too strong"* and, if so, what this was. I can see that the Home Office was consulted on the issue of discrimination: see the reply

from Mr Townsend to Mr Parker, dated 8 July [DHSC0002229_072]. The leaflet was mainly dealt with by Simon Glenarthur and Ken Clarke. So long after the event, I am afraid that I would really be speculating to comment on whether I held a view about the content being too strong and, if so, what I was referring to. Reflecting on it now, given the kind of language used in the later public education campaign, the language in the draft leaflet appears quite mild. But I am afraid I just cannot remember whether I had a concern at this stage and if so what it was.

6.34. The records show that there was then a series of exchanges about how the leaflet was to be distributed, including:

(1) Minute from Mr Parker to Dr Oliver, dated 19 July 1983, referring to the earlier Ministers' meeting of 6 July 1983 [DHSC0002321_026];

(2) Response from Dr Oliver dated 20 July 1983 [DHSC0002321_027];

(3) Minute from Mr Bolitho (Information Division) to Dr Oliver, dated 21 July 1983 [DHSC0002321_028];

(4) Minute from Lord Glenarthur's Private Office, dated 22 July 1983, suggesting merit in referring *"...to the 'European' advice when MS(H) announces the publication of our own leaflet"* [DHSC0002309_029] (see paragraph 6.24, above);

(5) Minute from Dr Oliver in response to Mr Bolitho, dated 25 July 1983: [DHSC0002321_029];

(6) Response from Ken Clarke's Private Office to Lord Glenarthur, 26 July 1983 [DHSC0002309_031];

(7) Submission from Mr Parker to Ken Clarke's Private Office dated 29 July 1983, copied to the Private Offices of Lord Glenarthur, John Patten, and Sir Ken Stowe: covering note at [DHSC0002327_016, p. 1], submission at [DHSC0002327_016, pp. 2-7]. This submission noted the survey of

Regional Transfusion Directors that had been undertaken and the competing merits of issuing the leaflet with donor call-up cards, and making the leaflet available at donor sessions. It was noted that there was a difference of view amongst the Regional Directors, influenced by what they saw as most appropriate for their Regions. Officials' recommendation was to permit the RTDs discretion to decide, for a 6-month trial period, the most effective means of distribution in their own Regions. Arguments for and against an early public statement were set out;

(8) Minute from Ken Clarke's Private Office, dated 2 August 1983, approving the suggested distribution approach [DHSC0002327_119];

(9) Minute from John Patten's Private Office, dated 2 August 1983, urging that the distribution arrangements should go ahead as soon as possible with the suggested low-key publicity, adding *"we need to do something, and for it to be known that we have done something, in case the worst does happen. Can it be done by end August? Is there any reason why Directors could not follow both methods of distribution for the trial period?"* [DHSC0002327_118];

(10) Response from Lord Glenarthur's Private Office, dated 3 August 1983. This stated that *"he favours using both methods of distribution and feels that the risk of embarrassment to potential donors is outweighed by the need to achieve wide distribution"* and includes his additional comment that *"we may be at the tip of an iceberg with AIDS and find ourselves in trouble in 18 months' time unless we are really positive in our approach – even if it does embarrass a few 'gay' people"* [DHSC0002327_120];

(11) Further response from Ken Clarke's Private Office dated 5 August 1983 including reference to the three weeks required for printing [DHSC0002309_033];

(12) Minute from Ken Clarke's Private Office (after the Minister had seen the Q&A briefing, draft press statement and recent press coverage on 26 August 1983): [DHSC0002309_034]. Ken Clarke asked about whether he had authority to insist on one method of distribution and what the options were;

(13) Minute dated 31 August 1983 from Ken Clarke's Private Office to Lord Glenarthur's Private Office referring to a meeting the previous day between the two Ministers, and further advice obtained from Mr Winstanley [DHSC0002309_035];

(14) Minute dated 31 August 1983 from Ken Clarke's Private Office to Mr Winstanley with Ken Clarke's final decision on the distribution approach subject to any last-minute further views from Lord Glenarthur [DHSC0002321_034];

(15) Minute from Lord Glenarthur's Private Office on 1 September 1983 agreeing the approach, but requesting a trial period of three rather than six months [DHSC0002309_036];

(16) The leaflet was published that same day, 1 September 1983 with a DHSS Press Release with a statement from Ken Clarke [DHSC0006401_006].

6.35. I understand that the final leaflet was published in the form shown overleaf:

A.I.D.S.

And how it concerns blood donors

Recently there has been considerable publicity in the newspapers and on radio and television about a new, serious, but rare disease called AIDS.

Since AIDS may be transmitted by transfusion of blood and blood products, the National Blood Transfusion Service wants blood donors to have the facts about the disease.

What is AIDS?

AIDS is short for **A**cquired **I**mmune **D**eficiency **S**yndrome. As its name implies, AIDS destroys the body's immune system which normally protects against infections and other illnesses. A person with the disease is therefore at risk of developing serious infections such as pneumonia, or even cancer. AIDS is probably caused by a virus, but this is not known for certain.

Who is at risk from AIDS?

Most of the information about AIDS has come from the USA where approximately 1,500 patients have been found to be suffering from the disease, up to the middle of 1983. Certain groups of people appear to be particularly susceptible; these are:

1. Homosexual men who have many different partners.
2. Drug addicts, male and female, using injections.
3. Sexual contacts of people suffering from AIDS.

It has also been found in a number of immigrants to the USA from the island of Haiti.

Patients with AIDS also seem more likely to have suffered, at some time, from various other diseases such as hepatitis B, syphilis or other sexually transmitted diseases.

Has AIDS occurred in the United Kingdom?

Yes, about a dozen cases have been reported, by the middle of 1983. No-one knows whether more people in the United Kingdom will develop AIDS and a careful watch is being kept for possible cases.

Can AIDS be transmitted by transfusion of blood and blood products?

Almost certainly yes, but there is only the most remote chance of this happening with ordinary blood transfusions given in hospital. However, in the USA a very small number of patients suffering from haemophilia, an illness in which the blood will not cl have developed AIDS. Haemophiliacs are more susceptible to AIDS because they need regular injections of a product called Factor VIII. This is made from plasma obtained from many donors. Should just one of the donors be suffering from AIDS, then the Factor VIII could transmit the disease.

How can the risks be reduced?

At present, there is no screening test the Transfusion Service can use to detect people with AIDS. So, until there is and until more is known about this disease, donors are asked not to give blood if they think they may either have the disease or be at risk from it.

Will donors be questioned sexual matters when they attend to give blood?

Definitely not.

The National Blood Transfusion Service has a very regard for donors as extremely responsible people give blood for the benefit of others and is confident they would not knowingly put patients at risk from a serious disease.

Where can donors obtain further information on AID

Donors can discuss in confidence whether to give b with the doctor on the blood collection session, the own doctor or the Director of their local Blood Transfusion Centre.

Please remember, AIDS is rare disease but a serious one.

...epared by the Departments of Health and Social Security, and the Central Off Information 1983

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6.36. I am asked about the accompanying Press Release. The terms of this were as follows:

"The Department of Health and Social Security has today published a leaflet – "AIDS and how it concerns Blood Donors". It has been produced in co-operation with Regional Blood Transfusion Directors.

Announcing publication, Kenneth Clarke, Minister for Heath said: "It has been suggested that AIDS may be transmitted in blood or blood products. There is no conclusive proof that this is so. Nevertheless I can well appreciate the concern that this suggestion may cause. We must continue to minimise any possible risk of transmission of the disease by blood donation but it is not possible to test a person's blood for the presence of AIDS. The best measure which can be taken at the present time is to ask people who think they may have AIDS or be at risk from it, to refrain from giving blood. This is what this leaflet sets out to do."

The Council of Europe has recommended that all member states should make information on AIDS available to blood donors. There is no question of donors being asked about their sexual lives at blood donation sessions or at any other time.

NOTE TO EDITORS
Half the Factor VIII used for the treatment of haemophilia in this country is produced here and the remainder imported from the USA. The US Food and Drug Administration have introduced special requirements for plasma collection which are designed to exclude donors from high risk groups from plasma donation. The Government is committed to making Britain self-sufficient in blood products – the National Blood Transfusion Service already meets demands for whole blood – and is redeveloping the Blood Products Laboratory at Elstree over the next 3 years".

6.37. Addressing some particular issues which the Inquiry has raised, I would say as follows.

6.38. As to the extent to which I was involved in the decisions on how the leaflet was distributed, the records suggest that this was handled at Ministerial level by Lord Glenarthur and Ken Clarke, with some additional input from John Patten. I have not seen any indication from the available papers that I intervened on that issue and I do not think that I did so. It was perfectly appropriate for this to be addressed by those Ministers.

6.39. The Inquiry asks about the further use of the 'no conclusive proof formulation' in the Press Release. I have addressed this in paragraph 6.13, above.

6.40. Finally, the Inquiry asks about the length of time that it took for the first version of the leaflet to be produced. I have done my best to set out the chronology above based on the available records which I have seen. These show that after the leaflet was raised with Ministers on 1 July 1983 there were frequent exchanges between officials, between officials and Ministers, and between the Ministers' Private Offices, before publication on 1 September 1983 (this two-month period included the printing time). It seems to me from the records that those dealing with this issue were keen to get it right. The records show concern being expressed, and deliberation given, to the difficult balance between: ensuring that at risk groups did not donate blood; avoiding a wider adverse impact on blood donation; avoiding allegations of discrimination or feeding the hostile treatment of gays and gay blood donors; and avoiding media panic. The Inquiry asks if I had concerns at the time, or have concerns now, about how long this took. It may be said, particularly with the benefit of hindsight, that the two-month period was too long. However, it seems to me that at the time, how to balance these difficult factors was being carefully considered. In that sense it is not surprising that agreement took time. I should mention that on other issues, I have experience of communications advice that August is a very bad time to seek to release information that requires publicity to achieve its best effect. However, I do not know one way or the other whether this was a factor on this issue in the summer of 1983.

Meeting of 13 July 1983 of the Biologicals Sub-Committee on the Safety of Medicines, knowledge and discussion of risks of use of pooled plasma products (incorporating Inquiry's questions 61-64)

6.41. The Inquiry asks what knowledge or involvement I had in relation to the discussions of this Sub-Committee on 13 July 1983 and whether I was involved in shaping or influencing its conclusions. I have been referred to a record of conclusions of the discussion of the Committee [DHSC0001208]. I have also been referred to the formal minutes of the meeting [ARCH0001710]; a Minute of 6 July 1983 from H Morgan to a number of officials [DHSC0003618_147]; the "suggested 'agenda' for the meeting [DHSC0001209]; and a paper by Dr K Fowler [DHSC0002229_059].

6.42. I certainly would not have had a role in shaping or influencing the conclusions of this Sub-Committee. The Committee on the Safety of Medicines had a statutory role to provide independent advice to the Health Ministers and it would have been quite wrong of Ministers to seek to shape or influence its conclusions.

6.43. There is no indication from the documents listed above that they were sent or copied to Ministers. I would not expect to have received written updates of decisions of this kind. It is more difficult to answer, after so many years, whether I may have been informed verbally of the broad outcome in the course of more general updates on events relating to the emergence of AIDS. If I was so informed, I would not have reason to question the advice coming from the CSM (or its sub-committees) unless – exceptionally – someone like the CMO raised with me that there was a particular problem or warned that the decision was particularly controversial or similar. I have no recollection of the CMO or his team raising such concerns at this time, and I have not seen any written records in the available materials to suggest that this was done.

6.44. From the materials available from this time and the months following, I have not seen briefings or submissions directed to me addressing whether blood products from pooled plasma (UK or non-UK products) should be withdrawn

from NHS use, or to the effect that patients should be treated with cryoprecipitate instead.

6.45. From the available materials, I have seen that officials provided drafts bringing together various further information for Lord Glenarthur to send to Baroness Masham: see Dr Walford's minute of 20 July 1983 [DHSC0001109]; Mr Parker's minute of 26 July 1983 [WITN0771082]; Mr Ghagan's minute of 23 August 1983 [WITN0771083]; Mr Winstanley's minute of 26 August 1983 [WITN0771084]; and the final letter of 30 August 1983 [DHSC0002231_037]. The final letter to Baroness Masham noted that:

> *"In March this year the US Food and Drug Administration initiated new Regulations for the collection of plasma, designed to exclude donors from high-risk groups. Although future supplies of Factor VIII both for export and for use in America will be manufactured from plasma collected in accordance with these Regulations, there is still a quantity of stock, some already in the UK and more in America awaiting shipment here, which has been made from "pre-March" plasma. The FDA has recently decided not to ban the use of similar stocks intended for the USA market because to do so would cause a crisis of supply. The same considerations apply to the UK supply position.*
>
> *My officials have been in close touch with the Haemophilia Society about the AIDS problem and we are all very grateful to them for the constructive and responsible attitude they have taken. Naturally this is a matter of great concern to them; but they did not support the cries from some quarters to ban the import of Factor VIII because they accepted that the possible risks of infection from AIDS must be balanced against the obvious risk of not having enough Factor VIII".*

The point about not banning the use of older (pre-FDA regulation) Factor VIII because of the risk of a crisis of supply was also contained in Lord Glenarthur's letter to Mr Jenkins of 26 August 1983: [DHSC0002231_036]. It should be noted

that the FDA in the United States had also decided not to ban the use of pre-March plasma on the grounds that it would have caused a crisis of supply.

6.46. It follows that the decision not to withdraw pre-March FDA Regulation stocks was known about at Ministerial level although I find it impossible now to recall whether I was personally aware of this at the time. But I am not aware of the withdrawal of pooled plasma products or reversion to treatment with cryoprecipitate being raised for Ministerial decision or as an area of controversy or concern upon which Ministers views were sought. As to the wider question of the risk of infection with AIDS to patients using blood and blood products and risk reduction measures, those submissions principally relevant are the ones the Inquiry has already invited my comment upon. I have referred, additionally, to the briefing to Lord Glenarthur of 22 June 1983, at paragraph 6.22, above.

6.47. I am asked whether I consider that I ought to have received such submissions at around this time (mid-1983 into 1984). The licensing of (or withdrawal of previously licensed) medicines, was appropriately a matter for the Committee on the Safety of Medicines and its relevant sub-committees. The licensing decisions were then made under delegated powers and it was not normal for Ministers to be consulted on such decisions. It would have been still more unusual, indeed wholly exceptional, for Ministers to overrule the recommendations of expert committees on these issues. As I have indicated above in the context of Dr Galbraith's earlier expressed views, the sort of circumstances in which Ministers might be involved would be if the CSM was seriously split, or unable to make a decision or if there were senior advisers who wished to raise remaining concerns. It was then for prescribing doctors to make prescribing recommendations from the available products in the best interests of their patients, obtaining appropriate consent. Clinicians' independence in prescribing practice was an important principle which was respected.

6.48. As regards blood donations from prisoners, I have been referred to the exchange of minutes between JB Brown and Mr Parker of 27 July 1983 [PRSE0004345], and Mr Winstanley's minute to Mr Brown of 23 August 1983 [PRSE0004729], responding on Mr Parker's behalf. From these records, there

is no indication that this was being raised at Ministerial level. Again, approaching 40 years later, it is I am afraid impossible to give a categoric answer to the question whether I was aware of this, although I doubt that I would have been. Mr Winstanley's response suggests that this was a matter for individual Regional Transfusion Directors, and that given the additional risk from AIDS, it was due to be discussed at their forthcoming meeting in September. I would not have expected to be made aware of that position. If it was considered sufficiently important or requiring a decision, it would have been raised first with the Minister responsible for that policy area (here, at this time, Lord Glenarthur). There is then always a discretion as to whether the Minister of State, and potentially the Secretary of State should also be alerted. Again, it is very easy when examining one important policy area in great detail after the event to fall into the trap of expecting that Ministers should have been aware of every detail in that area. But the context of the Department's incredibly wide remit does need to be remembered; and very many of those other areas also involved judgments of risk and the targeting of resources in areas involving patient safety. It is unrealistic to expect that every detailed aspect of policy should be briefed to Ministers.

Further use of "no conclusive proof" (incorporating Inquiry's questions 65-69)

6.49. The Inquiry has drawn my attention to the following:

(1) Minute from Dr Sibellas to Dr Field, dated 9 September 1983: [DHSC0001666]. This indicated that the total number of AIDS cases in the UK known to DHSS was 20, of whom seven had died. Two of the 20 patients were haemophiliacs – both of whom had received American factor VIII and one of whom had died.

(2) Minute from Dr Walford to Mr Egerton dated 20 September 1983: [DHSC0000207]. This included reference to the case of a haemophiliac in Bristol who had died of AIDS having received imported Factor VIII in

December 1981, some BPL Factor VIII in June 1982, but otherwise – as a mild haemophiliac – had been treated with cryoprecipitate.

(3) A 28 September 1983 article in The Guardian by Andrew Veitch [PRSE0004533], which refers to the same case of the Bristol patient who had died having received imported Factor VIII, and also referring to the suspected case in Cardiff, and reporting on the Haemophilia Society's views in favour of the continued use of Factor VIII. (I do not separately address the same article's reporting of funding decisions in relation to BPL save to note that it was not a fair reflection of the chronology set out in Section 4 of this statement, above).

(4) The written answer of Ken Clarke in the House of Commons on 14 November 1983 to a PQ from Edwina Currie [PRSE0000886]:

> *"**Mrs. Currie** asked the Secretary of State for Social Services what advice has been given to hospitals concerning the use of imported factor VIII in the light of recent concern about its possible contamination with the causative agent of acquired immune deficiency syndrome.*
>
> ***Mr. Kenneth Clarke**: 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".*

(5) The exchange of correspondence between Clive Jenkins, General Secretary of the ASTMS and Lord Glenarthur, namely Clive Jenkins' letter of 27 October 1983 [DHC0002235_041] and Lord Glenarthur's reply of 5 January 1984: [HSOC0001419]. Clive Jenkins argued that the evidence was *"very strong"* for the transmission of AIDS through blood

products, citing evidence in support of that view. Lord Glenarthur's response included that:

> *"It remains the case that there is no conclusive evidence of the transmission of AIDS through blood products, although the circumstantial evidence is strong. These two statements in no way contradict one another as you will readily appreciate from an analysis of a similar argument which you use in paragraph 7. Whilst there is strong evidence to suppose that the hepatitis vaccine will not transmit AIDS, the evidence is not conclusive and cannot be so until a means of testing for AIDS has been devised. In both cases, the conclusive evidence awaits the development of a test which can identify the AIDS agent (or agents)"* (original emphasis).

(6) The handwritten note from Mr Steven Green dated *"26 March"*, commenting that *"we dropped 'there is no conclusive proof that AIDS is transmitted through blood or blood products' from our standard line some time ago"*: [DHSC0002239_089]. I understand that in the available materials, this note sits alongside – and its content probably relates to - a Sunday Times Article of 25 March 1984 [PRSE0001580], so as the Inquiry has indicated, the date *"26 March"* would appear to be 26 March 1984.

6.50. The Inquiry asks whether I saw these at the time. I may have seen the media articles from the press cutting service (c.f. items (3) and (6), above). The proposed answer for Ken Clarke at (4) would have been sent to him to approve, and it is unlikely to have been copied to me. My Private Office does not appear to have been copied in to the correspondence with Clive Jenkins at (5), and I would not have seen Mr Green's note at (6).

6.51. The Inquiry also draws my attention to a later comment from Edwina Currie (23 July 1990 broadcast) that *"whoever wrote [the "no conclusive evidence"] answer for Kenneth Clarke needs his head examined"*.

6.52. I am not aware of the precise circumstances in which the no conclusive proof/evidence line continued to be used. Stepping back from precisely which documents may have gone to my Private Office and I may have seen, the wider point which is obviously being raised is whether the 'no conclusive evidence line' – if originally justified - was continued for too long and ought to have been dropped, or at least amended, earlier. I have already accepted, in paragraph 6.13 above, that if the 'no conclusive proof line' was to be used, it would have been better also to have included a reference to the fact that the evidence was suggestive that it was likely that AIDS could be transmitted by blood.

The Briefing paper of 19 November 1984 (incorporating Inquiry's questions 70 – 72)

6.53. I can confirm that on 19 November 1984, Dr Smithies (MED SEB) minuted my Principal Private Secretary with a note summarising the current situation on AIDS, indicating that I had made a request for a note on this subject: [DHSC0002309_053].

6.54. I do not now recall what led me to ask for this briefing note and I am reliant on the written records. Looking now at Dr Smithies' briefing, I note that paragraphs 2 – 16 are a summary of the then current position in several areas. However, paragraph 1, giving the background read as follows:

"Background

1. News from Australia that 13 people including 3 babies have died from AIDS after receiving a blood transfusion has caused nation wide concern in Australia. Legislation has been introduced in Queensland to fine or jail people who give blood whilst knowing they have AIDS."

As Dr Smithies gave this as the background, it may be that I had seen coverage of, and was concerned about, the Australian case and its implications and had asked for updating information. However, it may also have been a combination of other developments – for example I can see from the records that at around this time that Chris France had recently sent his report of BPL redevelopment to Ken Stowe [DHSC0003964_029]; Lord Glenarthur was raising questions about the ability to screen blood donations for HIV [WITN0771085]; John Patten was making his statement on self-sufficiency, research on the screening test and strengthening the donor leaflet [MACK0002638_029,WITN0771048]; and the CMO had been asking for information on AIDS and blood donations [DHSC0002323_009].

6.55. It would be normal for me (and any Minister) to ask for a briefing note on areas of concern if they felt they required further information. This was a normal part of wanting to get the requisite level of information. I cannot categorically state whether or not I had asked for previous briefing specifically on AIDS. If it was in writing, such briefing should have been retained on the official files but the records are imperfect. The Inquiry has asked me what parts of this briefing note I was already aware of at this particular stage and whether I consider that anything I had not previously been aware of should have been brought to my attention sooner. For the reasons I have already explained, I find it virtually impossible to piece together so long after the events precisely what I knew when. The fact that my Private Office was not copied in to many of the submissions (because they were being handled by the junior Ministers with responsibility in that area) is not determinative because we would have discussed matters but I hope the Inquiry will understand after so long how difficult it is to say precisely what information came to me and when.

6.56. The Inquiry also asks what steps I took on receiving this briefing. The available documents do not help me recall what my reaction was; there is no record of a written response from my Private Office, although having specifically asked for a note on the current situation I would have considered the content. I may have discussed it with officials or other Ministers but I cannot now recall. The briefing from Dr Smithies was of the updating kind, giving information on the current situation rather than seeking any particular decision or recommended action.

6.57. The Inquiry asks about John Patten's statement of 18 November 1984 announcing the strengthening of the blood donor leaflet: [MACK0002638_029]. There was also a Press Release on 19 November 1984 quoting Mr Patten [WITN0771048]. Paragraphs 5 and 10 of Dr Smithies' note had addressed the updating and strengthening of the leaflet and expressed the view that legislation of the kind being introduced in Queensland, Australia was not needed in the UK.

6.58. The Inquiry has asked questions around what role I had played in the strengthening of the leaflet. The records suggest that the revision of the donor leaflet had been handled by Lord Glenarthur (see the minute from his Private Office of 21 August 1984 at [DHSC0002309_046]) and Ken Clarke (see the minute from his Private Office of 16 October 1984 at [DHSC0002309_050]). Since both Ministers clearly agreed with the strengthening of the leaflet, there is no indication from the available records that it was escalated to me.

6.59. I do not now recall the details around the strengthening of the leaflet. As I have indicated, I think this was being handled principally by Lord Glenarthur and Ken Clarke. The strengthening measures that had been recommended by officials and endorsed by the Ministers at this stage were those contained in the submission dated 10 August 1984 from Mr Parker to Lord Glenarthur's Private Office [DHSC0002309_044]. All those RTCs who did not send out the leaflet individually to their registered donors were to be asked to do so at the next recall of those donors. Donor teams were to make certain that new or unregistered donors had an opportunity to read the leaflet before they committed to donation. In terms of the leaflet wording, the at risk groups were now said to be all

practising homosexual men (rather than those with multiple partners). And the version as it stood at that stage, contained the wording:

> *"The National Blood Transfusion Service has a very high regard for donors as extremely responsible people who give blood for the benefit of others and is confident that they would not knowingly put patients at risk from such a serious disease as AIDS. Until there is a reliable screening test the Blood Transfusion Service can use, and until more is known about the disease,* ***donors are asked not to give blood if they think they have the disease or are in one of the risk groups listed opposite****"* (original emphasis): [PRSE0000136].

6.60. However, the records show that that there was then advice to further revise and strengthen the leaflet, see the minute of 22 November 1984, which was copied to my Private Office [DHSC0002323_014]. It was said that Information Division were in agreement with the view of Mr Cashman that *"… the first revise had to be looked at again in the light of recent developments and ministerial statements. The need is for a much more strongly worded leaflet and for urgent approval, production and distribution*".

6.61. Following this, there were further submissions leading to the final revised leaflet. My Private Office was being copied into some of these exchanges, but Ken Clarke continued to take the lead on this:

(1) Minute of 30 November 1984 from John Patten's Private Office to the Private Secretaries to Lord Glenarthur and Ken Clarke [DHSC0002309_056];
(2) Submission of 3 December 1984 from Dr Abrams to Ken Clarke's Private Office [DHSC0002309_058];
(3) Minute of 4 December 1984 from Lord Glenarthur's Private Office to Ken Clarke's Private Secretary [DHSC0002309_117];
(4) Minute of 14 December 1984 from Mr Harris to Ken Clarke's Private Office [DHSC0002309_060];

(5) Note of 20 December 1984 from Mr Williams to Ken Clarke's Private Office which updated on developments but also sought urgent clearance for the revised leaflet [DHSC0002327_127];

(6) Minute of 20 December 1984 from Ken Clarke's Private Secretary replying to Dr Abrams's submission [DHSC0002309_062];

(7) Minute of 21 December 1984 from Information Division to Ken Clarke's Private Secretary with further revised wording [DHSC0002309_063] and response of 31 December 1984 [DHSC0002309_064];

(8) Minute of 3 January 1985 from Mr Williams to Mr Windsor (Information Division) with suggested final version [WITN0771218];

(9) Submission of 3 January 1985 from Mr Williams to Mr Harris and Lord Glenarthur's Private Office seeking agreement to the formal Health Circular to be issued with the revised leaflet [DHSC0002309_065, pp. 2-3];

(10) Lord Glenarthur's approval to the Health Circular, 15 January 1985 [DHSC0002482_010] and agreement to final leaflet wording of the same date, [DHSC0002482_011]; and

(11) Press release with statement by Ken Clarke, 1 February 1985 [DHSC0004764_111].

6.62. The final version of the leaflet [NHBT0096480_022] was strengthened further as compared to the suggested revised version circulated in August 1984. The at-risk groups now included: practising bisexual as well as homosexual men and the sexual contacts of those in the other high-risk groups. The leaflet was more directive in the message not to give blood, stating *"donors in the risk groups must **not** give blood. Some people in these groups may unknowingly carry the AIDS virus in their bodies*" (original emphasis). The back sheet of the leaflet carried the reminder:

> *"REMEMBER, AIDS IS A SERIOUS DISEASE.*
> *Please do **not** give blood*
> • *if you are a practising homosexual or bisexual man*
> • *if you are a drug abuser who injects drugs*
> • *if you are a sexual contact of any of these people"* (original emphasis).

6.63. The Health Circular [DHSC0002159] included the following:

"REVISED DISTRIBUTION ARRANGEMENTS

4. Ministers have decided that it is essential that the revised leaflet be brought to the attention of each donor on an individual basis. This would normally be achieved by sending each donor a copy of the leaflet with his next call-up notification. It is realised that this may not be practicable for industrial sessions (or for new donors presenting at sessions) in these cases alternative arrangements should be made to ensure that each donor is individually given the leaflet before any blood is taken. Displays of leaflets, whilst continuing to be useful, will not meet these new distribution requirements. Because the advice has changed significantly, the revised leaflet should be sent even to those who received the 1983 version".

Information about incidents of HTLV-III infected donors in the UK (Inquiry's question 73)

6.64. On 30 November 1984, Mr Alun Williams put a submission [DHSC0002309_057] up to Lord Glenarthur's Private Office stating that *"Ministers will wish be aware of three incidents of UK blood being given by donors found positive by the screening test for HTLV III antibody. In one case the infection had been transmitted to a number of recipients, none of whom had yet developed AIDS; but this is a possibility."*

6.65. The Inquiry asks if my Private Office was copied into this minute. I think it very probably was. The submission was addressed to Lord Glenarthur's Private Secretary. The distribution list included in typed print Private Secretaries to John Patten (Ms McKessack) and Ken Clarke (Ms Bateman). Above those was written in pen *"Miss E Roberts"*. The insertion of that name at the head of the distribution list and other documents from around this time suggest that Miss Roberts was, for a relatively short period, a member of my Private Office team. I therefore believe it is likely that this minute was copied to my Private Office.

6.66. The Inquiry asks whether I took any steps in response to this minute and if not, why not. There is no indication from the available records of a direct written response from my office to this minute; I cannot recall if I gave any verbal response or comment. However, while the submission conveyed a serious development, its purpose was to alert us as Ministers to the development, rather than seeking Ministerial policy direction or further decisions. The indication under the heading Defensive Press Briefing was that the incidents reinforced the current policies of the Department regarding: (i) the revision to the blood donation leaflet; (ii) developing a screening test and carrying out pilot studies of the test; and (iii) considering the use of heat-treatment of Factor VIII in reducing the risk of HTLV III transmission. In short, officials were indicating that appropriate action was already being taken.

6.67. The Inquiry asks when I first learned that British blood donors had tested positive for HTLV-III and/or had been diagnosed with AIDS. From the available records, I can see that Mr Parker/Mr Williams's submission to Lord Glenarthur of 10 August 1984 on the revision of the blood donor leaflet had referred to the fact that *"it is known that one patient with AIDS in the UK has been a blood donor (it was possible to trace his donations and eliminate them)"*: [DHSC0002309_044, para. 5]. That specific submission was not copied to my Private Office and I am unable to say now whether the point had been drawn to my attention prior to Mr Williams' submission.

Briefing from the CMO on AIDS and blood products, July 1985 (Inquiry's question 74)

6.68. On 4 July 1985, Dr Harris minuted the CMO Sir Donald Acheson on the heat treatment of Factor VIII: [DHSC0002484_063]. This minute does not appear to have been copied to Ministers. The information provided by Dr Harris included that:

"All 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.

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".

6.69. On the version provided to me, Sir Donald appears to have endorsed it with the request:

"*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".

6.70. On 8 July 1985, Sir Donald minuted Dr Harris, stating:

"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": [DHSC0002484_061].

6.71. On 9 July 1985, Dr Harris replied to the CMO's request – see [DHSC0002333_040].

6.72. On 11 July 1985, a minute to the CMO's office noted that his scheduled meeting with me on AIDS had needed to be postponed to 17 July 1985: [DHSC0002323_039].

6.73. On 16 July 1985, Sir Donald provided a covering note to me ahead of our meeting. He attached a paper covering the three key items for discussion: (i) control of further spread of HTLV III infection; (ii) confidentiality of the results of HTLV III testing; and (iii) provision of further resources in addition to the current PESC bid for counselling and other aspects of health education. The covering note included Sir Donald's advice that the Department should set up in-house a small multidisciplinary steering group to monitor the implementation of the various actions necessary: [DHSC0002327_032].

6.74. On the same day, 16 July 1985, Ken Stowe minuted my Principal Private Secretary indicating that he may not be able to make the meeting between the CMO and me, and he provided some supplementary points in writing: [WITN0771086].

6.75. On 30 July 1985, Sir Donald minuted me to provide further information/assurance on heat treatment of Factor VIII.

> *"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 un heat-treated form since December 1984. Although it is unlikely that there are any stocks in the country of un heat-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 HTLV III virus – [with manuscript addition] but sadly a very high proportion of the haemophiliac population already are infected due to previous use of un heat treated Factor VIII": [DHSC0000514].

6.76. The Inquiry asks what prompted this chain of correspondence.

6.77. Although it is hard to be definite given the passage of time, it is highly likely that this exchange was precipitated by the CMO's earlier paper to me (and other Ministers) dated 27 June 1985 [DHSC0002114], and discussions which I had with the CMO concerning this paper.

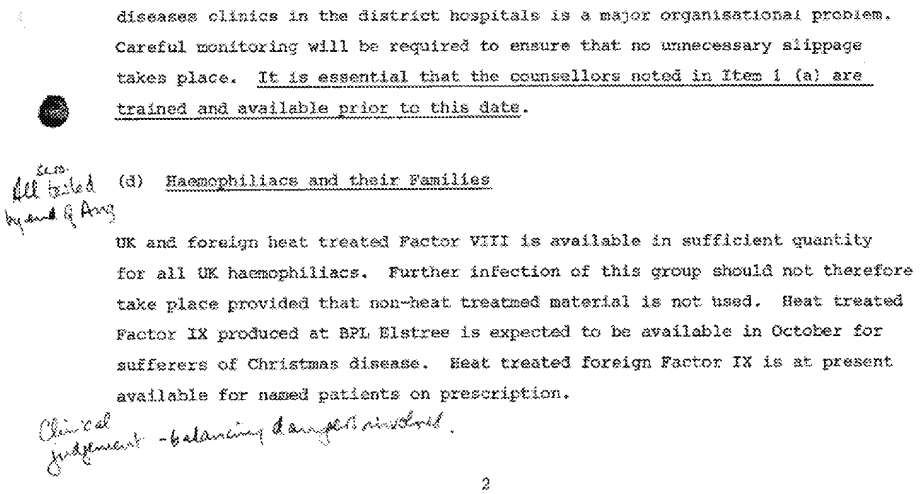
6.78. The CMO's paper was entitled 'HTLV3 infection, the AIDS epidemic and the control of its spread in the UK'. This was a wider strategic paper on AIDS, not confined to the risks from blood and blood products. The CMO was urging the case for a comprehensive campaign to reduce the spread of infection, principally by means of education directed at those specially at risk. He was warning of the risk of an exponential increase in the number of infected persons.

6.79. At section 9 of his paper, Sir Donald noted that *"[i]n 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 co-operation of the groups at risk*": [DHSC0002114, p. 12]. He then addressed the main at-risk groups. Under *"(c). "Haemophiliacs"*, the CMO stated "*check 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*." Under *"(d). Blood transfusion"*, the CMO stated "*introduce 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": [DHSC0002114, p. 13].

6.80. As I have indicated, Sir Donald addressed this paper to me on 27 June 1985 and it was copied to Ken Clarke, John Patten and Baroness Trumpington (who by now had succeeded Lord Glenarthur). The exchanges of information between CMO and Dr Harris that followed are highly likely to be the product of the need – which the CMO had identified – to check that all Factor VIII and Factor IX was now heat treated. Sir Donald's reference to Dr Harris on 8 July 1985 that he had given me an assurance that he would 'forthwith' look into ensuring the non-infectivity of Factor 8 and Factor 9 suggests that I had alighted on that issue in the information provided by the CMO and pressed for more information [DHSC0002484_061]. I read Sir Donald's minute of 30 July 1985 as being his response to this request that I had made following sight of his 27 June 1985 paper, rather than necessarily something that was discussed at our meeting in mid-July [DHSC0000514].

6.81. The Inquiry has asked about the marginalia on one version of Sir Donald's paper of 16 July 1985 [DHSC0002327_032]:



diseases clinics in the district hospitals is a major organisational problem. Careful monitoring will be required to ensure that no unnecessary slippage takes place. It is essential that the counsellors noted in Item 1 (a) are trained and available prior to this date.

(d) Haemophiliacs and their Families

UK and foreign heat treated Factor VIII is available in sufficient quantity for all UK haemophiliacs. Further infection of this group should not therefore take place provided that non-heat treatmed material is not used. Heat treated Factor IX produced at BPL Elstree is expected to be available in October for sufferers of Christmas disease. Heat treated foreign Factor IX is at present available for named patients on prescription.

2

This handwriting is not mine and I am afraid I am unable to assist with whose handwriting it is.

6.82. I cannot specifically recall whether I discussed with Sir Donald the manuscript addition to his minute of 30 July 1985 (see paragraph 6.75, above) DHSC0000514]. I think it is likely that we would have covered this as part of the discussions we were having about AIDS around this time. Given the passage of time, I cannot state with any confidence whether or not this was the first time that I had discussed the risks of infection of individuals with bleeding disorders with the CMO personally.

6.83. The Inquiry asks why at this time, Sir Donald was planning to arrange for a letter to be sent to haemophilia centre directors on the use of heat-treated Factor VIII and whether he should have done this sooner. This issue would be better addressed to the medical officers working with Sir Donald in this area. I would note, however, that it was not general practice for the CMO (and the Department more generally) to dictate prescribing practice to treating doctors. The relevant action point identified by Sir Donald in his 16 July 1985 paper 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"* [DHSC0002327_032, p. 4]. It may be that following Professor Bloom's letter to the BMJ of 22 June 1985 [PRSE0001917], the CMO wanted to make sure that there was no doubt amongst clinicians of the availability of UK heat-treated Factor VIII.

Screening test for blood donors (incorporating Inquiry's questions 75-80)

6.84. I am asked what role I played in the decisions concerning the introduction of a screening test for HTLV-III/HIV for blood donors in the United Kingdom.

6.85. For the reasons I have already addressed in earlier sections, this issue was principally handled by Ken Clarke and later John Patten.

6.86. From the available records, I have noted the following developments (save where otherwise marked (*), my own Private Office was not copied in):

(1) Mr Parker/Mr Williams's submission to Lord Glenarthur on the revision to the blood donor leaflet of 10 August 1984 referred to the work being undertaken on testing by the Middlesex Hospital: [DHSC0002309_044].

(2) On 31 August 1984, Lord Glenarthur was provided with a briefing note to give further information following publication in the Lancet of the results of the use of this blood screening test: [DHSC0000443].

(3) There was brief mention of this development at paragraph 6 of Dr Smithies' note summarising the current situation on AIDS provided to my Private Secretary* on 19 November 1984 (see paragraph 6.53*ff* above):

> *"A screening test for evidence of infection with the causative virus has been developed at the Chester Beatty Institute and the Middlesex Hospital. This has enabled studies of AIDS patients, haemophiliacs and blood donors on a research basis to be undertaken. It is hoped that this test can be extended to screen more blood donors as the reagent becomes available. Until more is known about the AIDS agent such a test is the best that can be used to ensure safe blood and plasma supplies. Tests are being developed in the USA and are expected to be available commercially early in 1985"*: [DHSC0002309_053, para. 6]

(4) A minute from Dr Abrams to Dr Smithies of 23 November 1984 reported on early views expressed by Ken Clarke on the apparent high cost/cost-effectiveness of HTLV-III testing, this having arisen in the context of briefing for an ITV interview: [DHSC0000435].

(5) Written answer from Ken Clarke to PQ from Charles Kennedy, 23 November 1984: [WITN771087].

(6) On 26 November 1984, Mr Williams put a brief updating submission on AIDS screening testing of blood donations to Lord Glenarthur: [DHSC0000436]. He noted that:

> *"It is not yet possible to forecast accurately the costs of such testing, which would depend amongst other things on the extent to which it is applied, but it is of the order of magnitude of £2m per annum. (MS(H) has decided that allocation from Central Reserves would be inappropriate; funding would therefore have to come from Regional Health Authorities existing budgets.)*
>
> *As well as technical problems, there are numerous medical and ethical implications of such testing, and these are being examined by the Working Group on AIDS set up under the Advisory Committee for the NBTS. The first meeting of the Working Party is being held tomorrow".*

(7) On 11 January 1985, Dr Smithies minuted the CMO's Private Office with a draft submission to Ministers on screening blood donations for the AIDS antibody: [DHSC0000562].

(8) On 15 January 1985, it is apparent that CMO put the finalised submission to Ministers no doubt based on the draft provided by Dr Smithies(*). I am advised by the Inquiry that this submission has not been recovered and no copy has been located in the available DHSS records either. Ken Clarke replied to the CMO on 22 January 1985 (*), and I note that my Private Office was included in the distribution list for his response, so it is likely my Private Office was copied into the 15 January 1985 submission as well: [DHSC0002482_012].

(9) On 31 January 1985, Sir Donald replied to Ken Clarke. The CMO provided Ken Clarke with the requested draft letter to RHA Chairman and a draft press release. He also affirmed, following the first meeting of the Expert Advisory Group on AIDS (EAGA), the advice that blood donations should

be screened for the AIDS antibody as soon as reliable testing facilities were available: [DHSC0002311_050].

(10) In a follow-up minute to Ken Clarke's Private Office dated 1 February 1985 (*), Sir Donald confirmed and expanded upon the need for both the antibody test and heat treatment: [DHSC0002327_028].

(11) On 20 February 1985, the commitment to a screening test was one of the five points of action announced by Ken Clarke in response to an inspired PQ from Dr Brian Mawhinney MP: *"… tests to screen blood donations for HTLV III antibody are being developed, and we are co-ordinating the evaluation work needed to ensure that such a test can be introduced routinely in the National Blood Transfusion Service as soon as possible. We have written today to regional health authorities asking them to set aside funds in 1985-86 for the introduction of this screening test in their Blood Transfusion Centres"*: [DHSC0002261_043]. This was mirrored in a Press Release of the same day: [DHSC0101892]. The establishment of the EAGA was another part of this announcement.

(12) The letters to RHAs referred to in this announcement were signed by Graham Hart the same day, 20 February 1985: [DHSC0002482_045]. He said:

> *"We hope that a reliable screening test, compatible with existing equipment, will be available within a few months. There is as yet no firm indication of what this will cost. As a broad indicator it would be prudent to assume for planning purposes a cost of around £2 per test, though we hope for a lower figure. Although there are many competing calls upon your resources, this test, when available, will be an important preventive development, meriting a very high priority. We would be grateful therefore if, in firming up the budgets for 1985-86, you would make suitable provision. As soon as there is firmer information about when in 1985 the test will be available and how much it will cost we will let you have it. We need to be able to*

assure patients that treatment involving blood or blood products does not expose them to the risk of contracting AIDS. I should add that the Blood Products Laboratory at Elstree hopes that all its Factor VIII will be heat treated from April 1985 onwards."

6.87. These exchanges show that Ken Clarke had some initial concerns about the cost-effectiveness of the screening test and raised a query as to whether it was necessary as well as heat treatment. However, he accepted the case for the introduction of screening once reliable testing was available. There is no indication in the available records that I intervened in this matter. Since Ken Clarke agreed with the principle of screening and the announcement of it, I do not think I would have seen a need to become involved. In the event that Ken Clarke had not agreed with the CMO's submission it is quite likely that the matter would have been raised for further discussion with me, but that eventuality did not arise. To the best of my knowledge, therefore, I did not play a direct role in the decisions leading to the announcement on 20 February 1985.

6.88. The Inquiry asks about the decision to form the EAGA and why this had not been done sooner. The EAGA was convened by the CMO with wide terms of reference. The available records do not help to explain exactly the thinking behind the formation of the new group. In his autobiography, "One Doctor's Odyssey" [WITN0771088 (internal page 186)], Sir Donald gave this explanation of the formation of the EAGA:

"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 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.

6.89. The Inquiry next asks me about the exchange of correspondence which I had with Nicholas Edwards, Secretary of State for Wales, in late 1985.

6.90. On 25 September 1985, in the context of the wider fight against AIDS, I had written to the Prime Minister in the following terms: [SCGV0000150_067]

"The AIDS infection represents one of the most serious public health hazards faced by this country for many decades. With the help of our Expert Advisory Group on AIDS a range of measures has been taken to control the spread of the infection, for which there is at present no specific treatment or vaccine.

Further action is in the pipeline. Barney Hayhoe will be announcing a package of measures on 26 September. This will include new money for the Thames Regions treating the majority of UK cases, assistance to Haemophiliac Reference Centres for counselling and further support for voluntary sector organisations doing valuable information and counselling work.

Experience in the United States (they have 12,000 fully developed cases while we have just over 200) indicates that we will shortly have to deal with a number of long term problems resulting from the spread of the infection. Problems already identified lie in the areas of housing, education, insurance, employment generally and particularly in bodies like the prison service and the armed forces. Cooperation between Departments on an ad hoc basis has worked well so far, but I am sure we need to establish more formal arrangements for the resolution of problems which will arise in the areas I have mentioned.

I therefore propose to ask Barney Hayhoe to invite colleagues from those Departments which have these broader interests to join him in a Steering Group. It will direct the work of an interdepartmental team of senior officials, under DHSS chairmanship, who will explore the details of problems and make recommendations to the Steering Group.

I think it is important that the Government should be seen to be taking action to cope not only with the public health problems involved, on which we are well advanced, but also with these wider implications. The announcement planned for 26 September will cover both aspects. I enclose a draft of what we intend to say.

I am copying this to Geoffrey Howe, Douglas Hurd, Nigel Lawson, Keith Joseph, Kenneth Baker, Leon Brittan, Michael Heseltine, David Young, George Younger, Nicholas Edwards, Tom King and to Sir Robert Armstrong".

6.91. On 8 October 1985, Nicholas Edwards wrote to me referring to my letter to the Prime Minister [DHSC0044118]. He pointed to the breadth of the Welsh Office's responsibilities (which encompassed housing, education and employment as well as health services) and the importance of Welsh Office representation on the Steering Group. In a handwritten addendum he gave strong support to the Steering Group commenting that following his own visit to the USA he saw it as of the first importance, and that the Group would have to face important and difficult issues.

6.92. Within his letter, Nicholas Edwards also raised AIDS testing kits, stating:

"It seems to me that the Government's strategy for containing and combating AIDS rests heavily upon the sensitivity and reliability of the testing kits that the BTS and the PHLS will use and upon public confidence in these tests. I think it is important that monitoring of the kits' performance, and if necessary their manufacture, be instituted as soon as they are

brought into use, and that arrangements be made to ensure quality control, and so maintain public confidence. I hope that this is being actively considered".

6.93. On 14 October 1985, Barney Hayhoe announced the start of routine screening of blood donations for antibodies to HTLVIII: [WITN0771089].

6.94. On 18 October 1985, Nick Edwards wrote to me again adding to his earlier comments on HIV testing: [ARCH0000068]. He said:

"Since I wrote to you on 8 October on this subject, I have been given a detailed presentation by my officials. In the course of it, I was given the results of the evaluation by the National Blood Transfusion Service of the Wellcome and Organon test kits which have been recommended for use in the BTS. As the table I attach shows, 1 in 5 of "strong positive" test material was missed by the Wellcome kit, and about half of the "weak positive" material was missed by the Organon kit. I understand that the manufacturers have given assurances about future quality control but I cannot help wondering how realistic their promises are: I would have expected that firms producing kits for evaluation in the knowledge that a very lucrative contract lay in the offing would have done their utmost to ensure the highest possible degree of quality control in the material supplied.

Be that as it may, I accept that even unreliable testing is better than no testing at all. But clearly we must take every step to ensure that we get the system as foolproof as it can be. I am therefore surprised to learn that no further evaluation is planned of the other test kits which are available on the market. I believe this is because there were considerable doubts about the suitability of the other kits, such as Abbott. However, the 4 October edition of the Journal of the American Medical Association (JAMA) reports (copy attached) that 5 months of experience with other kits in the American Blood Transfusion Services have shown a very high standard of performance. Whatever doubts we might have about their claims, it does

seem to me that we would be in an indefensible position if, in a few months time, the earlier doubts about the systems we are using were not allayed and we had no alternative available which the BTS could immediately turn to. In short, I consider it essential that all kits should be put into an evaluation programme. A public comparison between the report of the BTS on our present kits with the JAMA report would make life very difficult for us all!"

6.95. On 31 October 1985, Mr Harris (HS1) put a submission to the CMO and to my Private Office with a draft response to the letters from the Welsh Secretary [WITN0771090]. Again, I think it is helpful to set this out in full – in part because it gave the context to the concerns that had been raised, and in part because it was omitted in the documents raised by the Inquiry in its request on this issue. Mr Harris said:

"I attach a draft reply to the Welsh Secretary's letter of 18 October. It also disposes of a related point raised in paragraph 4 of his letter of 8 October.

2. The reaction of Mr Edwards is understandable. He has been shown the draft report of the evaluation in the BTS of two screening tests. The purpose of the evaluation was to look hard for problems. As expected it found some. The report is a highly technical document needing expert interpretation. A group of experts examined the findings. The Welsh Office were represented on this group. The group were able to put the problems found in their proper context. They had no hesitation in recommending the general use of these tests. The performance of the tests since introduction has been monitored. Experience to date suggests they are satisfactory.

3. A fairly robust response is proposed. The introduction of a screening test, after a rigorous two stage evaluation, is one of the Government's most notable achievements in response to the challenge of AIDS. It is highly undesirable that another member of the Government should have such a negative perception of this achievement. Private attitudes can

easily become reflected in the tone, if not the content, of public statements and correspondence. Damning the test by faint praise could lead to the very failure in public confidence which Mr Edwards wishes to avoid".

6.96. Mr Harris's submission contained a full and robust draft response to Nick Edwards' earlier letters: [WITN0771091]. As I have noted above, this was a submission that went up through the CMO. Mr Harris had already agreed its content with the DCMO Dr Ed Harris. The evaluation of testing kits was a specialist area, typical of issues where the medical officers led by the CMO would have been closely involved and taken the lead. I have not seen the CMO's own response, but on 15 November I sent the response to Nick Edwards as per the suggested draft (see further below). I infer that Sir Donald must have been supportive of the line taken by Mr Harris and Dr Harris, and I in turn would have relied on CMO's approval to the detailed response regarding the testing and the desirability of the firm response.

6.97. My letter of response of 15 November 1985 is at [DHSC0002482_126]. While it should be read in full, the opening passages included the following:

"I am concerned that you have obtained from your officials such a negative impression of the Government's achievements in this area. This is the more surprising since your officials have participated fully in the forums which gave us the medical and scientific advice on which our policy has been based.

Perhaps the most worrying misconception is the statement "unreliable testing is better than no testing at all". This is the complete opposite of our thinking. We have based policy on the firm conviction that unreliable testing would be disastrous and would engender a false sense of security. This was the reason why we delayed the introduction of screening until we were satisfied that the tests to be used were sufficiently reliable. To achieve this objective the tests now in use have been subjected to a rigorous two stage evaluation, which to our knowledge surpasses what has been done

elsewhere. The first step of the evaluation, which was carried out on a limited number of sera, identified two diagnostic kits particularly suitable for use in the BTS. The trials of these two kits carried out in the BTS was on a much larger scale and gave us a very clear indication of how the tests would perform in the field.

This first draft of the report of this evaluation did of course identify problems. This was the whole point of the exercise. The reasons for the apparent failures to which you draw attention were by no means clear cut and more work is being done to pinpoint the cause. The evaluation results were considered in detail by an "ad hoc panel" of leading experts (on which Welsh Office were represented). They had no hesitation in agreeing that routine testing of all blood donations should start, using these two test kits".

6.98. On 11 December 1985, Nick Edwards replied to my letter of 15 November 1985, thanking me for its comprehensive nature and the reassurance it provided: [DHSC0004360_061]. I read his response, which was carefully nuanced, as seeking to justify the concerns that the Welsh Office had raised through his earlier letters and their reasons for doing so, but acknowledging that more information had become available and they were re-assured.

6.99. The Inquiry has asked me a series of questions about this exchange, focussing on the line in my response that "*we have based policy on the firm conviction that unreliable testing would be disastrous and would engender a false sense of security*". Following the announcement of 20 February 1985 to which I have referred above at paragraph 6.86(11), I had not been involved in the detailed consideration of which tests should be used, their evaluation, or the assessment of speed of introduction versus reliability of results. I will revert to this in paragraph 6.105, below. The Inquiry asks if Nick Edwards' letter caused me concern at the time. Had I read it initially and in isolation, I expect that it would have done. From my general experience, however, upon receipt by the Private Office I expect that this letter would have been sent for advice from the relevant officials. So it is likely that I would first have seen Nick Edwards' letter when it came up to me through the CMO with the detailed explanation from Mr Harris.

Mr Harris' submission – which as I have indicated must have been supported by the CMO – was reassuring. He was able to detail the measures that had been taken to ensure that the chosen tests were satisfactory in their performance and the rigorous two stage evaluation that had been applied. I would have trusted and relied on that advice, and been reassured by it.

6.100. I do not know whether what lies behind the Inquiry's questions is the suggestion that it would have been better to adopt different alternative testing kits, or to introduce the same testing kits but to have done so sooner and without such thorough evaluation – in other words to risk greater unreliability and false results in the interests of greater speed of introduction. Although I was not involved in the detail of this, this is an area where we (in my view justifiably) relied on the expert medical advice being given on the balance to be struck between speed of implementation and reliability. Looking at it now, while it may be said that lives may have been saved by the most rapid introduction of *some* testing, the concern about unreliable results and engendering a false sense of security has force too, as it did at the time. Introducing a testing system involving less reliable testing, particularly if it had a tendency towards false negatives, would risk more cases slipping through the net. I do not feel that I am able to comment more meaningfully or in more detail on whether the balance was struck correctly, whether at the time or viewed with all the benefits of hindsight. What I do know is that if the tests were regarded as unreliable then this would have been justifiably criticised by experts and laymen alike. I have no reason to doubt that the judgments made at the time were made in good faith on the merits as were assessed at the time. In particular, the strategy that was adopted – approving a two-stage evaluation of rival tests – was in line with the advice given by the CMO, in what the CMO acknowledged to John Patten was a finely balanced decision: see further paragraph 6.105(10), below.

6.101. On 8 January 1986, Dr Smithies put a submission to Barney Hayhoe, via the CMO, on the results of HIV screening of blood donations from 14 October to 30 November 1985: [WITN0771092]. A draft press release was included. My Private Office was not copied into that particular submission. At that stage, seven donations out of 397,124 had tested positive (0.0018%). Dr Smithies

noted that the equivalent figures in Australia and the USA were 0.0033% and 0.25% respectively. Dr Smithies commented that:

> *"The campaign by the Department and the NBTS to discourage donors in high risk groups from giving blood seems to have been effective. Furthermore there is no evidence that individuals from high risk groups are donating blood to determine if they have positive anti HTLV III test".*

Barney Hayhoe's Private Office responded on 14 January 1986 with a suggested amendment to the Press Release: [WITN0771093].

6.102. On 20 January 1986, Dr Smithies updated Barney Hayhoe's Private Office because the figures up to the end of December 1985 had by that stage become available: [WITN0771094]. Again, my Private Office was not copied into this. The figures were now that 13 donors had been confirmed as positive from 593,396 donations (0.002%). The press announcement had been amended to include a reference to the SNBTS.

6.103. On 6 February 1986, Dr Smithies minuted the CMO's Private Office, who had asked for a new note on the presentation of the information. It does not look like Ministers were copied in: [WITN0771095]. The issue being canvassed was whether to refer to the majority of positive donors having come from high risk groups.

6.104. On 11 February 1986, the final DHSS Press Release was published, citing me rather than Barney Hayhoe as giving the announcement: [WITN0771096]. In the end, the Press Release – via a quotation from Dr Gunson – did refer to the fact that ten of the 13 donors with positive results were from recognised high risk groups. From the available papers, I have not seen any submission to my Private Office ahead of this Press Release. I am afraid that I cannot now recall what my response was to the figures provided at this time.

6.105. Finally in this sub-section, the Inquiry has also asked me a series of questions about the introduction of the screening test and whether I had concerns now or

at the time. The issues raised are the length of time taken, what is described as the preferential treatment given to a test produced by British companies, the process by which the UK companies had become involved, and the decision to request Regional Health Authorities to provide the funding for the tests. Appreciating that I remain ultimately accountable, I was not directly involved in the detail of the decision on the testing strategy, and I do not feel that I am best placed to comment on these issues beyond the observations which I have already made in paragraph 6.100, above. The Inquiry will be aware of the main milestones between the 20 February 1985 announcement and the start of testing on 14 October 1985. However, in order to try to assist from the available records I have set out some of the main developments below, seeking to focus on what was coming to Ministerial level. As I have indicated, in the vast majority of cases my Private Office was not copied in because other Ministers were directly engaged:

(1) Written answers to PQs by Ken Clarke 22, 25 and 26 February 1985: at [WITN0771097, PRSE0003350] and DHSC0002261_065] respectively.

(2) Lord Glenarthur, responding to debate in the Lords on 18 March 1985: [HSOC0018710, pp. 33-37].

(3) Letter from Ken Clarke to Peter Thomas QC MP dated 27 March 1985: [MACK0002649_018].

(4) Answer by John Patten to a PQ on 16 April 1985: [DHSC0002267_034]. In error, John Patten had referred in an answer to a supplementary question to a hope to have a screening test within a few weeks. A follow up submission to Mr Patten (copied to Baroness Trumpington's Private Office) noted that it would have been more accurate to say that the Department hoped to begin *evaluating* screening tests within the next few weeks and that realistically the introduction of the screening test was unlikely to be introduced until the latter half of 1985: [DHSC0000555].

(5) Response dated 29 April 1985 by the CMO to a Rule 43 letter from HM's Coroner for Inner North District Great London regarding the very sad death

of a baby at Great Ormond Street who had received a blood transfusion in the USA soon after birth [WITN0771098]. Sir Donald's letter referred, amongst other things, to the work being done on testing and was copied to the Private Office of Baroness Trumpington. See also the related earlier submission to Baroness Trumpington of 12 April 1985 [WITN0771098] which noted that a report on the introduction of a test for antibodies to the AIDS related virus had been prepared for submission to the EAGA.

(6) Correspondence between Ken Clarke and Sir Philip de Zulueta, Abbott Laboratories and associated briefing: 1 May 1985 [DHSC0000221]; minute from CMO to Ken Clarke, 30 May 1985 with a summary on the AIDS Screening Test position, copied to Private Offices of Baroness Trumpington and Mr Patten [DHSC0002482_028]; 5 June 1985 [DHSC0000219]; 12 June 1985 [DHSC0002110]; 1 August 1985 [DHSC0000220]; 2 August 1985 and response of 8 August 1985 [DHSC0002116], [DHSC0002311_059].

(7) Minute from Dr Harris (DCMO) to Mr Harris, dated 31 May 1985, 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: [WITN0771099].

(8) Minute from Mr Harris to Dr Smithies, dated 5 June 1985 (not copied to Ministers but reflecting views of both the CMO and John Patten) with draft Ministerial submission: [WITN0771100].

(9) Submission to John Patten, dated 7 June 1985, from Mr Harris and copied to Private Offices of Ken Clarke and Baroness Trumpington: [DHSC0002311_019]. The paper recognised at paragraph 5 that the choice between these options would reflect *"the balance of advantage between having a test in place quickly as a defence against criticism of*

tardiness; or waiting until [the Department] had a test which [could] be confidently recommended for BTS use". The recommendation was selection of a test after both PHLS evaluation and field trials in the BTS. The PHLS costs would involve an increase in PHLS funding in 1985/1986 of £742,000 (£0.5 million of this sum could come from centrally financed services, provided Ministers were content to give it priority over competing bids, but £242,000 would have to be found from as yet unidentified savings). Information Division signalled to Mr Patten their support for publicity to be given to the strategy, if agreed, including the important reasons for the time that would be taken to introduce the new test: [DHSC0002311_020].

(10) Sir Donald Acheson minuted John Patten on 10 June 1985: [WITN0771101]. The CMO commented that it was a finely balanced decision but he was in favour of the line recommended by Mr Harris, noting that we must do everything possible to ensure that PHLS was able to keep to its schedule (coped to the Private Offices of the same Ministers, Ken Clarke and Baroness Trumpington). He noted that support for a different view was likely to appear in the medical press, attaching a letter from Professor Bloom. Importantly, however, the CMO's view was in favour of the line that had been put to John Patten.

(11) I have not seen, within the available papers, John Patten's direct response to the submission. However, on 27 June 1985, a minute from Mr Williams to the CMO and Ken Clarke's Private Office (copied to the Private Offices of John Patten and Baroness Trumpington) reflects that the line had been agreed and was to be announced by Mr Clarke in response to an inspired PQ: [DHSC0003828_186]. CMO was to write to editors of medical journals to explain the scientific background to the decisions. The announcement by Ken Clarke went ahead that day in response to the PQ [HSOC0018679_003] and Press Release [DHSC0001184].

(12) 27 June 1985 was also the date of Sir Donald's major paper to me updating on the AIDS epidemic: [DHSC0002114]. The need to introduce at the

earliest opportunity an effective test for all donated blood simultaneously with a similar service for STD clinics was addressed at Section 9(d) of his paper (and in Section 10 on Social Implications) but this did not enter into the level of detail on screening tests raised in the earlier submission to John Patten, as the paper was wider in scope.

(13) Written answer by Ken Clarke to a PQ regarding funding of the tests on 5 July 1985: [DHSC0002271_019]. The 'if pressed' line envisaged the final stage (equipping, training and purchasing) happening in October 1985, which I understand is what was in fact achieved.

(14) Briefing for Ken Clarke's interview on the World in Action programme for, dated 10 July 1985: [DHSC0002337_008]. Testing is referred to at section heading 5.

(15) In the CMO's update to me dated 16 July 1985 [DHSC0002327_032], Sir Donald noted that action was already in hand to ensure the introduction of testing of all blood donations as soon as a sensitive and specific test was available. He went on to say that to introduce such a programme nationally, simultaneously with a programme involving STD clinics in the district hospitals, was a major organisational problem. Careful monitoring would be required to ensure that no unnecessary slippage took place and it would be essential that the counsellors were trained and available prior to this date.

(16) Minute to Private Secretary to Ken Clarke, dated 29 July 1985, advising that the results of the screening test kit evaluation (i.e. that by PHLS) were now available and would be issued to the NHS the next day: [WITN0771103]. This minute was copied to my Private Office, as well as to John Patten and Baroness Trumpington. See also the subsequent minute to Ken Clarke's Private Office of 31 July 1985 [WITN0771104] with a response at [WITN0771105] and a Press Release on 1 August 1985 [DHSC0000513].

(17) Briefing from Dr Smithies to John Patten of 16 August 1985, on an article in the New Scientist alleging that *"Ministers delayed launch of AIDS test"*: [DHSC0000501]. This was copied to CMO's Private Office and set out responses to all the points that had been made.

(18) There is reference in a minute dated 23 August 1985 to John Patten discussing with Sir Donald the need to have developed a clear policy for the use of the alternative facilities for AIDS blood testing, i.e. those to be available outside of the Blood Transfusion Service: [WITN0771106].

(19) Minute from Dr Smithies to Dr Hunt (PS/CMO), dated 2 September 1985, referring to a rebuttal of the New Scientist's earlier criticisms by Dr Napier: [DHSC0002277_075, PRSE0002548]. This was copied to the Private Offices of Ken Clarke, John Patten and Baroness Trumpington.

(20) On 23 August 1985, John Patten announced the date for the introduction of screening tests as mid-October: [PRSE0002603].

(21) Continued correspondence/dialogue between MS(H) and Abbott laboratories, taken up by Barney Hayhoe who had succeeded Ken Clarke and associated briefing: see documents of 17 September 1985 [DHSC0002482_101]; 18 September 1985 [DHSC0002129]; and 27 September 1985 [WITN0771107], [WITN0771108].

(22) Minute to Baroness Trumpington's Private Office on the Wellcome Test, 18 September 1985: [DHSC0002128].

(23) In my appearance on 'This Week – Next Week' on 22 September 1985 [DHSC0000490], I referred to the fact that testing would be introduced from the middle of October and that the reason it had not been introduced earlier (in May) was on the advice of our medical advisors, including the Public Health Authorities. I think by this latter observation, I would have had in mind that the PHLS had been involved in the test evaluations. Dr Jones

was of the view that this had been the wrong decision, but I stated that we had wanted to be sure of effectiveness of the screening test.

(24) Submission from Dr Harris to Barney Hayhoe on alternative site testing (which also covered counselling), dated 26 September 1985, copied to the Private Offices of Baroness Trumpington and Raymond Whitney (who had succeeded John Patten): [DHSC0002327_161]. Barney Hayhoe's response was provided on 2 October 1985: [WITN0771109].

(25) 27 September 1985 minute to CMO's office from the Chief Press Officer regarding publicity for CMO's "Dear Doctor" letter on the new screening tests for AIDS [WITN0771110] and CMO's Dear Doctor letter of 1 October 1985: [NHBT0008222_002].

(26) Consideration of CMO/MS(H) contribution to TV programmes in the lead up to the start of testing: see documents of 3 October 1985 [WITN0771111] and 4 October 1985 [WITN0771112, WITN0771113].

(27) Barney Hayhoe's announcement of the nationwide introduction of blood donation screening on 14 October 1985: [NHBT0004299].

Testing blood for United States military bases (1985) (Inquiry's question 81)

6.106. The Inquiry has referred me to letter from Alun Williams to Dr Darnborough dated 23 August 1985 [NHBT0004235, p. 2]. I have no recollection of this from the time, and there is no indication that it was brought to Ministers' attention, or to mine as Secretary of State. The Inquiry asks if I have concerns about it now. I do not have any further background to this issue to help me to comment further. On the face of this document alone, it may be that what appeared to be envisaged was the US Air Force using Abbot tests themselves to test blood supplied by the NBTS (the minute reads, *"the Abbott test used by the USAF was not one of the first two being evaluated for use in the NBTS"*). That would be somewhat different from the NBTS themselves testing blood donations

destined for USAF bases before such screening was introduced for NBTS supplies for NHS / British private hospital use. In any event, Mr Williams' minute recognised that there were problems whatever response was given ("*refusing to supply any blood to the USAF during that period, or continuing to make supplies available and dealing with any results which may emerge.*") I do not see that it necessarily called for Ministers being made aware of the issue. I note that this was only marginally before the introduction of screening tests by the NBTS. I do not think that I can meaningfully comment any further.

Anonymised testing without consent (Inquiry's question 82)

6.107. The Inquiry asks about my involvement in, and my views of, proposals to undertake anonymised screening of blood donations for HIV without patient consent.

6.108. There had been early consideration of the question and options for screening and voluntary testing at the H(A) Committee. I had mentioned screening as one priority issue in the first meeting of 11 November 1986 [CABO0100010]. See also: the paper at H(A)(86)(8) [CABO0100012]; and the 3rd meeting of the Committee on 20 November 1986 [CABO0100009]. However, the Inquiry's question is directed at a later minute to my Private Secretary from Dr Harris, DCMO, dated 23 January 1987 [DHSC0101033] concerning screening for epidemiological/prevalence reasons. Dr Harris drew my attention to a letter from Sir Richard Doll (MRC Epidemiology Sub-Committee AIDS) in the BMJ, in which he stated that he had failed to obtain support from the medical profession for the conduct of anonymised screening for AIDS in the general population. Dr Harris explained that the Department presently took the line against such anonymised screening. His explanation for this was that:

> "*(1) The scientific value of information obtained is limited and inevitably will be biased by the type of patients requiring a sample of blood to be taken for other purposes. Also because the samples are anonymised one could not determine if the positives come from recognised 'at risk' groups.*

(2) It is considered unethical for the medical profession to have reports of positive antibody tests without the ability to inform the patient of the result and to counsel that individual about life-style and risk to others, including sexual partners. Positive results obtained from ante-natal screening pose even greater ethical problems because any mother found to be positive should be offered the option of termination of pregnancy in her own health interest and if the pregnancy is advanced beyond the stage of abortion then she should be offered a Caesarean section which lessens the risk of infecting her baby. She should also be advised not to breastfeed the infant.

(3) Legal advice is that unless a patient has consented to blood being used for anonymised testing, such testing would invalidate any consent to take blood and, should blood taken be infected, there could be a breach of the doctors duty to inform the patient of the result".

6.109. Dr Harris's minute flagged that the Department's line differed from that of Sir Richard Doll, his MRC Epidemiology Sub-Committee on AIDS and the TUC, and was likely to be raised in the forthcoming Select Committee hearing on 4 February 1987 on that basis. He noted that the media were already interested in this issue and it had been reported that day. Dr Harris also flagged that the H(A) Sub-Committee had asked for a paper on the issue and the EAGA's views would be sought at their 27 February 1987 meeting. Dr Harris's line for the Press Office was that: *"this raises difficult clinical, ethical and legal problems which require careful study*".

6.110. Dr Harris's minute to my Private Secretary was not seeking any Ministerial decision at that stage. I would have recognised that this was a complex issue. While it was an important matter, I already knew that it was being referred to the EAGA for their advice. The matter had already been discussed at the H(A) meeting on 14 January 1987: H(A)(87)(1), [WITN0771114, p. 10]. A paper for the committee (H(A)(87)(2), [WITN0771115] which was closely based on a DHSS draft, had argued that anonymised testing raised unacceptable ethical

and legal considerations, although the BMA were now in favour of anonymised testing in hospitals. Sir Donald, who attended the meeting in person, had asked that the matter should be given further consideration by his EAGA. Returning to Dr Harris's minute, and against this background set out above, I would have noted the content of the minute and recognised that this was going to be the subject of further expert consideration. As my Principal Private Secretary's annotation (*"SofS To note"*) conveys, this was information for me to note at this stage, knowing that the EAGA would shortly be considering the matter.

6.111. I note from the available records that on 12 February 1987, the Chair of the Royal College of Obstetricians and Gynaecologists, Professor Macnaughton, wrote to Tony Newton (by then the Minister of State for Health) on this same issue: [WITN0771116]. Professor Macnaughton noted that the RCOG Ethics Committee had concluded that blind screening of antenatal patients for HIV was unethical, a decision reached following a meeting which Sir Richard Doll had attended. He added however that the College would obey an instruction to undertake such screening if it was recommended by the CMO on the basis that widespread screening was necessary in the public interest.

6.112. On 24 February 1987, at the meeting of the H(A) Sub-Committee on AIDS, I noted that the issue of anonymised testing was due for consideration by the EAGA: [WITN0771117 , p. 15]. There had been inaccurate media reports to the effect that the Government had it in mind to introduce prevalence surveys based on the testing of anonymised samples, whereas it was the BMA who had positively been advocating this before the Select Committee.

6.113. On 27 February 1987, I wrote to Sir Geoffrey Howe, who had written to me enclosing a letter from the Chair of East Surrey Health Authority: [WITN0771118]. One of the points raised was the allied question of screening of health care personnel for AIDS. I noted that there were no plans for such compulsory screening, that testing without the consent of the patients may constitute assault and that doctors may be reluctant to take part in such procedures.

6.114. On 24 March 1987, our AIDS Unit provided briefing to Number 10: [WITN0771119]. I had just announced that Dr Joe Smith, Director PHLS, had been asked to chair a group to consider how the surveillance of HIV infection and AIDS could be improved and to make recommendations as to what further studies were needed. This was to be a sub-group of the EAGA. The background note included in this briefing referred to the discussions that had been ongoing between the MRC, the RCOG and DHSS and Scottish Home and Health Department officials about whether pilot antenatal screening for HIV antibodies might be worthwhile. Consent would be obtained either by direct questioning or by implied consent by it being made known through leaflets and posters that such screening was taking place. Truly anonymised testing was still a possibility. The briefing to Number 10 also included a note which Sir Donald had provided to me that same day on a report in the Daily Express.

6.115. The complexity of the issue was further illustrated by the strong representations against ante-natal screening of pregnant women – see in this regard Cardinal Basil Hume's letter to me of 27 March 1987 [WITN0771120] and my reply of 8 April 1987 [WITN0771121].

6.116. A minute from Dr Pickles (AIDS unit) dated 1 April 1987, which was not copied to Ministers, refers to the fact that there had not yet been full in-house discussion within DHSS on ante-natal screening nor had a Ministerial view been given: [WITN0771122 and WITN0771123]. However, Dr Pickles referred to the fact that I had given a BBC interview the previous week giving *"...a strong steer against anonymised screening*". Her paper set out options that might be adopted.

6.117. On 2 April 1987, my Private Office was sent a draft paper for the H(A) Sub-Committee entitled 'AIDS: Improving the Data Base' which had been agreed by the CMO and Strachan Heppell: [WITN0771124 and WITN0771125]. Paragraph 7 of that paper addressed proposals for better information. Paragraph 8 noted that Dr Smith's group had been asked to report to the CMO as soon as possible. The finalised paper became H(A) (87)(12) dated 3 April 1987: [WITN0771126]. This paper was then discussed at the H(A) Sub-

Committee on AIDS meeting on 9 April 1987: [WITN0771127]. It was noted that I had convened a conference the previous month to consider how the database on HIV infection and AIDS could be improved. I alerted colleagues that, of the options for obtaining better data on prevalence, the greater the quantity of reliable data that any option would provide, the greater were the legal and ethical difficulties that it would present. It was for that reason, as I explained, that Dr Smith's group had been established to report, as soon as possible, to the CMO. In summing up, Lord Whitelaw noted that while it was clearly important that the database should be improved, this was an area of considerable political importance which would require very careful handling. He wanted the 'room for manoeuvre' to be kept open until the position the government might wish to take was easier to discern. It was agreed that proposals would be brought forward in light of the advice from Dr Smith's group.

6.118. On 27 April 1987, an opinion piece in The Independent by Nicholas Timmins put the case for anonymised screening: [DHSC0006354_096]. It referred to a part of my announcement of Dr Smith's group where I had said that there were *"strong arguments against [anonymised screening]"*, suggesting that I had appeared to kick straight into touch one of *"the most important recommendations"* the group could make.

6.119. Dr Smith's group held their first meeting on 28 April 1987, with the CMO attending: [WITN0771128]. I would not have received minutes of this meeting.

6.120. Anonymised testing was addressed in briefing for my appearance before the Social Services Committee in May 1987: [DHSC0003899_040]. On anonymised screening, the briefing suggested the following line:

> *"ii) Anonymised Screening*
>
> *Anonymised screening, sometimes called blind screening, has been proposed by a number of researchers. It is as well to be absolutely clear about what is meant by anonymised screening. In essence it would involve testing for HIV the blood of a sample of patients, for example*

hospital in-patients, whose blood needs to be taken for other purposes. However, to preserve the anonymity of those tested, the blood samples would simply record the age and sex of the patient, not the person's name.

This approach clearly offers some significant advantages. If carried out on a sufficiently wide basis it would provide information on the scale of the infection, geographical variations and on the rate of spread. This would increase our ability to evaluate the effectiveness of our public education campaign and would be helpful for planning services.

But it also presents a number of difficulties. From the epidemiological viewpoint the information provided is not complete. It would not be possible, for example, to ascertain the spread of the infection into the heterosexual population because those in the "risk groups" could not be identified.

In addition, substantial ethical and legal problems arise:
- first in connection with testing of blood for HIV without seeking prior consent;
- second, as a result of not being in a position to inform, counsel, or provide assistance to people whose blood is found to be positive.

These considerations require detailed examination before any decisions can be reached.

Dr Smith's expert group on monitoring and surveillance may well decide to consider the question of anonymised screening along with other possibilities and is currently actively considering this option together with others. But I, obviously, cannot anticipate their findings": ([DHSC0003899_040] at page 10).

Selective screening was separately addressed in the next sub-section of the briefing.

6.121. The Committee's Report addressed the issue at §12*ff*: [CBLA0002374]. They were unable to recommend the general use of anonymised screening but supported an urgent need for further epidemiological studies with informed consent. They were also in favour of the routine testing (but with consent) of all pregnant women, preceded by carful pre-test counselling by trained medical and nursing staff: see §16 and Recommendation 4.

6.122. I am informed that Dr Smith's group reported in January 1988, with publication in May 1988, which was well after I had moved on to be Secretary of State for Employment. I understand that they were not in favour of *"involuntary testing"*, i.e. the testing for HIV antibodies, without seeking the consent of the individual, of blood samples secured for other purposes in the course of medical diagnostic procedures.

6.123. From the above, I would observe there was clearly disagreement among medical experts on the efficacy of anonymised testing without consent, its ethics and even its legality. I agreed to and announced the setting up of a specialist sub-group of the EAGA to consider this further but had moved to the Department of Employment before it reported. To the extent that I referred to arguments against anonymised testing without consent, these were issues that had been raised in the then-current medical and legal advice within the Department. Those reservations would appear to have been borne out in the subsequent sub-committee's report, although I understand that these were then put out to consultation and there was (again after my time) increasing support for a form of anonymised testing.

Funding support to Haemophilia Reference Centres including for counselling (Inquiry's question 83)

6.124. The Inquiry asks me about Ken Clarke's answer to a Parliamentary Question on 19 February 1985, in which he said that staffing levels for haemophilia reference centres were a matter for individual health authorities to determine against their other priorities and that we were *"urgently considering what advice*

to give to health authorities concerning AIDS-related counselling including the needs of haemophiliacs": [HSOC0018722].

6.125. The Inquiry asks if I was aware of this issue at the time, what my position was on it and whether I considered allocating additional funding to it.

6.126. The question of funding for counselling was raised in submissions at around this time and so I would have been aware of it. For example, it was touched upon in the draft submission to Ministers to which I have referred at paragraph 6.86(7), above. It was one of the issues which the EAGA was asked to consider.

6.127. Additional funding was provided towards counselling but, as I have explained, there was fierce competition from many deserving quarters for finite resources, and it could not all be centrally funded. In terms of action at this time (1985):

(1) On 18 March 1985, Lord Glenarthur announced a grant of £25,000 for the Terrence Higgins Trust with the aim of allowing them to expand their work, including in counselling: [WITN0771129];

(2) CMO's submission to me of 16 July 1985 (which was copied to the other Health Ministers) raised the provision of further resources in addition to the current PESC bid for counselling and other aspects of health education: [DHSC0002327_032];

(3) On 6 August 1985, John Patten announced that DHSS had asked Health Authorities to draw up plans for a nationwide AIDS counselling service: [WITN0771130]. £50,000 was being provided to enable St Mary's Hospital to run training courses for AIDS counsellors over the next two years;

(4) Barney Hayhoe's announcement of 26 September 1985 explained that part of the additional £1 million funding for that year would be used to help the three Thames Regions who were carrying the heaviest AIDS burden to provide treatment and counselling to those infected, and would also be used to support the counselling work of the Haemophilia Reference

Centres and to provide help to the voluntary sector for the valuable information and advice work they were doing: [WITN0771131]. This funding included £680,000 (in total) for the three Thames RHA areas, £90,000 for the Haemophilia Reference Centres, and a further £10,000 for the Terrence Higgins Trust. See also my letter to the Prime Minister of 25 September 1985: [SCGV0000150_067].

(5) On 1 October 1985, Barney Hayhoe attended the EAGA meeting personally. In response to concerns about funding levels the minutes record Barney Hayhoe explaining the constraints under which the Health Ministers had to act: [WITN0771132]. See also the discussion under agenda item 7 at that meeting: [WITN0771132, p. 6].

(6) On 2 December 1985, I was able to announce the allocation of an additional £6.3 million to support action on AIDS, important aspects of which were targeted towards counselling. £270,000 was to be provided to the six Haemophilia Reference Centres to continue support for specialist counselling services they had set up and £100,000 was to be used for the training of health professionals in the counselling of AIDS sufferers: [WITN0771133], [DHSC0003685_047].

6.128. I would only add these observations. As the paragraphs above demonstrate, we did find funds for the training of counsellors and to support counselling within Haemophilia Reference Centres. In his answer to the PQ on 19 February 1985, Ken Clarke did refer to individual health authorities needing to determine staffing levels for Haemophilia Reference Centres against their other priorities. Encouraging health authorities to consider the allocation of existing funding to the AIDS effort was a necessary part of the response given the Treasury's restriction on new funding. In the sixth meeting of the EAGA on 1 October 1995, to which I have already referred, it can be seen that Barney Hayhoe was having to explain to those present that decisions on overall allocations were not dependent on Health Ministers alone. He explained that we had made a strong case for additional monies and would continue to argue for the need for more

resources. My general recollection, which is not tied to this specific period, is that AIDS was not seen as a priority in the Treasury or for that matter at No. 10.

Guidance on children with AIDS attending school and meetings with mothers of children with haemophilia (incorporating Inquiry's questions 84-85)

6.129. The Inquiry asks me whether there had been a delay in the introduction of guidance in relation to children with AIDS attending school. This is raised in the context of criticism made by Dr Peter Jones during the 'This Week – Next Week' programme on 22 September 1985, in which we both appeared: [DHSC0000490], see also paragraph 6.105(23), above.

6.130. The background to this item was parents who had kept their children off school on discovering that a haemophiliac boy had HIV. The essence of Dr Jones' point was that DHSS and DES had had sufficient evidence since April 1985 to give clear guidance on the issue.

6.131. As I sought to make clear in the programme, I entirely agreed with Dr Jones' wider point that there was no evidence to suggest that a child with haemophilia and HIV would be a risk to his fellow pupils.

6.132. As to the timing of guidance issued by DES, that is primarily a matter which the Inquiry would need to pursue with that Department. From the records available to me on the health side, I can say that:

(1) The minutes of the sixth meeting of the EAGA on 1 October 1985 refer to the fact that interim guidance had gone to the Department of Education and Science, but had not yet been agreed by their Ministers: see §12.4 of the minutes, [WITN0771132, p.10].

(2) At the seventh EAGA meeting on 26 November 1985, 'Health Care Arrangements for Children at School Infected with HTLVIII: Guidance to

DES' was item 6 on the agenda: [DHSC0002287_060]. At §35, the background was briefly explained in that:

> *"The Chairman welcomed Dr Abrams. He informed members that the Department of Education and Science had formally requested medical advice on the issue; consequently the Department had convened a working group which had drawn up guidance after two meetings".*

(3) In a submission dated 6 December 1985, Dr Abrams advised the Private Secretary to Barney Hayhoe of the completion of the draft guidance which had been endorsed by the EAGA and about which the CMO was content: [WITN0771134]. This was copied to my Private Office. The guidance took into account the US Centres for Disease Control Morbidity and Mortality Weekly Report of 30 August 1985, which I understand from the available records had been presented to the EAGA meeting of 1 October 1985 as EAGA 6(14): [WITN0771135] [WITN0771136] [WITN0771137].

(4) On 14 January 1986, guidance was issued by the DES, requesting responses on the non-medical aspects by 21 February 1986: [OXUH0001271]. It referred to the interim guidance that had been issued by DES in October 1985.

6.133. From the above, I cannot see that there was delay in the provision of medical input once this had been requested by DES. However, I would need to be given access to wider records, including the full correspondence between DHSS and DES on this issue, in order to comment in more detail.

6.134. One point I would however wish to make is that the need for better co-ordination of efforts between Departments was one of my main motivations for writing to the Prime Minister on 25 September 1985: [SCGV0000150_067]. Sir Keith Joseph, Secretary of State for Education and Science, was one of those copied

in and his Department was identified as one of those with a leading interest. I noted that:

> *"Problems already identified lie in the areas of housing, education, insurance, employment generally and particularly in bodies like the prison service and the armed forces. Cooperation between Departments on an ad hoc basis has worked well so far, but I am sure we need to establish more formal arrangements for the resolution of problems which will arise in the areas I have mentioned"*.

6.135. As to other criticisms raised by Dr Jones in the same programme, upon which the Inquiry also invites me to comment, I have set out in as much detail as I am able the responses to issues such as the screening of blood donations in earlier sections of this statement.

6.136. The Inquiry has also referred me to a meeting with two constituents whose sons had haemophilia: [HCDO0000276_037]. No precise date is given but from the context I assume this was sometime in early 1987. I am very sorry but after so many years I have on the most general recollection of this meeting. The records made available to me do not include anything in relation to this meeting and, as it appears to have been a meeting in my constituency capacity (my recollection is of it being in my advice surgery), there would not have been a Departmental official present. Accordingly, I only have the report of the meeting in the Haemophilia Society bulletin to go on. I cannot confirm one way or the other whether there were questions I could not immediately answer and, if so, what they were. If points were raised in such a meeting which I was not able to address straight away, I would indeed have made that clear. The Inquiry asks me whether I gained further knowledge later of issues raised in the meeting. I have endeavoured to set out as fully as I can in this statement – inevitably based very largely on the written records – what information came to me at different times.

6.137. As to meetings with the Haemophilia Society, the available records suggest that it was normally the Ministers with blood products in their portfolio of

responsibilities (or sometimes the Minister of State) who would attend meetings with the Society and correspond with them. Examples are the meetings (or planned meetings) with Gerry Vaughan, Geoffrey Finsberg and Lord Glenarthur; and the correspondence between the Society and Barney Hayhoe and Baroness Trumpington. In the debate on 21 November 1986, I made plain the openness of the Department to meeting voluntary organisations: [HSOC0018220, p. 6].

6.138. In terms of meeting bleeding disorder patients and family members, the available records do not provide me with much assistance and I obviously cannot now recall every hospital visit, nor did I distinguish between HIV/AIDS patients based on how they acquired the infection when making such visits. My memoir refers to my visit to the new ward at the Middlesex Hospital after returning from the US in January 1987 but this was, as I recall it, before its official opening. I visited a second London hospital dealing with AIDS patients, as referred to in the minutes for the 4 February 1987 H(A) meeting [WITN0771138]. This may have been the Chelsea and Westminster Hospital, however I am unable to recall whether any of the patients had been infected through contaminated blood or blood products. Another visit I should mention was my first visit to the Mildmay Mission Hospital in East London which is a much smaller hospital but one we kept open because of its specialism in HIV and AIDS.

1987 Social Service Select Committee (Inquiry's question 86)

6.139. I gave evidence to the Social Service Select Committee on 13 May 1987: see the briefing ahead of my evidence at [DHSC0003899_039 and DHSC0003899_40] and my evidence (alongside that of Tony Newton, Sir Donald Acheson, and Strachan Heppell) at [WITN0771140].

6.140. The Committee reported on 15 May 1987: [CBLA0002374].

6.141. The issue which the Inquiry raises in relation to this report is the discrepancy in the funding of Haemophilia Reference Centres in Scotland compared to the rest of the UK. This was referenced in paragraph 162 of the report, which stated:

> *"162. The DHSS has provided each of the seven Haemophilia Reference Centres in England with £40-45,000 a year for the last 2 years to cope with the extra burden of work placed on them by HIV. The Welsh and Northern Ireland Offices have provided similar levels of funding for the centres in Cardiff and Belfast. However, in Scotland, the Edinburgh Centre has received only temporary support from the Lothian Health Board, and the Glasgow Centre has had a small counselling research project funded by SHHD. There has been no support comparable to that in the rest of the UK. We hope this discrepancy will be rectified as soon as possible. We recommend that all haemophilia centres have the requisite funding to enable them to cope with the extra work AIDS and HIV entail for them. Ideally, this money should include specific provision for a fully-trained AIDS counselling service"*: [CBLA0002374, pp. 98-99].

6.142. The recommendation arising from this was #80:

> *"80. We recommend that all haemophilia centres have the requisite funding to enable them to cope with the extra work AIDS and HIV entails for them. Ideally, this money should include specific provision for a fully-trained AIDS counselling service. (para 162)"*: [CBLA0002374, p. 121].

6.143. In the DHSS Press Release following the report, I said that:

> *"I welcome the work that the Social Services Committee have done and in particular the focus they have brought to bear on AIDS issues. Their assessment of the position and recommendations will be carefully considered.*
>
> *The Government has taken, and continues to take, the threat of AIDS extremely seriously. The Government's evidence to the Committee,*

including my own evidence to them at Wednesday's session, set out the Government's response. It is summarised overleaf.

"One of the Committee's recommendations is that additional help should be given for the provision of hospice care. I am glad to say that the Government will be providing contributions towards two London projects.

First, the London Lighthouse in West London. £500,000 will be contributed to capital costs and £100,000 to revenue costs for this year.

Second, the Mildmay Mission Hospital in East London. £150,000 will be contributed to capital costs of a new AIDS hospice ward and £50,000 to immediate running costs": [DHSC0003920_058].

6.144. The formal response to the report was issued in January 1988, six months after I had left to become Secretary of State for Employment: [DHSC0004437_064]. On recommendation 80, the response was:

"*4.37 The care of haemophiliacs with HIV infection is well established. The Government has given £650,000 to haemophilia centres since September 1985 for HIV counselling of haemophiliacs and their families. Counsellors at haemophilia centres have been trained and the Haemophilia Centre Directors have organised two seminars to discuss the problems of counselling.*

4.38 The main demand for counselling haemophiliacs derived from their use of infected non heat-treated Factor VIII. This is now treated to inactivate HIV and new cases of infection are not arising. Further expansion of counselling facilities for haemophiliacs is not, therefore, considered necessary.

4.39 The Government has recognised the unique position of haemophiliacs with HIV infection, and that their circumstances are wholly exceptional. It has decided that an ex-gratia grant of £10 million will be

made to the Haemophilia Society. This is not compensation but is to enable the Society to establish a special trust fund to make payments to affected individuals and families throughout the United Kingdom": [DHSC0004437_064, p. 33].

6.145. The Inquiry asks whether I considered and agreed with the recommendations and what steps were taken to implement them. I would naturally have read the report as soon after its publication as practicable. I am, however, unable now to recall my specific reaction to the discrepancy in funding whereby Scottish centres had not received the extra funding that had been provided to the English and Welsh Haemophilia Reference Centres. Any steps for levelling up that service in terms of an injection of funding in Scotland would have been for the Scottish Office. Moreover, the June 1987 election had been called. An internal note records that, while officials had to start preparatory work on the response on the report, *"until Ministers are in office decisions cannot be taken on the form the response should take"*: [WITN0771141].

6.146. The Government's response to this recommendation, which I have set out above at paragraph 6.144, fell to my successor. Looking at it now, my observation would be that against the finite resources available a wholly separate national counselling service – if that is what was envisaged – was probably too ambitious at this stage. But what merited consideration was ongoing efforts to ensure that there were sufficient numbers of trained counsellors in the relevant centres. I will address compensation in the next section of my statement, but the Government's final January 1988 response, in referring to the ex-gratia grant of £10 million, reflects developments handled by Tony Newton and John Moore after I had left the Department. As to the recommendations more generally, the Government response to the Social Services Committee report would have taken some months to formulate, starting with officials' consideration. As I have explained, it would then have been for the new, post-1987-election, Health Ministers to decide upon.

The wider AIDS campaign and funding (incorporating Inquiry's questions 87-94)

6.147. In this section, the Inquiry asks about my proposal to the Prime Minister for an interdepartmental steering group, contained in my letter of 25 September 1985: [SGV0000150_067]. The Inquiry asks about the key decisions and actions taken by the DHSS in the wider public information campaign relating to AIDS. It also raises a number of discrete issues concerning the wider AIDS campaign and funding.

6.148. In his autobiography, Sir Donald Acheson speaks of the significance for him of learning in 1985 (from a US colleague) of cases of infection in US soldiers from vaginal rather than anal intercourse, and then the impact of an FCO report of the developing prevalence of HIV in a number of African countries: [WITN0771088]. He goes on to say:

> *"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"*: [WITN0771088].

6.149. The urgent appointment request of which Sir Donald speaks can, I think, be linked in the available records to Sir Donald's paper to me of 27 June 1985, to which I have already referred: [DHSC0002114]. It is reflected too in his minute of 16 July 1985: [DHSC0002327_032].

6.150. This was the catalyst to the wider public information campaign about which the Inquiry asks, but also to the measures that I took to drive forward more effective cross-Government action. I would like to think that Sir Donald's description of

me giving *"unfailing support and encouragement"* to this effort is accurate. For my last two years in office at DHSS this was my undoubted priority. In saying that, I am immediately conscious that for the haemophiliac community issues in the preceding 1982 – 1985 timeframe had been critical. As the CMO had advised in his minute to me of 30 July 1985: *"I am satisfied that it is extremely unlikely that any patients with haemophilia treated in the UK will in future be infected with HTLV III virus – but sadly a very high proportion of the haemophiliac population already are infected due to previous use of un heat treated Factor VIII"*: [DHSC0000514]. In recognising that AIDS became my highest priority as Secretary of State from the second half of 1985 to 1987, I should not be taken to imply that previous measures and decisions were viewed as unimportant. Rather, at this stage in 1985, I recognised that it was going to need a member of the Cabinet to fight for the necessary further actions and reforms. We were right to anticipate this need. There was indeed substantial opposition at the very highest level of Government, and more generally among some elements of the public, to the various measures I introduced, although we in fact received far fewer public complaints and objections than we anticipated.

6.151. The challenges that we faced can be seen in the CMO's papers of 27 June [DHSC0002114] and 16 July 1985: [DHSC0002327_032]. 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. It was estimated that 10,000 – 20,000 people, mostly men, had been infected. The number was rising rapidly. There had been 170 UK cases of AIDS to the end of June 1985 (which was to rise to 275 by the end of the year). The long incubation period meant that those infected were often unaware of both their infection and their infectiousness. As those involved in this Inquiry will be all too familiar, infection was usually fatal: there were no drugs for treatment at this stage and no cure, and the personal and social consequences of HIV infection to the infected person and his or her family were calamitous. The CMO warned that plans should be based on the assumption that no means would be available to prevent the disease by immunisation in the next five years.

6.152. In his 27 June 1985 paper, to address the risks to haemophiliacs and from blood donation, the CMO identified the following needs:

(a) Check that all Factor VIII and Factor IX used in UK was now heat-treated;
(b) Provide health education and advice for infected haemophiliacs and their families;
(c) Introduce at the earliest opportunity an effective test for all donated blood simultaneously with a similar service for STD clinics;
(d) Introduce counselling and education for donors with HIV positive tests and train an appropriate number of counsellors.

6.153. In his 16 July 1985 paper, CMO added / clarified that:

(a) For blood donors, action was in hand to ensure the introduction of testing of all blood donations as soon as a sensitive and specific test was available. To introduce such a programme nationally, simultaneously with a programme involving sexually transmitted diseases clinics in the district hospitals, was a major organisational problem. Careful monitoring would be required to ensure that no unnecessary slippage took place. It was essential that the counsellors were trained and available prior to this date;

(b) For haemophiliacs and their families, UK and foreign heat-treated Factor VIII was available in sufficient quantity for all UK haemophiliacs. Further infection of this group should not therefore take place provided that non-heat-treated material is not used. Heat-treated Factor IX produced at BPL Elstree was expected to be available in October 1985 for sufferers of Christmas disease. Heat-treated foreign Factor IX was already available for named patients on prescription. The action identified was to ask Professor Arthur Bloom to contact all the Directors informing them of the availability of heat-treated Factor VIII: [DHSC0002327_032, p. 4].

6.154. For haemophiliacs and blood donors, therefore, CMO's main message was that important action had been taken; it was important to see through other action already in hand; and that counselling needed to be prioritised. I have addressed

each of these issues in earlier sections of this statement but I have set them out here again because they are important context.

6.155. Underlying much of what the CMO was identifying in the wider areas was the desire to warn all those that had not contracted the virus of the precautions that they could take. This would have to encompass: public education directed at the general population and in secondary schools (as part of sex education) on the nature and risks of AIDS and on condom use; a programme of education and advice for the gay community throughout the UK; and solutions to the plight of injecting drug users where shared needles and the transfer of blood were a major cause of infection. For the general public, we had to combat the perception that AIDS was the exclusive concern of small sub-groups of the population. CMO noted that "*it is essential to get across a balanced but informed view of the scale of the infection, its rapid increase, the crucial need to control it and the fact that unless control is successful, it is likely to spread (probably slowly) to other sections of the population.*" [DHSC0002327_032].

6.156. At the end of July 1985, John Patten visited New York and Washington and reported back on his discussions concerning AIDS. The themes he raised chimed very much with those of the CMO: [DHSC0002327_148], see also [WITN0771144 and WITN0771145].

6.157. This in broad terms was the background to my letter to the Prime Minister of 25 September 1985 [SCGV0000150_067] as well as Barney Hayhoe's announcement the next day: [WITN0771131].

6.158. To seek to address in full the wider action taken in relation to AIDS after this point would make this already lengthy statement yet more protracted. It would also require me to be given fuller access to the relevant Cabinet and Cabinet-Committee papers (I have been provided with some but not all of the Cabinet Committee papers for 1986, and a fuller set for 1987). However, as requested by the Inquiry, I would wish to highlight some key aspects.

6.159. In my letter to the Prime Minister, I was pressing for an interdepartmental team of senior officials, under DHSS chairmanship, who would explore the details of problems and make recommendations to the Steering Group to be chaired by Barney Hayhoe. The inter-Departmental Group on AIDS first met on 21 January 1986 and was chaired at Deputy Secretary level. Barney Hayhoe's Ministerial Group first met on 20 November 1985.

6.160. Early work on the national health education campaign can be seen from the minutes of 7th meeting of the EAGA on 26 November 1985:

> *"43 …. An agency had been retained and had initially concerned itself with market research into the 'at-risk' groups' and the general public knowledge of AIDS and how they responded to existing AIDS literature. The agency was liaising with a number of groups such as the Haemophilia Society, the Terrence Higgins Trust and organisations concerned with drug abuse. A presentation of the Agency's initial findings had been made to Ministers and the Chief Medical Officer. The Departmental Steering Group had now commissioned the agency to develop proposals which might form the basis of a national AIDS information campaign":* [DHSC0002287_060].

6.161. In the first months of 1986, work continued with the agency towards large scale national advertising, planned for early March 1986: see the minutes of the 8th meeting of EAGA on 15 January 1986 at [DHSC0000833]. At the same time, the Health Education Council were working towards a new leaflet (commissioned and funded by the Department) that would contain *"…the more explicit information on high risk and safer sexual practices which may not be appropriate for Press advertising. It will be promoted as part of the national campaign and will be provided to members of the general public who make a conscious decision to ask for explicit information on AIDS*": see the submission of 6 February 1986 at [DHSC0002363_015, p. 1]. The terms of the draft leaflet ('AIDS - what everybody needs to know') [DHSC0002363_015, p. 2] may seem routine today but for the time it was ground breaking and controversial for government-funded literature to be so explicit.

6.162. In March 1986, the final guidance 'Children at school and problems related to AIDS' was published by DES and the Welsh Office: [WITN0771146].

6.163. That month my Department provided a briefing package for all MPs: [DHSC0105117]. In my covering letter I sought to explain to MPs why a national information campaign was necessary, including the provision of basic facts and dispelling myths about AIDS and HIV. It was also necessary to alert high-risk groups to the danger of infection and encourage them to change their lifestyles, while emphasising to the general public the dangers of sexual contact with people who may be infected. I warned that some people would be offended by the references to sexual activity in the campaign material but that, without that information, the campaign could not achieve the change in behaviour necessary to contain the spread of the virus.

6.164. The middle of March 1986 (only slightly delayed from the target date) saw the launch of the first part of the media campaign, with the prominent placement of the information piece 'Are You At Risk From AIDS" on Sunday 16 March 1986: [WITN0771147]. Further advertising followed on 17 March and 6, 7 April 1986, in late July 1986, and in September 1986. As I explain below, getting to agreement and publication of the original print advertisement took weeks and it was only a start. The later print advertisements moved towards more direct and simpler messaging.

6.165. Getting agreement to this advertisement demonstrated that the way that government was organised at the time remained an obstacle. AIDS was dealt with by the general Home Affairs committee of cabinet. It was one, and only one, of a number of items that appeared on the agenda. If I needed to get proposals through AIDS was given no priority. The members of the cabinet committee were generalists who in the main in 1985/1986 had no special knowledge. As the months went by it was increasingly apparent that the Home Affairs Committee, which could not focus solely on AIDS issues, was not an effective forum to get swift agreement to the action that was needed.

6.166. At this stage, however, the March advertisement needed to be approved by the Home Affairs committee. We ran into immediate problems. I, supported by the CMO and Barney Hayhoe, had taken the view that the messages needed to be clear and should not be muffled. When the advertisement was circulated the part on risky sex provoked the alarm of the Prime Minister. Mrs Thatcher made two attempts to change our approach. After she raised her initial reservations (*"Do we have to have the section on risky sex? I should have thought it could do immense harm if young teenagers were to read it"* she had queried), the committee in fact supported me. Then, just before the publication, Number 10 came back again with further objections voiced by her PPS Nigel Wicks:

> *"The Prime Minister has emphasised that she still remains against certain parts of the advertisement. She thinks that the anxiety on the part of parents and many teenagers, who would never be in danger from Aids, would exceed the good which the advertisement might do. In her view it would be better to follow the VD precedent of putting notices in doctors' surgeries, public lavatories etc. But to place advertisements in newspapers which every young person could read and learn of practices they never knew about would, in her view, do harm":* [open-source reporting of documents released into the National Archive, WITN0771148].

After what I think was only very minor change, the advertisement went ahead.

6.167. However, it was becoming quite clear that we could not go on like this with delay written into the whole process. Later in the year, with the invaluable support of Robert Armstrong the Cabinet Secretary and Ken Stowe it was proposed to the Prime Minister that a special cabinet committee on AIDS should be formed chaired by William Whitelaw (see further below).

6.168. Following the first stage of the media campaign, the next stages were to consider a universal leaflet drop and television advertising – see in this regard (internal to DHSS) the submission of 4 June 1986 [WITN0771149]; the CMO's further submission to Barney Hayhoe of 13 June 1986 [WITN0771150]; a further

submission to the Minister of State of 18 June 1986 [DHSC0002311_048]; and my approval of 23 June 1986 [DHSC0003898_109].

6.169. At around the same time, Sir Donald raised with Ken Baker, by now Secretary of State for Education, the need for further action in schools on AIDS including risk education: [WITN0771151]. See also: Barney's Hayhoe's letter of 28 June 1986, [WITN0771152].

6.170. On 21 August 1986, I wrote to William Whitelaw, making the case for considerably stepping up the public education campaign [DHSC0003836_045]. I said:

> *"I have approved a further round of advertising for September and we shall be developing a campaign aimed particularly at young people, alongside our main campaign aimed at the general public, and the work which voluntary bodies are doing with our help to influence the high risk groups of injecting drug abusers and committed homosexuals. I am enclosing for information copies of the advertising material from which we shall be selecting the September advertisements. …*
>
> *But we need as soon as possible to make a special effort to bring home to people the real magnitude of the risks from AIDS, what must be done if we are to control it and the priority the Government gives to this. Having considered the options, I propose that we should have an AIDS leaflet delivered to every household in the UK spelling out in simple and explicit language what they need to know. A number of other countries, including West Germany, Austria, Switzerland and Denmark have already done this. The leaflet 'drop' will need substantial related advertising and other publicity to ensure it gets maximum attention. The aim will be to achieve this in November. I would hope in this single step to achieve a breakthrough in public recognition of the seriousness of the problem. We shall be able also to say more in the leaflet than has been possible in the newspaper advertising or would be possible in television commercials".*

6.171. The September 1986 press advertisements focussed more directly on the key questions of how to avoid AIDS and what constituted risky behaviour. The language used was more direct and more explicit (based on the evidence that most people had not been offended by the earlier advertisements): [WITN0771153]

6.172. A submission to Tony Newton on 24 September 1986, shortly after he had taken over as Minister of State, updated him on the leaflet drop plans: [WITN0771154]. I took other opportunities to publicise the crucial role of public education and the message that the threat of AIDS was an issue on which the nation should unite not divide: see The Guardian, 17 November 1986 [HSOC0015702].

6.173. Once set up in November 1986 (the first meeting was on 11 November 1986 [CABO0100010]) the Special AIDS Committee under Willie Whitelaw achieved rapid results:

(1) The first decision approved the letter box drop of an AIDS leaflet to every household in the country: [CABO0100010]. See also our paper to the Committee, 'Public Education Campaign', H(A)(86) 3 at [CABO0100013]. This decision had been somewhat held up in the general committee on the ground that it might cause offence: [WITN0771154]. A delivery and a media campaign were planned for the very beginning of the New Year: see [HSOC0018220].

(2) The next decisions involved using television, radio and posters to get over the message "Don't Die of Ignorance". Every advertisement was approved by myself and the CMO. We had follow up research undertaken on the advertisements which I will come to later.

(3) The most difficult meeting of the special committee was my later proposal on the distribution of clean needles. An argument raised against this proposal was that it would condone crime (drug taking) and one member said that under no circumstances could he support it. In the end, thanks

partly to sympathetic chairing of Willie Whitelaw, the proposals scraped through. In fact it was spectacularly successful and infections were radically reduced.

6.174. In the debate in the Commons on 21 November 1986, I stressed that public education on AIDS had to be the number one priority. I was able to announce that:

> *"…The Government will expand and intensify their public education campaign. We shall be making £20 million available over the next 12 months for that purpose. The main elements of the campaign that I shall shortly be launching are as follows: from this Sunday there will be a further intensive round of newspaper advertising lasting over the week—the fifth round of such advertisements; that will be backed up by a general poster campaign, with posters appearing in 1,500 sites around the country; shortly after that there will be a youth campaign, using magazines, radio and cinema; early in the new year there will be a leaflet drop to all 23 million households in this country accompanied by television and radio advertising to maximise its effect; the HEC leaflet "Don't Aid AIDS" will be sent to all pharmacies—around 11,000 outlets—where members of the public can get them free.*
>
> *In addition, I have had talks over the past few days with the chairmen of the BBC and the Independent Broadcasting Authority about the role of broadcasting in the education campaign. Both chairmen recognised the gravity of the situation and agreed that the broadcasting organisations had a role to play. They also showed their readiness to co-operate in public service broadcasting. I am extremely grateful for their co-operation and advice. The IBA yesterday issued a statement welcoming our proposals for radio and television advertising on AIDS and also announcing its intention to follow up those advertisements by a series of public service announcements on both independent television and independent radio"*: [HSOC0018220, p. 3].

As I address at 6.205 below, I had to find the funding for this without recourse to new Treasury income. In the same debate, I also announced the reconstituting of the Health Education Council as an SHA, mindful of the role that it would need to play in ongoing education in relation to AIDS.

6.175. In previous jobs I had always sought to find out how other countries were facing the same problems. I applied the same approach here and I was engaged in a series of foreign visits in late 1986 and into 1987 specifically aimed at furthering our programme on AIDS. This included to the WHO in Geneva (November 1986) [WITN0771155 and WITN0771156]; West Berlin and the Netherlands (December 1986) [WITN0771157 and WITN0771158]; the USA (January 1987) (see in this regard my paper to the H(A) Sub-Committee, H(A) (87)(5), dated 2 February 1987 [WITN0771159] and the H(A) Sub-Committee on AIDS meeting on 4 February 1987 [WITN0771160]); and West Germany (April 1987) [WITN0771161]. The most significant of these visits was the one to the USA, including California, Washington and New York. I had expected that they would be able to give public health guides but I was disappointed. The President, even more than our Prime Minister, ignored the whole issue. Activity on the ground depended on individual states and particularly on voluntary effort. The visit received substantial press and television coverage although I had envisaged it as a visit to expand knowledge. I was accompanied throughout by the CMO (again demonstrating our close relationship). As I have mentioned in the introduction section to this statement, one photograph which drew attention on both sides of the Atlantic was myself shaking hands with an AIDS patient who died a few weeks later. This was considered unusual by many who did not believe our publicity that you could not contract HIV by the act of shaking hands. The picture (not arranged by us) served in a very direct way to help fight the stigma that surrounded AIDS and which more generally was a leading aim of our policy. Princess Diana much more importantly added to the campaign with the famous picture of her shaking hands with an AIDS patient.

6.176. The Prime Minister held a meeting with me, Willie Whitelaw, Sir Donald and Tony Newton on 27 November 1986: [WITN0771162]. The Prime Minister was attentive to the AIDS issues we wanted to raise[8].

6.177. On 17 December 1986, Sir Ken Stowe made a confidential record of advice he had received from the DPP that our planned leaflet would not offend against the law, and the Solicitor General's view that needle exchange would not do so either: [WITN0771164].

6.178. I announced plans for trials of needle exchanges in a written answer to a PQ on 18 December 1986: [WITN0771165].

6.179. Ken Stowe worked with me to make preparations for further engagement with the main church groups over the further public education campaign – see his minute of 23 December 1986: [WITN0771166].

6.180. On the same day, I wrote to all District Health Authority Chairmen: [DHSC0003899_100]. I encouraged them to tie their local health education activities to the national AIDS campaign. I called on them to ensure that their plans included adequate provision for STD clinics involved in testing and counselling as well as public education and treatment of AIDS cases. I stressed the importance of meeting the submission of plans by the end of the year.

6.181. Over the Christmas and New Year period 1986-1987, to my regret, one of our proposals for the campaign – a ministerial broadcast on AIDS – was vetoed by the Prime Minister. This plan had been approved by the AIDS committee. Michael Meacher, the Shadow Social Services Secretary, had agreed that Labour would not ask for the usual Opposition right of reply – indicating the bi-partisan approach of the parties at that time. The proposal then went to Number

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[8] Insofar as relevant to HIV/AIDS, my diary for Thursday 27 November 1986 records, "A 30 minute briefing of the Prime Minister on AIDS prior to Cabinet. I take along Donald Acheson. It goes well. She asks good questions and shows a wide understanding of the disease and what should be done to prevent its spread". Later in the same entry, "In the evening I take off for Geneva to see the World Health Organisation on AIDS" [WITN0771163]

10 as I was told that a ministerial broadcast needed the specific authority of the Prime Minister. In spite of the Cabinet committee's approval this was not forthcoming. I asked to see Mrs Thatcher and on New Year's Eve 1986 I met with her at No. 10. She said that she had not had a ministerial broadcast on either the Falklands War or the inner city riots - neither of which could be called bi-partisan actions. She was entirely immoveable on the issue and added the advice that I *"mustn't become known as just the minister for AIDS"* . However, as I recorded in my diary, my feeling was that I had "*...a duty (if that doesn't sound too pompous) to inform the public of the dangers ... My fear would be that unless we do this then in five years' time the judgement will be that the government 'didn't do enough'. I do not believe that can be said now but we must ensure that it remains the case*". (Diary entry, 31 December 1986 [WITN0771168]). It became clear later that what she meant was that I should in effect do something else. I should have remembered my first attempt to get a newspaper advertisement approved by the Prime Minister earlier in 1986.

6.182. On 8 January 1987, I held a press conference on the AIDS publicity campaign: [DHSC0003836_090]. The drop of the AIDS leaflet 'Don't Die of Ignorance' was to take place for 2-3 weeks from 12 January 1987 with TV advertising to highlight the importance of studying it carefully. One of the TV adverts featured the tombstone/monolith to which I shall return later in this section.

6.183. An independent report on the campaign was also carried out by the British Market Research Bureau which monitored four waves of advertising from February 1986 to February 1987 (the summary of which I exhibit at [WITN0771169]). The leading results included:

(1) The proportion of people who claimed to have seen or heard or read 'anything about AIDS recently' increased from 44% to 94%.
(2) The 'proven recall' figures for various groups varied between 78% and 87% - it was stated that *"these are among the highest figures for any social persuasion advertising campaign in Britain"*.
(3) *"Attitudes to the advertising were generally very favourable. In particular there was throughout the year widespread support for the fact that the*

Government was undertaking the campaign. There was only a low level of offence or embarrassment felt".

(4) The proportion claiming to know more about AIDS than a couple of months ago rose from 38% to 70% among the adult sample over the four waves and from 60% to 84% among the youth sample between Waves 3 and 4.

The review stated: *"It is concluded that the advertising campaign substantially achieved the objectives of educating the public and influencing the climate of opinion as a basis for behaviour modification".*

6.184. Following our engagement with them, the broadcasting authorities contributed by issuing several informative documentaries and news programmes, by giving free 'air time' to AIDS advertising on all channels and by running an 'AIDS Week' on radio at the end of 1986 and broadcasting 19 hours of television programmes in an 'AIDS Television Week' in February 1987. The DES also published a facts booklet for teachers, lecturers and youth workers.

6.185. In addition, in May 1987 we set up the National Aids Trust which campaigned for better services for all with HIV: [WITN0771170]. It was an independent charitable trust, whose work was divided into: (i) *"the coordination of voluntary effort in the AIDS field, the distribution of funds to voluntary organisations and the provision of advice and information to those in the field*"; and (ii) *"the coordination and encouragement of public support and fund-raising for AIDS work"*: [DHSC0002537_348].

6.186. I turn to a number of discrete questions raised under this section of the Inquiry's request.

6.187. The Inquiry has asked me about the debate in the Commons on 21 November 1986 [HSOC0018220]. As I recall it, this was a debate that I had pressed for as part of our efforts reaching a climax at the start of 1987. As to why no full debate had taken place in the Commons earlier than this, I would make three points:

(1) Debates in the Commons happen normally because of the need to pass legislation. That took priority. A general debate with no vote was much more unusual;
(2) The people who decided whether there should be a debate were the Leader of the House and the Chief Whip with obviously the Prime Minister and the Deputy Prime Minister being closely consulted;
(3) Another way of obtaining a debate was for the Opposition to ask for one, which as far as I am aware they did not. Policy on AIDS was broadly bi-partisan.

6.188. I accept that I was likely in error in stating that *"the first case of transmission by blood transfusion was reported in the United States in 1983"*. Briefing on 26 February 1987 to Tony Newton for a media interview [DHSC0001376] stated:

> *"We became aware in 1982 that haemophiliacs in the USA were contracting AIDS. Although the mechanism of infection was not known, it was presumed that it had been transmitted through use of blood products, such as Factor VIII. By mid 1984 the virus had been clearly characterised and shown to be the causative agent for AIDS*".

See to similar effect, Tony Newton's PQ written answer on 5 May 1987: [DHSC0004232_008]. I made the reference to the first case being in 1983 in opening the debate and I would have been reading from a text which would have been prepared by officials with changes made by me. On this aspect I would have been reliant on the officials' draft however the responsibility for the error remains mine. Had it been drawn to my attention subsequently, I would have issued a correction.

6.189. In a later section of my speech opening the debate, I said that:

> *"Since 1983, warnings have gone to all blood donors telling those in high risk groups not to give blood. The evidence is that those warnings have largely been successful".*

I think this would have been a reference to the relative success in persuading high risk groups not to give blood. The Inquiry asks what the evidential basis for this was. Without access to the full briefing for this debate (which does not appear to be within the documents currently available to me), I am unable to answer that with certainty but I would have been relying on the advice of officials in making such an assertion. I note however that this was indeed the view when the first results of HIV antibody screening of blood donations became available. The briefing from Dr Smithies to Barney Hayhoe on 8 January 1986 had said that *"the campaign by the Department and the NBTS to discourage donors in high risk groups from giving blood seems to have been effective"*: [WITN0771092].

6.190. As I have indicated in my introductory comments, I know that the Inquiry has heard evidence from those infected with HIV and their families about the issue of stigma. In its request, the Inquiry draws my attention to this, noting that the Inquiry has heard from individuals infected with HIV/AIDS and their families who have described *"the fear and stigma they associated with some of the imagery in the public health campaign (for example, the tombstone feature in television announcements)"*.

6.191. I accept this is an important and difficult issue and I have sought to address it in my introductory comments.

6.192. The Inquiry asks about the extent of my involvement in the messaging and imagery used in the campaign. With the CMO, I did approve each of the advertisements, both those in print and the television advertisements.

6.193. The Inquiry asks about stigma and whether we considered this in the relation to the imagery. I do wish to re-emphasise that, in my view, the stigma was not created by the campaign. It was created by those who criticised and opposed the campaign and/or were bigoted and prejudiced, such as Chief Constable Sir James Anderton claiming that claiming that victims of the disease were *"swirling in a human cesspit of their own making"* and Lord Monkton suggesting that *"there is only one way to stop AIDS. That is to screen the entire population*

regularly and to quarantine all carriers of the disease for life".' It is easy to forget now the vigour of such outrageous comments as these. I stood up to this kind of response and would not be deflected from our non-judgemental stance and the need to speak openly and rationally about the risks. By the straight talking and non-judgemental language used in the campaigns, we were careful not to condemn any group. As I have already referred to, photographs of me shaking hands with an AIDS patient on one of the wards in San Francisco were unusual for the time, though I had not sought the coverage. So we – and I personally – were trying to mitigate stigma.

6.194. The Inquiry also asks whether we considered that the advertisements could lead to fear amongst those infected or at risk of infection, or their families. As regards those *at risk* of infection the adverts were intended to be startling and hard-hitting precisely because of the urgent need to raise awareness, get people's attention, and change behaviours to save lives. This approach was endorsed by the H(A) Committee. For example, at the very first meeting, on 11 November 1986, in discussion the point was made that, "The material in the advertisements should be visually striking and hard-hitting" [CABO0100010]. We had to consider tough advertising that would have the necessary impact. At the AIDS sub-committee discussion on 14 January 1987 [WITN0771171] we considered an advertisement under development that that depicted the developing disfiguring skin conditions characteristic of AIDS because surveys had shown that people responded more vividly to the threat of disfigurement than to that of death. We rejected this. Nevertheless, the number one purpose was to prevent more people contracting HIV and to prevent deaths. We had no drugs and no vaccine. Effective advertising was our only way forward. As I set out in my memoir, 'AIDS Don't Die of Prejudice', we *did* also reject early ideas from the agency on the basis that they were too reminiscent of trailers for a horror film. The (H)A Sub-Committee agreed that the public education campaign had been pitched at the right level: H(A) minutes of 14 January 1987), [WITN0771171]. As I noted at the time, "*…in pitching the tone and content of our message on this point we had a particularly difficult but important balance to strike"*: paper to H(A), H(A) 87(3), paragraph 3, 13 January 1987 [WITN0771172]

6.195. The final advertisements were direct and effective. The public education campaign is widely regarded as having been successful in raising awareness and saving lives. The tensions or balances about which the Inquiry asks are perhaps illustrated by the fact that the 'tombstone' advert is often mentioned as being the most memorable in the campaign that was successful in saving lives; yet that same advert is the one identified in evidence to this Inquiry as having been the most difficult for the infected and their families. I am not sure whether it would have been possible to navigate a middle course that would have avoided adding to the fears of those already infected, without detracting from need to get the message across vividly so as to avoid further fatalities. Our motivation was to prevent further infections and further loss of life. As a result of the campaign there was a reduction in HIV and other sexual disease.

6.196. The Inquiry has asked me about a draft brief for the advertising agency [DHSC0003898_011] which contains the following:

> *"i General Population*
> *Specific issues may need to be addressed as they arise. In 1985 gays and haemophiliacs were the subject of much press coverage and were of high interest. One message was to de-vilify these two groups and to make it clear that all are at risk. This is no longer a priority, although any reference to sexual practices should not draw attention to particular groups, except by inference or implication, or suggest they are pools of infection".*

6.197. With the various manuscript amendments, this document has the hallmarks of a draft. I very much doubt that I would have seen this draft at the time and the covering minute does not suggest that I did: [DHSC0003898_008]. A later version retains this text but appears still to be a draft: [DHSC0105127].

6.198. I am not clear precisely what is being referred to as the message in 1985 to de-vilify gays and those with haemophilia, nor why it was being said that this was no longer a priority. When I saw this document for the first time in preparing this statement, I did not understand the references to which the Inquiry draws my

attention and they do not reflect my own thinking. I was not consulted on this wording.

6.199. As I have indicated, I was responsible for the final articles and advertisements and for the direction of the public education campaign. The advertisements were also always cleared with the CMO personally and he was careful to ensure their medical accuracy. I would not have been involved in writing the agency briefings however. The CMO and I were very clear that the main purpose of the public education campaign was to educate both the general population and the at-risk groups about what the risks were and how to avoid or reduce them. We were mindful that the risks were wider than just to homosexual men and haemophiliacs and wanted to convey that message clearly (hence *"Does AIDS only affect homosexuals?" "No"* in the first advert). We wanted, throughout, to be clear and non-judgemental in the language used. We wanted to reduce unnecessary fears by dispelling myths and by providing accurate information about HIV and AIDS. Dispelling such myths was in part to avoid unfair and inappropriate treatment of those with HIV.

6.200. The Inquiry raises the question of funding to take appropriate measures against the risks of AIDS, both with respect to individuals with bleeding disorders and the wider population. To a large extent, I have addressed this in previous sections of this statement. In particular, I have already referred to the announcement I made on 2 December 1985 announcing a further £6.3 million to combat AIDS (c.£22.7m in today's money): [DHSC0003685_047]. The Inquiry may be further assisted by the summary provided to the CMO in November 1985: [DHSC0002484_080].

6.201. The Inquiry has additionally referred me to my letter to the Chief Secretary to the Treasury of 30 May 1986 on the 1986 Public Expenditure Survey (PES): [HMTR0005018]. My 30 May 1986 letter illustrates both the efforts my Department was making to secure AIDS funding, but equally the many other deserving and demanding areas such as breast and cervical cancer screening for which we had to seek additional funding.

6.202. There is also contemporaneous briefing on AIDS funding as at June 1986 when there was a Social Services Committee Enquiry Into Public Expenditure: [WITN0771173]. This included a summary of Government funding then allocated to AIDS: [WITN0771174].

6.203. The Treasury's response of 24 July 1986 [HMTR0005021] is typical of the pressure that was applied in the spending round, with the Treasury wanting my bid for Hospital and Community Health Services' additional AIDS funding to be found by efficiencies, not extra funds, despite the fact that we had already committed to finding the necessary Centrally Administered Health and Personal Social Services AIDS funds from efficiencies.

6.204. In the debate on 21 November 1986, I announced £20 million to be spent on the further public health education campaign (c£62m in today's money). I provided further information on funding in answer to a PQ from Michael Meacher on 1 December 1986: [WITN0771175].

6.205. On 11 December 1986, I wrote again to the Chief Secretary of the Treasury: [HMTR0005022]. My letter set out the need for me immediately to divert more resources to the AIDS programme (I had only recently made the announcement of significant new funding in the debate on 21 November 1986). I set out the savings and transfers from other funds that I intended to use to achieve this. The transfer between different funds needed Treasury approval which I requested. The Inquiry asks if I can recall the response to this from the Treasury. The nature of the response is evident from a note to my Private Secretary dated 19 December 1986 [WITN0771176].

6.206. On 5 February 1987, I announced a further £7 million (c£20 million in today's money) to be provided to health authorities for the treatment, care and counselling of victims and carriers of AIDS [MRCO0000554_010 and WITN0771177]. The wider treatment of AIDS patients is a broader issue, but our approach is evident from the paper put the H(A) Sub-Committee on 7 April 1987: H(A) (87) 3 at [WITN0771178], discussed at the fourth meeting of the Sub-Committee on 9 April 1987 [WITN0771179]

6.207. I have already explained how DHSS repeatedly found the (very substantial) additional funds to meet the BPL overspend.

6.208. The Inquiry asks if in my view the funding was adequate. In one sense, that is an impossible question because in no area of healthcare could the spending match that what would be desirable if that area of medical need was viewed in isolation. Funding was finite and – as I have repeatedly tried to make clear – there were other demanding and potentially life-saving priorities that had be balanced and decided between. In the vast majority of cases, what we had to do with DHSS central funds was to re-allocate funds to the emerging AIDS situation from other areas of health spending. We did that – although we would wished to have been able to find more funding.

6.209. The Inquiry asks specifically about funding for research. AIDS research was co-ordinated by the MRC. However, DHSS provided some direct funding. This direct DHSS funding as at August 1985 was summarised in the submission to John Patten as £45,000 over 3 years: [WITN0771144, WITN0771145]. In November 1985, the DES sought a further contribution towards the epidemiological surveillance centre [WITN0771180, see also [WITN0771181] of £300,000 pa between DHSS and the health departments of the Territorial Departments. I agreed to find £250,000 pa of this, with the remainder to come from the Territorial Departments: [WITN0771182].

6.210. Following the debate in the Commons on 21 November 1986, I alerted colleagues in the H(A) Sub-Committee to the strong plea for more research: see minutes of 4th meeting, 1 December 1986 [WITN0771183 at pp. 3 and 4]. I personally felt that the very substantial funds being invested in the USA did point to the need for us to try to find more research funding in the UK. The MRC had a paper on research in preparation for the committee (see further below). There is a note dated 9 December 1986 from Sir Ken Stowe to his opposite number in the DES regarding the funding of AIDS research, which was to be discussed in the H(A) Sub-Committee on 16 December 1986. Sir Ken Stowe made clear

the difficulty that DHSS itself would have in contributing more to AIDS research, given the unforeseen extra costs of AIDS on other fronts: [WITN0771184].

6.211. However, by February 1987, the MRC was able to launch a directed Research Programme for AIDS, for which purpose the DES increased the grant in aid to the MRC by £14.5m over 3 years (c.£41 million in today's money). I referred to this in the House of Commons on 25 February 1987 [WITN0771185] and by Press Release the same day: [WITN0771186]. This reflected discussions that had been ongoing in the H(A) Sub-Committee and papers put before it:

- H(A) 87 (5), 2 February 1987, [WITN0771159 p. 2]: I had noted following my visit to the USA that while we could not match the resources being put into research by the USA, we must ensure that where the UK can make a distinctive contribution it does so. I recognised that it was doubtful that we had yet convinced the public that we were doing enough.

- H(A) Sub-Committee on AIDS, 2nd meeting of 1987 on 4 February 1987, [WITN0771160 p. 4]: I warned that, while our public education campaign was a contrast in the UK's favour when compared to the USA, the UK Government might be vulnerable to the comparison with the USA on AIDS research. I noted that drawing upon particular UK expertise may involve only relatively small additional amounts of money and noted that the MRC was currently working up detailed proposals. In discussion it was noted that the MRC's first call for additional funds had been met in full but equally their second current call for funds would not prove to be the last and there was a case for such funds to be provided. Papers would be prepared for the next meeting (see below).

- H(A) 87 (6), 20 February 1987, [WITN0771187]; paper from Secretary of State for Education and Science (Ken Baker) on DES/ MRC proposals for AIDS research.

- H(A) 87(7) 23 February 1987 [WITN0771188]: I set out the research being done in addition to the MRC programme. We were expecting to increase substantially our financial contribution to research in support of further proposals.

- H(A) Sub-Committee on AIDS, 3rd meeting of 1987 on 24 February 1987, [WITN0771189]: Ken Baker addressed the further research proposals from the MRC. Despite some concerns being expressed in discussion about the need for funding discipline, the Sub-Committee agreed that there was an exceptional case for funding the first three years of the research programme. I was accordingly invited to make the announcement, as I did the next day.

6.212. As regards AZT, this was raised in a submission to Tony Newton on 10 October 1986 [WITN0771190] and in a further submission to my Private Secretary on 15 January 1987 [WITN0771191] I referred to it in H(A) 87(5) 1987, 2 February 1987: [WITN0771159]. There was an announcement by me of the licensing of AZT on 4 March 1987 [NHBT0053064] with a further submission to me the next day: [WITN0771192]. AZT had been allowed to "jump the queue" in licensing terms, but the normal assessments had been applied. This was the very early stages of treatment; supplies were limited. The submission noted that it was expensive, treatment may cost £4,000 per patient per year, and that we would have to look carefully to make sure there were adequate resources to pay for the treatment. I note that I referred to AZT treatment in my evidence to the Select Committee on 13 May 1987: [WITN0771140]. I referred to the hope that we would be able to provide a grant to the three regions most affected in order to give 'breathing space' in dealing with the cost: [WITN0771140]. So I think that the position shortly before the 1987 election was that we were hoping to provide some ad hoc grant support to ease the immediate burden on the most affected health authorities.

SECTION 7: COMPENSATION AND FINANCIAL ASSISTANCE

Outline chronology (Inquiry's question 95)

7.1. I am asked to describe my involvement in decisions and actions taken by the DHSS in relation to compensation or other financial support for individuals infected with HIV through the use of blood products. From the available records, I have sought to set out below a chronological account of what happened at ministerial level, but also touching on some of the discussions that the documents show went on amongst officials in the Department.

7.2. From the available documents, the first reference I have seen is from 25 February 1985 when Ken Clarke, as Minister of State, provided a written answer to a PQ about plans to compensate people who had contracted AIDS as a result of contaminated blood: [PRSE0003350]. He said: "*There has never been a general state scheme to compensate those who suffer the unavoidable adverse effects which can unhappily arise from many medical procedures*". There was some media reporting of this at the time: [WITN0771193].

7.3. The main thrust of the line taken here was that it was too difficult to distinguish between those infected by HIV through blood (or blood products) and the many and varied cases of those who suffer adverse treatment outcomes in the absence of negligence.

7.4. On 18 March 1986, Baroness Trumpington replied to Anthony Nelson MP who had written to Barney Hayhoe on behalf of his constituent: [DHSC0000194]. Compensation was one of the issues addressed. Baroness Trumpington stated:

> *"The Government have the deepest sympathy for the plight of haemophiliacs. However, there has never been a general state scheme to compensate those who suffer the unavoidable adverse effects which can in rare cases unhappily arise from many medical procedures. Compensation is awarded by the Courts in cases where negligence has been proved. It would, of course, be improper to prejudge any case which*

a haemophiliac might bring, but no suggestion has been made that the doctors treating haemophiliacs have acted negligently. Before the availability of heat-treated Factor VIII, the possible risks of unheated Factor VIII had to be weighed against the effects on the lives of haemophiliacs of ceasing to have treatment. Doctors treating haemophiliacs were, we believe, careful in explaining these risks to their patients. The whole range of health services, social security and social services provision is available to help HTLV III positive individuals".

7.5. On 18 August 1986, Dr Smithies minuted Barney Hayhoe's Private Secretary regarding media reports that the Haemophilia Society intended to seek damages on behalf of infected haemophiliacs: covering note at [DHSC0001025]. The minute does not appear to have been copied to my Private Office. Dr Smithies stated: "*As any litigation would be between the Haemophilia Society and the NHS, it would be improper for the Department to comment where legal proceedings are impending*". The attached background briefing advised that the Department should not comment on the reports and noted that "*the evidence for the statement that the NHS could be the main target for legal action is weak. Whilst the NHS product has indeed been contaminated the HCD survey last year showed unequivocally that the NHS product was far safer than commercial products*".

7.6. The Inquiry has referred me to a minute dated 8 December 1986 regarding a meeting I attended with RHA Chairs on 19 November 1986: [DHSC0014947_002]. The minute attached draft notes of the meeting: [DHSC0014947_003]. The notes say that Mr Wilson, representing the Chairs of the RHAs, undertook to notify me of any compensation claims against the NHS arising from HIV contaminated blood. This was one of the regular meetings I held with chairmen of Regional Health Authorities where both we and they could raise issues of concern. My memory is that this was Mr Don Wilson who at the time was chairman of the Chairs of the RHAs – this was a position which revolved amongst the Chairs. The item presumably followed the issue of litigation being raised but I do not recall anything further and the minute of the meeting does not expand on the point.

7.7. On 28 November 1986, Baroness Trumpington's Private Secretary minuted Dr Moore noting that the Minister had seen a letter from a haemophiliac who contracted AIDS (and that she had heard and read of similar cases) which "*prompted her to ask if any form of compensation should be considered*": [WITN0771194]. This minute was not copied to my Private Office.

7.8. On 12 January 1987, Mr Merkel of the AIDS unit sent the diary secretary to Tony Newton some introductory remarks for the Minister of State to use before the backbench health committee: [WITN0771195]. Question 22 in the briefing Q&A addressed compensation and the line to take was that *"we will be considering this question fully since it has far reaching implications. Officials are preparing a full report on all of the problems faced by haemophiliacs*": [WITN0771196]. These documents were not copied to my Private Office.

7.9. The Inquiry has referred me to a minute dated 13 January 1987 which was circulated by Mr Harris of HS1 to other officials (but not to ministers): [WITN0771210]. The minute noted the increasing pressure for haemophiliacs infected with AIDS to receive state compensation and expressed the view that a ministerial submission would be required in near future. The minute observed:

> "*Our line to date has been that there is no state scheme for compensating those who suffer adverse effects from medical treatment; but that compensation is awarded by the Courts when negligence is proven. I suspect we have little alternative but to adhere to this line. Apart from the inherent cost of a scheme for haemophiliacs it would be difficult to distinguish their problem from that of others who may have fallen foul of drugs with adverse reactions. It might also open up the whole subject of no-fault compensation for medical accidents. We will need in the submission to distinguish the circumstances of haemophiliacs and those of the recipients of vaccine damage payments*".

7.10. The minute attached the headings for a planned Ministerial submission, allocating officials to draft the various sub-sections: [WITN0771210].

7.11. On 15 January 1987, R F Tooher (Finance Division A) replied to Mr Harris' minute. He told Mr Harris that:

> *"You can expect strong Treasury objections to any suggestion that a special compensation scheme should be set up for haemophiliacs because of repercussions for other medical accidents. The Treasury have given approval to medical compensation schemes in very restricted circumstances. This is where the medical risk is assessed as being so slight that it virtually does not exist and where there is a special motive"*: [DHSC0014947_034].

7.12. On 15 January 1987, Tony Newton gave a written answer to a PQ from Frank Dobson MP which adopted a similar line to that taken in Baroness Trumpington's letter of 18 March 1986, and elsewhere [WITN0771197]:

> *"There is no state compensation scheme for those who, like haemophiliacs infected with the AIDS virus, unfortunately suffer adverse effects from their medical treatment. Compensation may be awarded by the courts in cases where negligence has been proved. Compensation for the families of haemophiliacs who die from AIDS infection may similarly be awarded by the courts"*.

7.13. The Inquiry has referred me to correspondence concerning Dr Ludlam's and Dr Jones' support for no-fault compensation for infected patients. Dr Ludlam wrote to his MP, Sir Alex Fletcher, enclosing a letter from Dr Peter Jones published in the Times newspaper: [SCGV0000014_044]. On 26 January 1987, Sir Alex Fletcher MP sent the correspondence to Lord Glenarthur: [SCGV0000014_044].

7.14. On 19 January 1987, Baroness Trumpington wrote to Dr Jones in response to an earlier letter from Dr Jones to the Prime Minister: [HSOC0023125]. She stated:

> *"We all feel the greatest sympathy for haemophiliacs who have suffered this grave misfortune and indeed for all those people who have become HIV antibody positive since the emergence of this new disease.*
>
> *As you may be aware however, there is no State scheme to compensate those who, like haemophiliacs infected with the AIDS virus, unfortunately suffer adverse effects from their medical treatment. Compensation may be awarded by the Courts in cases where negligence has been proved.*
>
> *We do recognise that HIV has put the greatest pressures upon patients and staff alike at haemophilia centres. For this reason we will again be funding centres from a central allocation to support the vital counselling services you provide. Officials will be writing to you all shortly on this matter.*
>
> *Meanwhile, the full range of social security benefits are of course available to those who are infected, and I hope your patients will fully avail themselves of such assistance".*

7.15. I have also seen a letter dated 30 January 1987 from Michael Hirst MP to Dr Ludlam saying a letter from Dr Ludlam had been passed on to me: [LOTH0000009_022]. I have not seen the letter from Mr Hirst to me or the letter from Dr Ludlam to which he refers, but assume it was in similar terms to the Dr Ludlam correspondence that was sent to Lord Glenarthur.

7.16. The Inquiry has referred me to a minute of 4 February 1987 from Mr Heppell to Mr Brockman, solicitor [DHSC0014947_004]. That minute reflects that at a recent meeting of the Health Services Supervisory Board, the question had been raised of the liability for infection arising from contaminated blood or blood products. The point had been made at that meeting that District Health

Authorities (DHAs) should consult RHAs or DHSS about the legal position before entering into any settlement or other recognition. Mr Heppell noted that I had concluded this discussion by asking for advice on the point. Mr Heppell was accordingly seeking advice on the possible liability of the NHS to haemophiliacs with HIV infection and the way in which DHAs could most properly be invited to consult RHAs or DHSS before entering into negotiation or settlement. The minute was copied to the Private Secretaries to Sir Ken Stowe, the CMO and Len Peach (Chief Executive of the NHS Management Board), but not to my Private Office. On 6 February 1987, Mr Brockman replied to Mr Heppell, albeit that he did no more than provide general advice on the law of negligence: [DHSC0014947_027].

7.17. On 4 February 1987, Tony Newton was quoted by the Northern Echo newspaper, who were supporting the campaign for compensation led by Dr Peter Jones and Jack Ashley MP, as follows:

> "*The Government is aware of the points that have been made, but we do see very great difficulties in going down the path that is being urged because of the implications it would have for people who may suffer adverse effects from many kinds of treatment in the Health Service which can arise from a variety of causes without any question of negligence*": [WITN0771199].

7.18. The Inquiry has referred me to a DHSS brief for a Northern Echo interview that was sent to Tony Newton's Private Secretary: [WITN0771219]. The document carries a handwritten date of 26 February 1987. I assume the date is wrong and the document was circulated prior to Tony Newton's interview with the Northern Echo (or, possibly, there was a subsequent interview, but I have seen nothing to suggest that was the case). The briefing maintained the line taken to date. It noted the idea of a system of "no fault" compensation had been considered by the Pearson Commission in the late 1970s but rejected. It also referred to a chronology of key days regarding withdrawal of Armour Factor VIII. The briefing drew a distinction between the situation with haemophiliacs and statutory vaccine damage payments:

"Some people have suggested that there is a parallel under the Vaccine Damage Payments Act 1979, but this is not the case. Vaccines are given to the healthy as a matter of public policy to protect the health of individuals. The Vaccine Damage Payments Act recognises that a finite risk is incurred and provides financial assistance for those children who become vaccine damaged": [WITN0771219].

7.19. On 6 February 1987, Baroness Trumpington replied to a letter from Robert Brown MP which had enclosed a letter from Dr Peter Jones about the problems of haemophiliacs infected with HIV: [WITN0771200]. On 16 February 1987, Baroness Trumpington replied to another letter from an MP which had enclosed a letter in similar vein from Dr Aronstam: [HSOC0013606]. The line taken in Baroness Trumpington's letters was broadly the same as that adopted in her earlier letter of 18 March 1986.

7.20. On 17 February 1987, Dr Smithies replied to Mr Harris' minute of 13 January 1987: [DHSC0001383]. The Inquiry has referred me to this document, although it was not copied to ministers. In relation to compensation, the minute said:

"*It seems likely that we have a finite number of haemophiliacs who have contracted HIV infection. Their position is pitiful and has attracted great sympathy in particular because of the perceived stigma of the disease which is associated with promiscuous sexual activity. The equally sad fact that a number of haemophiliacs will undoubtedly die of chronic hepatitis as a result of non-A non-B infection has not been recognised publicly.*

Some patients are relieved of their symptoms (say of arthritis) by taking non-steroidal anti-inflammatory drugs which can and do cause death. I find it difficult to advocate that there are any special circumstances surrounding the care of haemophilia which makes their case for compensation greater than that of other patients who take medicines which kill them. That is, of course, provided the doctors caring for the patients have prescribed their treatment in a proper manner".

Tony Newton answered a further PQ on 19 March 1987 with details of what representations we had received on the subject of compensation: [WITN0771201].

7.21. On 14 April 1987, Baroness Trumpington's Private Secretary minuted Dr Moore (with a copy sent to Tony Newton's private office, but not to mine) referring to an article in the Sunday Today newspaper about a compensation scheme for infected haemophiliacs in Germany which prompted the Minister to ask "*how does this affect our policy*": [WITN0771202]. On 2 June 1987, Mr Arthur of HS1A replied saying there was no evidence the German government intended to set up a state compensation fund; what had been proposed was a pharmaceutical industry fund against potential claims that might be made: [WITN0771202].

7.22. On 6 May 1987, officials circulated a minute [WITN0771203], proposed PQ reply [WITN0771204] and background note [WITN0771205]. Lord Allen's PQ asked if the government was prepared to introduce an experimental "no fault" scheme for medical accidents. The background note discusses policy issues around "no fault" compensation in general terms, and also contains the line taken previously, as set out above, on compensation for haemophiliacs infected with HIV.

7.23. On 8 May 1987, Mr Molesworth in the AIDS Unit minuted Jane McKessack, one of my Private Secretaries, with a briefing ahead of my appearance at the Social Services Select Committee's enquiry on AIDS on 13 May 1987: minute at [DHSC0003899_039], briefing note at [DHSC0003899_040, pp 1-35] summary fact sheets at [DHSC0003899_040, pp. 36-43]. Question 20 of the attached briefing document concerned compensation for haemophiliacs: [DHSC0003899_040, p. 30]. The document set out the background to the issue and under the heading "*Speaking Note*" repeated the line previously taken, namely:

"*There has never been a general State scheme to compensate those who suffer the unavoidable adverse effects which may arise from some medical*

procedures. Compensation can only be awarded by the courts when negligence has been proved. However all the facilities of the NHS and a range of Social Security benefits are available to those who suffer illness, unemployment or loss of earnings as a result of infection with HIV or as a result of contracting AIDS itself'.

7.24. The Inquiry has referred me to an article in The Guardian newspaper dated 15 May 1987: [DHSC0004541_212]. The article says Tony Newton and I had argued before the Select Committee that: "*it was one matter to compensate healthy people who became ill by trying to stay healthy and another to compensate people who needed NHS treatment to get well*". From the record of the Select Committee evidence, it was in fact Tony Newton who answered this part of the questioning: [WITN0771140]. I have set out below the evidence he gave on this point, rather than the precis which was reported:

"Chairman

1754. We did speak earlier of the problem of people who might be injected with HIV through infected blood products. Haemophiliacs, of course, are particularly vulnerable in this regard. Are you considering introducing compensation if any haemophiliacs are so affected?

(Mr Newton) It goes without saying that we are intensely sympathetic to this group as I would imagine anyone who looked into this problem at all would be, but I have to say so far we have found it very difficult to discern a basis on which one could distinguish between medical treatment with blood products given in good faith and without negligence and medical treatment of any other kind given in good faith and without negligence that results in an injury or prolonged disabling condition. As the Committee will be well aware, there has never been a general state scheme in this country to compensate those who suffer the unavoidable adverse effects which may arise from some medical procedures.

1755. There has not been. Perhaps you could consider whether there should be. This is why I asked the question. There is a risk of this, is there not?

(Mr Newton) If you accept the problem of distinguishing on the basis I described between necessary medical treatment given in good faith and without negligence which has certain adverse consequences in this field and that given in a number of other areas and aspects of medicine where it may arise-indeed sometimes does arise-then the question does become the much wider one which was, of course, considered by the Pearson Commission not all that long ago, less than a decade, when it reported, having studied the evidence from a number of other countries, that it concluded such a scheme should not be introduced in this country at present and recommended that negligence should continue to be the basis of liability for most medical injuries. I do not think anybody who knows anything about the history of this area or of this whole issue which quite often comes up in relation to disabilities of various kinds would suggest anything other than that the Pearson Commission was a pretty thorough piece of work, a Royal Commission Inquiry, not just a hasty look.

Sir David Price

1756. It did lead to a compensation scheme for vaccine damage and you distinguish vaccine damage from the particular group of haemophiliacs

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(Mr Newton) Again it seems to me there is a clear distinction which can be drawn between the administration of a particular procedure to a healthy person that is seen as being in the interests in part of the community at large, though also in the interests of that person, but to a healthy person, and the administration of medical treatment required to care for that person with a condition they already have, in this case haemophilia.

1757. We will not debate it now. I would suggest, Minister, the distinction is not quite as clear-cut as—

(Mr Newton) Like so much else in this field, there are some very difficult issues that come up and they have come up repeatedly on a number of fronts during the course of this session. But while debatable, let me put it the other way round, it is not clear that the immunisation programme in this country is on all fours with the provision-is intellectually the same if you like, academically the same or practically the same - or comes closer to the point of giving of medical treatment to somebody who needs medical treatment for a condition from which they are suffering".

7.25. I am asked if the quote from The Guardian was an accurate description of (one of) my reasons for opposing compensation. The fuller citation from the Select Committee evidence is a better expression of our reasoning at that time than the precis in the newspaper article. The answer that Tony Newton gave was consistent with the briefing note and advice on this point which had stated:

"*Some people have suggested that there is a parallel under the Vaccine Damage Payments Act 1979, but this is not the case. Vaccines are given to the healthy as a matter of public policy to protect the health of individuals. The Vaccine Damage Payments Act recognises that a finite risk is incurred and provides financial assistance for those children who become vaccine damaged.*

On the other hand haemophiliacs are treated in the normal course of medical care for their disorder. There is no public policy promoting the use of Factor VIII for their treatment": [DHSC0003899_040, pp 31 and 32].

7.26. It is fair to say that at this time we were seeking to draw a distinction between the statutory vaccine damage scheme and those who had been infected with HIV through blood products on the grounds articulated by Tony Newton in his evidence.

7.27. The Select Committee's report "*Problems associated with AIDS*" [CBLA0002374] considered the calls for compensation and concluded:

> "*Calls for compensation as a consequence of infected blood transfusions and for special life insurance arrangements for haemophiliacs deserve careful consideration. We are conscious however that demands for compensation raise many difficult issues which will need to be further considered in the future*": [CBLA0002374, p. 99].

7.28. The Inquiry has referred me to a partial transcript of a press conference that took place on 4 June 1987: [HMTR0005023]. This appears to have taken place as part of the 1987 general election campaign. I see from the document that I was present, although I now have no personal recollection of the event. I see from the document that a question was directed to me about compensation for haemophiliacs with HIV. The question was answered by Tony Newton, who maintained the line taken above and referred to the difficulty in drawing a distinction between haemophiliacs and others who suffer medical accidents.

7.29. After I had left DHSS to become to become Secretary of State for Employment, the following events occurred:

(1) On 7 July 1987, Dr Moore put a submission to Tony Newton (copied to my successor, John Moore) regarding a forthcoming campaign by the Haemophilia Society for compensation: [WITN0771206]. The submission said: "*The Departmental line has previously been to refuse compensation. However in anticipation of increased pressure, officials are examining ways of compensating haemophiliacs as a special case and costing these options*". The submission sought ministerial agreement to acknowledge the review publicly and for officials to consult internally on a scheme.

(2) On 24 September 1987, John Moore wrote to Mrs Thatcher explaining that:

> *"I have looked at the case for compensation again carefully in the light of the impending campaign but have concluded that the line taken with*

the Social Services Committee [i.e by Tony Newton and me] was right. Any special arrangements for compensation could cost a minimum of £3 million and could only be funded at the expense of other priorities. Moreover, it is logically difficult to distinguish the claim by haemophiliacs from the claim of many others damaged in the course of their medical treatment. And there is no doubt that compensating haemophiliacs would lead to pressure from many other groups for similar treatment": [WITN0771207].

(3) On 13 October 1987, Dr Smithies in a minute to the CMO noted that – as set out above - the Secretary of State had written to the Prime Minister saying a special case for compensation should not be made: [WITN0771208]. The Secretary of State would meet the Haemophilia Society in November 1987.

(4) At some stage shortly before 3 November 1987, Tony Newton wrote to the Prime Minister: [WITN0771209]. He opened by referring to the previous letter from John Moore which had argued that there was not a good case for compensation, bearing in mind the precedent it would set. Tony Newton's letter went on:

"*Whilst John* [Moore] *and I still consider those arguments to be intellectually valid, there is a powerful practical case for recognising the particular circumstances of the infected haemophiliacs. This is reinforced by the Society's argument that those affected are a clearly defined group whose numbers are already determined. There is also very strong support for the Society, particularly from our own supporters inside and outside the House. In view of this we have concluded that the line we have been taking is unlikely to prove politically sustainable.*

Against this background, we believe it would be counter-productive to hold to our present line when we see the Haemophilia Society on Tuesday. We therefore propose to respond more positively by saying

that the Government understood and sympathised with the case that the Society were making. We were therefore considering how best we might respond and would talk to them again when we had reached a decision".

(5) The case for a form of ex gratia assistance with a sum suggested of £10 million was also put to the H(A) Sub-Committee – see: H(A) (87) 26, 'Special Financial Assistance For Haemophiliacs' of 4 November 1987, [JEVA0000021]; Secretariat briefing to Lord Whitelaw on 6 November 1987 (noting the concerns of the Chief Secretary of the Treasury at the precedent that would be set), CABO0000205]; and discussion at the 8th Meeting of the Sub-Committee that year, 10 November 1987 [CABO0100016_011]]. At the meeting the Chief Secretary to the Treasury (John Major) accepted there was a strong case for financial assistance provided that the scheme could be ring-fenced as tightly as possible. He wanted to discuss some of the funding coming from DHSS's centrally financed programme but if this was not feasible the whole sum would be met from the Reserve.

(6) It was against this background that approval was given to the proposal for the £10 million ex gratia fund for haemophiliacs infected with HIV, to which the Inquiry has referred.

7.30. Having addressed the chronology, I turn to some of the specific issued raised by the Inquiry.

Guardian newspaper article of 15 May 1987 (Inquiry's question 96)

7.31. I have addressed this article in paragraphs 7.24-7.26, above.

7.32. The Inquiry asks about my point of view now, which I will address further below in the context of the Inquiry's other questions. Even with hindsight, however, I do not believe it was unreasonable or wrong to point to a distinction between the established vaccine damage payment scheme and a - then quite novel –

proposed scheme for compensating those who were given blood contaminated with HIV.

The £10 million ex gratia fund (Inquiry's question 97)

7.33. I have set out above how the position on compensation moved on after I left DHSS. The Inquiry asks if I was involved in the proposed £10 million ex gratia fund. The proposal for this scheme did not come to me, or to other DHSS ministers, during my time as Secretary of State. It also appears, from the available documents, that officials' consideration of this form of payment scheme to haemophiliacs took place after I had left office.

7.34. The Inquiry also raises whether I would have supported the proposals after I moved Departments. I was not consulted on it. It is not that as a new Secretary of State for Employment I was totally engulfed in my new responsibilities – it was much more that the new Secretary of State Mr Moore wanted to make his own policy. He was obviously helped by his Minister of Health, Tony Newton, who knew my general views. He did not consult me on this issue, nor did he do so on any a number of areas (for example, unknown to me, he wanted to abolish one of my already legislated plans in Social Security for a Social Fund, but he was over ruled on this by a Cabinet committee I did attend). The relationship between an incoming Secretary of State and their predecessor can be a tricky process. However, while Mr Moore did not discuss the plans with me, I was naturally very pleased that a way had been found to get clearance for some financial support. As Secretary of State for Employment, I attended the H(A) meeting on 10 November 1987 where this issue was discussed [CABO0100016_011] and I would have supported the financial support proposal; indeed it was the strong consensus of that meeting to go forward with the £10 million support scheme.

Reflections now on compensation issues (Inquiry's Question 98)

7.35. I have noted in the chronology above that the DHSS' response to calls for compensation appear to have been largely dealt with at Minister of State level,

but I of course do not seek to abrogate responsibility for the decisions taken in the Department. In this period, we were in the middle of a tumult with responding to the AIDS epidemic, in particular with pressing issues around screening, testing and public education.

7.36. From reading the documents, and from my recollection, when compensation issues were raised, despite sympathy for those infected, there was a strongly-rooted concern about setting a precedent for no-fault compensation. It is very easy to underestimate – or indeed overlook – the intense financial pressures of the time. There was a very significant Treasury-driven concern that establishing a (what would have then been fairly novel) scheme of financial support for a group of patients affected by a medical accident in the absence of negligence could have a floodgates effect.

7.37. The move taken later that year towards making a special case for infected haemophiliacs and providing a form of financial support was the right thing to do. The award of 'full compensation' is a very much wider question and certainly would not have been countenanced at that time.

7.38. As I have addressed elsewhere in this statement, the Treasury tightly controlled any new spending and had not been well-disposed to novel spending on AIDS; it was not seen as a priority by them.

7.39. The available papers convey the belief we were unlikely to get support for a financial scheme because of the difficulty distinguishing the case of infected haemophiliacs from many other cases of adverse outcomes from medical treatment – see Mr Harris's comment that *"I suspect we have little alternative but to adhere to this line"* and Mr Tooher's comment that we could "*expect strong Treasury objections to any suggestion that a special compensation scheme should be set up for haemophiliacs"*: [WITN0771210, DHSC0014947_034].

7.40. I remember that in discussions, both Tony Newton and I saw this as a significant issue, but it was one where we felt we were very unlikely to win with the Treasury

and other colleagues. I regret that we were unable to achieve support for it earlier.

7.41. One point I would flag with the Inquiry on this aspect is about the political realities involved. I am very doubtful that I would have succeeded in late 1986/early 1987 in obtaining any level of funding in the way that John Moore with Tony Newton were able to do later in 1987. By this stage I had – to a large extent – expended my political capital with Number 10 and the Treasury on the other AIDS battles I had seen through, sometimes against opposition.

SECTION 8: GENERAL/OTHER ISSUES

Pharmaceutical Companies (Inquiry's question 99)

8.1. The Inquiry asks about my experience in general terms of the interaction between Ministers and officials in the DHSS and pharmaceutical companies, whether I was concerned about the pressure they exerted and what systems or processes were in place to prevent them exerting influence.

8.2. In my period of office the Department of Health was not only the chief customer of the pharmaceutical industry but also the sponsor minister for the UK pharmaceutical sector with the aim of achieving a prosperous industry. These two roles could be contradictory.

8.3. A notable example of this was the selected or limited list of drugs which we sought to introduce in 1985. There could be a big gap between the price that the NHS had to pay for a name branded drug and a generic one. The companies wanted doctors to prescribe the more expensive patented variety, such as 'Valium' or 'Aspro', rather than their cheaper generic equivalents diazepam and aspirin. By 1984 the drugs bill had reached £1.4 billion but doctors had the freedom to prescribe branded drugs like cold remedies, laxatives and tonics. It was an obvious candidate for sensible economy and we set out a list of branded drugs which could no longer be prescribed under the NHS. The public did not lose out but overall the health service benefitted.

8.4. This did not prevent a nasty row breaking out with the industry - extraordinarily supported by the BMA and the Royal College of General Practitioners who said that their right to prescribe had been curtailed. They campaigned against us and one company threatened to write to patients and post replies of MPs on surgery notice boards. Another fact that became apparent was that there were a number of MPs with pharmaceutical industry links who could speak out against the policy. It was another way that the industry could try to influence policy and at the same time add to spending.

8.5. We persisted with the policy and it was finally accepted, but not until there had been a fierce provider campaign against it. The row showed clearly that it could not be assumed that the interests of the health service and the pharmaceutical companies were the same.

8.6. I remember giving a small dinner in New York to explain our policy, with the effect that some of the US pharmaceutical guests almost all walked out and accused us of running 'socialist' policies. I do not think we appreciate sufficiently in Britain that not everyone in the industry has sympathy with the principles of the NHS. I do not believe I was perceived as a friend of the US pharmaceutical companies.

8.7. My partial solution to the conflict of interest was to suggest transferring the sponsorship of the UK pharmaceutical industry to the Department of Industry but in my time at the DHSS there was neither interest from the pharmaceutical industry or the Department of Industry.

8.8. Officials and (on occasions) Ministers were content to meet with both UK and US pharmaceutical companies and discuss issues. In my experience, Ministers and officials were conscious of the need to ensure that the companies did not inappropriately influence decision making. However, it would have been better if the sponsorship of the UK pharmaceutical industry had been taken away from the DHSS responsibilities.

Abbott Laboratories correspondence

8.9. On 13 March 1987, the Chief Executive of Abbott Laboratories, an American health care company, wrote to me about cooperation between government and industry in the fight against AIDS: [DHSC0006358_051]. The company offered 100,000 US dollars to enable UK scientists to travel to the US to meet their counterparts in AIDS research.

8.10. On 3 April 1987, I signed a letter of reply thanking him and accepting the offer: [DHSC0006358_050]. My letter asked that further details be discussed with

David Gibbons, who was Managing Director of Abbott Laboratories UK. My letter indicated that I would wish to acknowledge publicly Abbott's contribution.

8.11. The available documents have not revealed the draft letter which would have been sent to me for approval before this final letter was sent out. As will be apparent, I would not have replied to Abbott's letter without officials considering the proposal and providing their advice and a suggested draft reply. I would not expect officials to indicate the offer should be accepted if it was in any way outside the applicable rules and principles. I would have been reluctant to turn down funding which may have been useful to the sharing of learning and research efforts on AIDS, at that time in short supply.

8.12. Although I have no personal recollection of this correspondence, I would have thought the opportunity for UK scientists to travel to the USA in the context of an exchange of ideas on AIDS was important and worthwhile. In broad terms, the Department would not wish to reject a proper potential learning and research opportunity that was offered by a pharmaceutical company.

8.13. I would not have been involved in the detail, but I see from the available papers that following my letter, the matter went to officials to work out how to administer the funds. The Department initially envisaged granting scholarships to UK health care professionals: [WITN0771212]. This ran into difficulties, not because it was wrong to take the money, but because government accounting rules did not allow DHSS to receive the money from Abbott in the way suggested and then ringfence it for the agreed purpose. The proposal instead was for DHSS to set up a selection scheme and Abbott to pay over the funds to the successful candidate: [WITN0771213].

Role of Chief Medical Officer and DHSS in issuing guidance (Inquiry's questions 100 - 102)

8.14. 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.

8.15. 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.

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

8.17. 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. For example:

(1) On 15 May 1985, Sir Donald Acheson, CMO, wrote to all doctors in England about AIDS: [DHSC0105232]. He enclosed papers from the Expert Advisory Group on AIDS ("EAGA") and from the Communicable Disease Surveillance Centre ("CDSC"). He noted AIDS was a "*very recently recognised disease*" and much of the information was not yet in medical textbooks.

(2) On 15 August 1985, Dr Ed Harris, DCMO, wrote to all Haemophilia Centre Directors about the availability of heat-treated Factor VIII which I have addressed in Section 6 of this statement: [DHSC0002489_110].

(3) On 1 October 1985, Sir Donald wrote again to all doctors in England: [NHBT0008222_002]. His correspondence concerned the introduction of the screening test for HTLV-III which again I have addressed in Section 6 of this statement. From mid-October, all blood donations would be screened at Regional Transfusion Centres for the HTLV-III antibody.

8.18. In addition to this kind of correspondence, I am aware from the available records that the DHSS issued various notices on a range of matters concerning the use of blood products within the health service. These sometimes took the form of Health Circulars (sometimes called Health Service Circulars) and Health Notices. I set out below, from the available documents, the notices issued during my time:

(1) In March 1984, the DHSS issued Health Circular HC(84)7 on "*Blood transfusion: record-keeping and stock control arrangements*": [CBLA0001819]. This was sent to all Regional and District Health Authorities. The Circular asked health authorities to review their arrangements for the supply of blood and blood products. The need for records to permit tracing of any unit of blood was emphasised.

(2) In January 1985, the DHSS issued Health Circular HC(85)3: [DHSC0002159]. The Circular was addressed to all RHAs and asked them to ensure that the revised leaflet '*AIDS – important new advice for blood donors*' was distributed to every donor. I have addressed this in Section 6 of this statement, above.

(3) On 20 February 1985, the DHSS wrote to Regional General Managers in the National Blood Transfusion Service asking them to make financial provision in their budgets for a screening test for HIV: [DHSC0002261_031]. It was hoped a reliable test would become available

within a few months. I have addressed this in Section 6 of this statement, above.

(4) On 1 August 1985, the DHSS wrote to the blood service about the completion of the first stage of evaluation of commercially available tests for HIV: [BART0000778]. The letter attached recommendations on the most suitable test kits. The letter noted DHSS had funded PHLS to set up facilities to confirm the results of any positive donations.

(5) On 24 September 1985, the DHSS wrote to Regional General Managers notifying them that the further revised leaflet '*AIDS – important information for blood donors*' was being printed: [WITN0771214]. The revised leaflet contained advice for 'at-risk' groups about not giving blood despite the introduction of blood tests for antibodies to HTLV-III; and advised members of 'at-risk' groups where they could obtain a test outside of the transfusion service.

(6) In June 1986, the DHSS issued Health Notice HN(86)20 concerning Guidelines, drawn up by the Advisory Committee on Dangerous Pathogens, on measures to be taken to safeguard those who, because of their work, come into contact with HIV patients: [WITN0771215].

8.19. 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.

Reflections on relevant events (Inquiry's questions 103 – 107)

8.20. In this section, the Inquiry asks me to reflect on relevant events, and consider whether the Government responded in a timely way to the risks; whether I

personally could have taken steps that would have improved the response; and whether more broadly, others could and should have acted differently to improve the Government response. The Inquiry also asks whether there were structural difficulties or failings in the way that health policy was administered.

8.21. In Section 4 of this statement, I have set out my reflections now in relation to the redevelopment of BPL. I have set out my own view that – in reality – it was too late during my tenure as Secretary of State to achieve a high degree of self-sufficiency any earlier than the Spring of 1985, at which point heat treatment had been introduced. What would potentially have made a difference was for the funding green light, and the start of redevelopment, to have come years earlier. Poor financial control (amongst other factors) contributed to the very significant overspend on the BPL redevelopment when I was Secretary of State. In the face of that, we chose to find the money. That was the right thing to do. By August 1986, Ken Stowe was critical of Geoffrey's Finsberg's earlier decision in 1982 not to have a DHSS representative on the redevelopment project steering board. I have explained in paragraph 4.83 why I am somewhat sceptical about that view. I do not see that this was a case of structural difficulties or failings acting as an impediment. Undoubtedly, however, at operational and supervisory levels, there should have been better management of this project (although I observe that the same has occurred in other major publicly procured complex building projects). But the key point would have been to start the project years earlier.

8.22. On the communication of risk in 1983, I have accepted in Section 6 of this statement that we in the Department should have spotted this need to reflect the balance of the background note more precisely in the line to take. I would not wish that to be taken in isolation from the other points I have made in paragraph 6.13.

8.23. As regards the timeliness of Government action, the AIDS timing issues which the Inquiry has most prominently raised in its request to me relate to the first blood donor leaflet in 1983 and the introduction of HIV antibody screening of blood donations in 1985:

(1) As to the donor leaflet, at Ministerial level, settling the terms of the blood donor leaflet took from 1 July to 1 September 1983. With hindsight it can be suggested this was too long. But I would refer back to paragraph 6.40, above. The exchanges in this period were grappling with the balance of: ensuring that the at risk groups did not donate blood; avoiding a wider adverse impact on blood donation; avoiding allegations of discrimination or feeding the hostile treatment of gays and gay blood donors; and avoiding media panic.

(2) As to the introduction of the screening test, there was recognition at the time of the case made by some that, with some testing kits already available on the market, screening should have been introduced sooner. The time taken for the introduction of UK testing was because of the strategy of a two-stage evaluation of rival tests with the aim of ensuring that the testing that was introduced was as reliable as practicable. The advice to Ministers was in favour of that course and was endorsed by the CMO. I can only repeat that the judgments made at the time were made in good faith on the merits as they were assessed at the time, and followed medical advice.

8.24. I have explained that the CSM's decision not to withdraw product licenses for imported Factor VIII did not come to me, nor, so far as I can see, the other health Ministers. The reality is that this was a matter for expert advice to the Medicines Division who would act under delegated powers. Ministers were not in a position to second guess that advice or substitute their own inexpert views. Even today, I do not feel that I am in a position to comment on whether or not that judgement was the right one with the information that was known at the time, but it is notable that the Haemophilia Society were opposed to an import ban. In the absence of sufficient UK-sourced Factor VIII, clinicians had to consider the balance of risk in their treatment recommendations for individual patients, which was a dilemma. It was not viewed at the time as a matter for central prescriptive guidance from Government, because DHSS did not supervise or direct clinicians in that way. There was no switch that we could turn at this stage to

produce a sufficient supply of domestic UK Factor VIII: the redevelopment project was already being constructed on a fast-tracked method. The reality is that the redeveloped BPL came too late to help the haemophiliac community. However, I hope that this Inquiry will not overlook that the amount of money we committed to the BPL redevelopment (ultimately £60 million within my tenure as Secretary of State, equating to about £180 million in today's money) was very sizeable when compared to the overall spending we were able to secure on AIDS at this time, and was a very significant sum.

8.25. Reflecting further on the records and on events as I remember them, I have accepted in this statement that my own direct involvement in HIV/AIDS was mainly from the second half of 1985 through until I moved Departments, and was focussed on the public education campaign. Inevitably, that causes me to reflect on whether I could have been more involved earlier. Should I, in other words, have taken personal charge and directed the earlier Ministerial decisions which (when issues were raised at Ministerial level) were very largely being taken by the more junior Ministers to whom the subject areas were devolved or by the Minister of State? There are several aspects to this:

(1) In the first instance, this pre-supposes that I would have ended up taking a different approach. I have no reason to think that I would have taken a materially different approach to, for example, the blood donor leaflet in 1983 or the screening test for blood donations in 1985. The Inquiry might speculate that action on these may have been a little quicker if I as Secretary of State had stepped in more directly. But this may simply have confused things or added a further voice – very capable Ministers were already handling these matters.

(2) Devolving to other Ministers, as I have explained, was essential in a Department of the scale of the DHSS of the 1980s. There is little point in devolving if you then seek to micro-manage.

(3) My direct involvement following Sir Donald's paper in the summer of 1985 was also in relation to a different type of challenge. By that stage, the risks

were much better understood. What was now required was to force through a radical public education campaign. This could only be done at Secretary of State level. It needed a Cabinet Minister (albeit with important support from CMO, Sir Ken Stowe, Robert Armstrong, William Whitelaw, our own AIDS unit etc.) to corral cross-department action, and to convince those who would stand in the way of the necessary blunt public education message.

(4) In contrast, the challenge in 1983 to the uncertainties posed by AIDS was principally (although not exclusively) a medical one. Other than the redevelopment of BPL (which could not realistically be suddenly further accelerated), decisions needed to be taken on the balance of risk, which was a medical matter calling for judgements by both the specialist clinicians and the expert advisors on medicines. Issues such as the blood donor leaflet in 1983 and the approach to screening tests to blood donations in 1985 were important, but I remain of the view that they were suitable for my Health Minister colleagues to handle. That is with the caveat I have already made clear, namely that any other Minister could refer issues to me, especially if there was an issue of special concern.

(5) Not without some hesitation, I also come back to the contrast between the two CMOs. 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. I would be surprised if anyone who worked with Sir Donald in the Department did not hold him in very high regard; I certainly did so, and still do. He was my right hand man. As I have indicated, I regret that by contrast Sir Henry Yellowlees was a less effective figure, and I doubt that I am alone in that assessment. I also reflect that his advice to his successor Sir Donald is rather telling, especially in relation to

Sir Henry's approach to Ministers[9]. It is impossible to raise this observation without risking being accused of blaming Sir Henry, who of course is no longer alive. That is not my intention and his attitude was not an unusual one for that time for some senior medical figures towards politicians. Moreover, it is only fair to note that: (i) the understanding of HIV was far less developed in 1983 than it was by 1985, and even then much was still not understood; (ii) Sir Donald was in sole charge of the medical side by the start of 1984. Nevertheless, I understand that the Inquiry seeks candid reflection and 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. I must however repeat that there were far greater uncertainties in 1982/1983 and these observations should not be misunderstood as a simplistic assertion that Sir Henry should have been doing in 1983 (on blood transfusion / blood products HIV risks) what Sir Donald did in the summer of 1985 (on the need for a public education campaign on HIV/AIDS).

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[9] *"Treat the Ministers exactly as you would patients suffering from stress – that's basically what they are! As for the officials, the system works like clockwork. If you listen to them they'll keep you from falling into any of Whitehall's 'elephant traps'."* (quoted by Sir Donald, *One Doctor's Odyssey,* [WITN0771088 at page 5]

(6) There is another factor. I have already set out in the introduction to this statement the wide remit of the then combined DHSS. By the second half of 1985, I had been Secretary of State for about four years. In the end, I held the post for longer than any other. This meant that by late 1985 and 1986/1987 I had the time, perspective and experience to see that the public education campaign was an area where I could (and should) intervene directly to force change through, taking on Cabinet colleagues as necessary. I strongly doubt that I could have done the same as a relatively new Health Secretary in 1981 – 1983, grappling as I was with the pay dispute, NHS management change, equivalent challenges on the social security side, and all the other challenges of what was – in effect – two huge Departments of State.

Any other issues arising relevant to the Inquiry's Terms of Reference (Inquiry's question 108)

8.26. The Inquiry asks me if there are any other issues arising during my tenure as Secretary of State for health that may be relevant to the Inquiry's terms of reference.

8.27. Although I do not recall being personally involved in it, I should mention that Ministers were alerted – in July 1986 – to the fact that there would likely be criticism of the Department for allowing BPL to make, until June 1986, heat treated Factor VIII from plasma which had not been screened for the AIDS virus.

8.28. This was raised in a submission from Dr Moore to Baroness Trumpington on 15 July 1986: [DHSC0001036_001]. It was said that *"although there is no concern over product safety, officials were misinformed by the Central Blood Laboratories Authority regarding this practice"*. I note from the available papers that this was followed by:

(1) Response from Baroness Trumpington, dated 17 July 1986: [DHSC0001037];

(2) Submission from Dr Moore to Barney Hayhoe, precise date unclear but sometime in July 1986: [DHSC0003962_140];
(3) Views from the CMO, 21 July 1986: [DHSC0001038];
(4) Minute from Dr Moore dated 25 July 1986 re PQs from Lord Irving of Dartford: [DHSC0001043];
(5) Minute from Dr Smithies to PS/CMO, dated 28 July 1986: [DHSC0001045];
(6) Minute from PS/Barney Hayhoe to PS/CMO, 28 July 1986: [DHSC0001044];
(7) PQ from Lord Irving of Dartford and response by Baroness Trumpington, 29 July 1986: [DHSC0001056];
(8) Letter from Dr Harris to Dr Lane, dated 1 August 1986: [BPLL0002411_001];
(9) Views of Baroness Trumpington, 7 August 1986: [DHSC0001048, p. 1 only];
(10) Minute from PS/Barney Hayhoe on 30 July 2986 ahead of a meeting that day (*"CMO has been further investigating the problem of the usage of unscreened FACTOR VIII. A further submission is expected"*): [WITN0771216].

8.29. As I have indicated, I do not believe I was directly involved in this issue but I raise it conscious that it was addressed by Ministers, and that both Baroness Trumpington and Barney Hayhoe have since died.

Parliamentary interventions (Inquiry's question 109)

8.30. I have included at Appendix 1 a table of my Parliamentary interventions based on relevant searches of Hansard undertaken on my behalf. It is correct to the best of knowledge but is dependent on the accuracy of the searches undertaken. If the Inquiry alerts me to any further relevant interventions, I will of course address these.

A final observation

8.31. I have done my very best to assist the Inquiry in the many areas it has raised. Drawing this statement of evidence together so very many years after the events, with (at best) faded recollection, imperfect records and many of the key figures no longer being alive, is exceptionally difficult. This is not a commentary on the current Inquiry but on the way in which an Inquiry like this is initiated. It re-enforces the need for an inquiry such as this to take place much closer in time to the events if it is to as effective as possible. As it happened, I advocated for an inquiry into the lessons of AIDS in the health education area as long ago as 1991. Although this was not on the specific issue of contaminated blood, it might have been extended to cover it. This is the first public inquiry to which I have been asked to give evidence. Based on that experience, I believe we should look again at how such delay can be avoided. It is a very obvious lesson for the future that if there is to be an inquiry into major events, such extreme delay does need to be avoided. Otherwise it risks an injustice to those ministers and advisers who have died in the meantime, and to surviving witnesses who simply cannot recall matters in any detail after the passage of so many years. But very much more importantly, it risks serious injustice to those who have suffered and the families of those who have died.

Statement of Truth

I believe that the facts stated in this written statement are true.

Signed GRO-C Dated 17 July 2021

APPENDIX 1 HANSARD REFERENCES

Date	Reference	Event	Subject matter	Link
03 March 1982	HC Deb 03 March 1982 vol 19 c171W	Written Answers (Commons)	Blood use (committee of inquiry)	https://api.parliament.uk/historic-hansard/written_answers/1982/mar/03/blood-use-committee-of-inquiry#S6CV0019P0_19820303_CWA_256
18 May 1982	HC Deb 18 May 1982 vol 24 c83W	Written Answers (Commons)	Central Blood Laboratories	https://api.parliament.uk/historic-hansard/written_answers/1982/may/18/central-blood-laboratories#S6CV0024P0_19820518_CWA_216
08 November 1983	HC Deb 08 November 1983 vol 48 c73W	Written Answers (Commons)	Blood Supplies (Handling Charges)	https://api.parliament.uk/historic-hansard/written_answers/1983/nov/08/blood-supplies-handling-charges#S6CV0048P0_19831108_CWA_116
27 November 1984	HC Deb 27 November 1984 vol	Commons sitting	NHS (Government Support)	https://api.parliament.uk/historic-hansard/commons/1984/nov/27/nhs-government-support#S6CV0068P0_19841127_HOC_30

Date	Reference	Event	Subject matter	Link
	68 cc764-5			
02 December 1985	HC Deb 02 December 1985 vol 88 cc1-2W	Written Answers (Commons)	AIDS	https://api.parliament.uk/historic-hansard/written-answers/1985/dec/02/aids#S6CV0088P0_19851202_CWA_4
21 November 1986	HC Deb 21 November 1986 vol 105 cc799-864	Commons Sitting	AIDS	https://api.parliament.uk/historic-hansard/commons/1986/nov/21/acquired-immune-deficiency-syndrome#S6CV0105P0_19861121_HOC_5
25 November 1986	HC Deb 25 November 1986 vol 106 cc123-4	Commons Sitting	AIDS	https://api.parliament.uk/historic-hansard/commons/1986/nov/25/aids#S6CV0106P0_19861125_HOC_19

Date	Reference	Event	Subject matter	Link
01 December 1986	HC Deb 01 December 1986 vol 106 c526-8W	Written Answers (Commons)	AIDS	https://api.parliament.uk/historic-hansard/written_answers/1986/dec/01/aids-1#S6CV0106P0_19861201_CWA_660
18 December 1986	HC Deb 18 December 1986 vol 107 cc700-1W	Written Answers (Commons)	AIDS	https://api.parliament.uk/historic-hansard/written-answers/1986/dec/18/aids-2#S6CV0107P0_19861218_CWA_641
12 January 1987	HC Deb 12 January 1987 vol 108 cc99-101W	Written Answers (Commons)	Department Initiatives	https://api.parliament.uk/historic-hansard/written_answers/1987/jan/12/departmental-initiatives#S6CV0108P0_19870112_CWA_619

Date	Reference	Event	Subject matter	Link
13 January 1987	HC Deb 13 January 1987 vol 108 cc164-5W	Written Answers (Commons)	AIDS	https://api.parliament.uk/historic-hansard/written_answers/1987/jan/13/aids#S6CV0108P0_19870113_CWA_193
05 February 1987	HC Deb 05 February 1987 vol 109 cc803-5W	Written Answers (Commons)	AIDS	https://api.parliament.uk/historic-hansard/written_answers/1987/feb/05/aids-1#S6CV0109P0_19870205_CWA_494
25 February 1987	HC Deb 25 February 1987 vol 111 cc271-82	Commons Sitting	Cancer Screening and AIDS research	https://api.parliament.uk/historic-hansard/commons/1987/feb/25/cancer-screening-and-aids-research#S6CV0111P0_19870225_HOC_154

Date	Reference	Event	Subject matter	Link
03 March 1987	HC Deb 03 March 1987 vol 111 cc576-8W	Written Answers (Commons)	Departmental Achievements	https://api.parliament.uk/historic-hansard/written_answers/1987/mar/03/departmental-achievements#S6CV0111P0_19870303_CWA_347
10 March 1987	HC Deb 10 March 1987 vol 112 cc139-41	Commons Sitting	AIDS	https://api.parliament.uk/historic-hansard/commons/1987/mar/10/aids#S6CV0112P0_19870310_HOC_67
19 March 1987	HC Deb 19 March 1987 vol 112 cc616-7W	Written Answers (Commons)	AIDS	https://api.parliament.uk/historic-hansard/written_answers/1987/mar/19/aids#S6CV0112P0_19870319_CWA_397
20 March 1987	HC Deb 20 March 1987 vol 112 cc672-4W	Written Answers (Commons)	AIDS	https://api.parliament.uk/historic-hansard/written_answers/1987/mar/20/aids#S6CV0112P0_19870320_CWA_234

Date	Reference	Event	Subject matter	Link
24 March 1987	HC Deb 26 March 1987 vol 113 c125W	Written Answers (Commons)	AIDS	https://api.parliament.uk/historic-hansard/written_answers/1987/mar/24/aids#S6CV0113P0_19870324_CWA_259
02 April 1987	HC Deb 02 April 1987 vol 113 cc622-3W	Written Answers (Commons)	AIDS	https://api.parliament.uk/historic-hansard/written_answers/1987/apr/02/aids#S6CV0113P0_19870402_CWA_313
07 April 1987	HC Deb 07 April 1987 vol 114 cc151-3	Commons Sitting	AIDS	https://api.parliament.uk/historic-hansard/commons/1987/apr/07/aids#S6CV0114P0_19870407_HOC_73
07 April 1987	HC Deb 07 April 1987 vol 114 c207W	Written Answers (Commons)	Official Visits	https://api.parliament.uk/historic-hansard/written_answers/1987/apr/07/official-visits-12#S6CV0114P0_19870407_CWA_493

Date	Reference	Event	Subject matter	Link
10 April 1987	HC Deb 10 April 1987 vol 114 cc482-3W	Written Answers (Commons)	AIDS	https://api.parliament.uk/historic-hansard/written_answers/1987/apr/10/aids-1#S6CV0114P0_19870410_CWA_391