DH COMMENTARY ON GROUNDS FOR JUDICIAL REVIEW

IN THE ADMINISTRATIVE COURT

R (ANDREW MICHAEL MARCH)

Claimant

-

SECRETARY OF STATE FOR HEALTH

Defendant

GROUNDS FOR JUDICIAL REVIEW

1. The Claimant is a haemophiliac who was infected with HIV and Hepatitis C as a result of NHS treatment with blood products since his birth on GRO C 1973. By these proceedings, the Claimant seeks judicial review of the Defendant ("the Government") 's decision not to implement recommendation 6(h) in Chapter 12 of Lord Archer's Independent report on NHS supplied contaminated blood and blood products, published on 23rd February 2009 ("The Archer Report").

2. In recommendation 6(h), the Archer Report supported the position that payments from Government funds made to those who had contracted HIV or Hepatitis C from NHS supplied contaminated blood products, and their carers, should be at least equivalent to those payable under the scheme which applies at any time in Ireland

3. The Government's decision not to implement this recommendation is contained in the Government's Response to the Archer Report, dated 20 May 2009 ("the Response") and public announcement communicating the reasons for that decision. It is fatally flawed by reason of a fundamental mischaracterization of the Irish position, which can properly be characterized in different ways under the (axiomatically overlapping) applicable grounds for judicial review. They each justify the same conclusion, that judicial review should be granted.

We do not believe there is a mischaracterization of the Irish position – see later for details.

Factual Background

4. In the 1970s and 1980s, a significant number of patients in the UK, predominantly haemophiliacs, contracted infections from NHS-supplied blood or blood products. 4,670 patients became infected in this way with Hepatitis C, and approximately 1,200 with HIV (Archer Report p. 5). By February 2007, 1,757 members of the haemophilia community had died from these infections.

5. Chapters 1-5 of the Archer Report gives a detailed account of the history of treatment for haemophilia in the 1970s and 1980s, and the series of events by which contaminated blood products came to be supplied by the NHS, and by which the dangers of this blood supply came to be understood. In summary:

a. In the 1970s, a new form of treatment for haemophilia (known as Factor VIII and Factor IX concentrate) was developed, which made use of clotting factors made from human plasma. In order to be processed economically, the treatment required a large amount of plasma, pooled from a large number of donors (p.13).

b. The UK was unable to meet demand for Factor VIII and Factor IX from domestic supplies, and so large quantities of blood products were obtained by the NHS from commercial suppliers in the US, even though it was known in medical and governmental circles, these products carried an increased risk of infection (pp. 24-26). Large numbers of patients became infected with Hepatitis C or with HIV as a result

c. The need for the UK to become self-sufficient in blood products as soon as possible — for these and other reasons — was understood from 1973 (Archer Report Ch. 4). However, self-sufficiency was never achieved, and by the mid-1980s the need had been dispelled by the availability of heat treatment, which made safe commercial concentrates from the USA.

d. Patients receiving blood products from the NHS remained at risk of infection until 1985, when heat treatment was introduced (p. 45). Testing of all donations for HIV was introduced in 1985, and testing for Hepatitis C was introduced in 1991.

The Government's response to the Archer report details the UK's self sufficiency background – **Rowena**: do you have anything to add to factual accuracy of this?

Government funding for victims

6. Those who contracted Hepatitis C or HIV from contaminated blood products. in the manner described above, faced increased financial burdens, due to the loss of earning capacity and pension rights, and the increased expense of everyday living. In the 1980s, the UK Haemophilia Society began to lobby the Government to provide financial relief for those affected (Archer Report, p. 76).

No comment required.

The Macfarlane Trust

7. In response, the Government set up the Macfarlane Trust in 1987. This Trust was originally endowed with £10 million, and was charged with making payments to haemophilia patients who had been infected with HIV from contaminated NHS blood products, and who were in need, and to their dependants. At first, those seeking relief from the Macfarlane Trust had to apply to the Trust and establish that they were in need for specific purposes. The Trust made monthly payments to beneficiaries as well as an annual supplement and discretionary payments to meet expenses imposed by HIV (Archer Report p.77).

8. In 1989, a number of victims who had been infected with HIV and had begun proceedings against the Department of Health and the National Blood Transfusion Service consolidated their claims. They alleged that the Department of Health had been negligent in failing to address the inadequacies of the NHS-controlled Blood Products Laboratory (which processed blood donations collected in the UK), thus impeding self- sufficiency, and in importing products which were known to be at risk of infection, and in failing to provide timely surrogate testing. (Archer Report p. 78). A settlement of these proceedings was reached on the government's agreeing to make a payment of a further £42 million into the Macfarlane Trust, of which £24 million was set aside for the plaintiffs, and the plaintiffs agreeing to sign a waiver renouncing the right to make further claims through litigation, in respect of infection with HIV or Hepatitis (Archer Report p. 79).

9. In 2003, a Department of Health review concluded that Government funding of the Macfarlane Trust should rise to £7 million annually for the five years commencing in April 2006, representing an increase of nearly 100%. However, funding for the Trust was in fact increased only by 11% to £3.754 million a year (Archer Report pp. 84-84).

10. Of the original 1,246 registrants of the Macfarlane Trust, about 370 are still alive, together with 42 "intimates" (Archer Report p. 77).

Jonathan/Brian – please can you comment on the accuracy of this section.

The Eileen Trust

11. In 1993, following the commencement of similar proceedings against the Department of Health by a number of people who were not haemophilia sufferers, but who had suffered HIV infection from blood or blood products, the Government established the Eileen Trust to make payments to such victims, with a grant of £600,000. A further grant of £500,000 was made in 2001 and the Eileen Trust is now funded at an annual rate of £178,000. There are 27 registrants, who receive sums at the same level as registrants of the Macfarlane Trust (Archer Report p. 82).

Jonathan/Brian – please can you comment on the accuracy of this section.

The Ski pton Fund

12. The Skipton Fund was set up in 2003 to make financial provision for those who had been infected with Hepatitis C by the use of contaminated blood products. It makes lump sum payments of £20,000 to those who qualify ("first-stage payments"), and a further £25,000 to those who establish that infection has led to severe liver disease ("second-stage payments"). (Archer Report pp 82-83). By May 2007 there had been 3,751 first-stage payments, amounting in total to just over £75 million, and 600 second-stage payments, amounting to a further £15 million (Archer Report p. 83).

Jonathan/Brian – please can you comment on the accuracy of this section.

The Archer Inquiry

13. Since 1988, the UK Haemophilia Society has campaigned for a Public Inquiry into events leading to the transmission of Hepatitis C and HIV by means of contaminated blood products. However, successive governments have refused to hold an Inquiry.

14. On 19 February 2007, Lord Morris of Manchester announced that the Rt Hon Lord Archer of Sandwell QC had agreed to chair an Independent Inquiry. The Inquiry's terms of reference were

"To investigate the circumstances surrounding the supply to patients of contaminated NHS blood and blood products; its consequences for the haemophilia community and others afflicted, and further steps to address both their problems and needs and those of bereaved families." (Archer Report p. 7).

15 . The Inquiry was privately funded and was not a statutory inquiry under the Inquiries Act 2005. Its members had no legal power to compel the giving of evidence or production of documents. However, 300 witnesses submitted statements, 64 of

whom gave oral evidence, and the members were presented with more than 20,000 documents (Archer Report pp. 7-8). The Department of Health declined to provide witnesses to give evidence in public, but supplied documents, responded to questions, and sent representatives to three private, informal meetings (p.9).

Rowena – can you please comment on this? My understanding is that no witnesses were asked from DH to give evidence, not that we declined. I know Lord Archer asked that someone from the Department meet with him, and officials did so on several occasions.

15. The Archer Inquiry culminated in the Archer Report, published on 23rd February 2009. The Government published its Response to this Report on 20th May 2009.

The comparison with Ireland and recommendation 6(h)

16. The Archer Report makes a number of recommendations, set out in Chapter

12. The recommendation with which the Claimant's challenge is concerned is set out in paragraph 6(h) of Chapter 12, as follows:

'We suggest that payments should be at least the equivalent of those payable under the Scheme which applies at any time in Ireland"

17. The relevance of the comparison with the compensation scheme in force in Ireland ("the Irish scheme") is discussed on pages 87 to 93 of the Archer Report On pp. 87-88 the Report makes the following observations:

a. The comparison is a natural one since population of Ireland is approximately one tenth of that of the UK and the proportion of people infected with Hepatitis C and HIV to the total population is about the same;

b. In 1989 the Irish government established a trust fund with a sum of £1 million which was similar in structure to the Macfarlane Trust In

1991 this was refonned to provide for a scale of lump sum payments to persons infected through contaminated blood with HIV, whereby payments were made to a single person of £77,000, to a married person with dependent children of £101,000, to a married person with no dependent children of £94,000, and to the parents of a deceased person of £20,000;

c. In 1992, the government established the Hepatitis C Compensation Tribunal to assess loss and damage suffered in consequence of Hepatitis C infections. (This was originally a non-statutory Tribunal, but was placed on a statutory footing in 1995, and extended by statute in 2002 to include HIV victims). Payments by this Tribunal have ranged from 14,000 to 3,100,000 Euros, the average payment being 853,636 Euros. Payments have been made to 2,200 claimants, and amount in total to 778 million Euros.

The background to the Irish compensation scheme has been provided separately. There are very distinct differences between events in Ireland and the UK, hence each country took a different decision in response to the (then) pending legal action claims.

The attempt to distinguish the Irish situation

18. The Archer Report notes that "In view of comparisons made between financial provisions in England and Ireland the United Kingdom Government sought to distinguish the situation in the two countries." (p. 88). The Report cites Lord

Warner's explanation of the relevant distinction, offered in the House of Lords on 11 December 2003:

"In Ireland and Canada...compensation schemes were paid because the blood authorities were both found to be at fault Indeed, in Canada, criminal prosecutions were filed against those responsible. It is important to state that, despite our decision to make ex gratia payments; the position with regard to accepting liability has not changed. The payments are made on compassionate grounds and are not compensation. With that in mind, the payments cannot be expected to take account of loss of earnings or compare with positive damages awarded by the Courts in other countries"

and again on 25th March 2004:

"My understanding of the position in Ireland, which has been corroborated by officials in the Department of Health and Children in Dublin since my last utterance on the subject in the House, is that the Irish Government set up their Hepatitis C compensation scheme following evidence of negligence by the Irish Blood Transfusion Service. A judicial inquiry, the Lindsay report, found that "wrongful acts were committed' It is important to stress that the blood services in the UK have not been found to be similarly at fault Compensation has therefore been given in very different, specific circumstances in Ireland that do not apply in the UK"

19. The Archer Report then comments as follows:

'The Minister's briefing from the Department appears not to have been wholly clear. To distinguish between the situation in the United Kingdom and that in Ireland on the basis that the Official Inquiry in Ireland had made certain criticisms of the Irish Blood Transfusion Service is a curious argument since successive Governments in England have declined to establish an Inquiry, and so have precluded any possibility of comparing the comments of an Official Inquiry in Ireland and an Official Inquiry in England. The payments by the Irish Government were equally made without an admission of liability. However, recipients were required to sign waivers, as in England, exempting the Government from further claims...

Ms Carol Grayson, who provided the Inquiry with a great deal of helpful information, supplied us with a letter written to her on the 26 February 2004, by an Assistant Financial Officer in the Public Service in Ireland, in reply to a question about the basis of compensation by the Hepatitis C and HIV Compensation TribunaL It includes the following:

"As you rightly point out, compensation for persons with haemophilia was made on compassionate grounds, without legal liability on the part of the State — he (the Minister) acknowledged extraordinary suffering endured by persons with haemophilia who were infected, and by their families."

The background to the Irish compensation scheme has been provided separately. Lord Warner's statements are correct. It is also correct that successive Governments did not decide to hold a public inquiry.

The Government's Response to the Archer Report

20. The Government published a Response to the Archer Report on 20th May 2009. In relation to recommendation 6, the Response stated as follows:

"The Government recognizes Lord Archer's concern about financial relief We therefore intend to increase the funding available to the Macfarlane and Eileen Trusts to allow them to move to a system of annual payments for infected individuals. The current average annual payment is around £6,400. We intend that, in future, payments of £12,800 per annum would be made to each infected individual, thus eliminating the need for them to make repeated detailed applications. We will also increase the funding available to the Trusts so that the Trustees can make higher payments to dependents. Payments to dependents will continue to be decided on a case-by-case basis — and left to the decision of the Trustees.

The Skipton Fund provides lump sum payments to people infected with hepatitis C from infected blood and blood products. £97m has been paid out to date to over 4000 individuals.

The Skipton Fund will continue to make payments to people infected with hepatitis C and I commit to reviewing it in 2014 when the Fund will have been in existence for ten years..."

21. The Response makes no mention of Recommendation 6(h), nor does it explicitly consider the question of parity with levels of payment made under the Irish scheme. However, by pledging to increase annual payments made from the Macfarlane and Eileen Trusts only to £12,800 per annum, and declining to review payments made out of the Skipton Fund until 2014, the Government has implicitly rejected recommendation 6(h).

Correct – the situation in Ireland is different and the Government did not therefore intend our ex-gratia payment schemes to mirror the Irish compensation scheme.

Reasons for rejecting recommendation 6(h)

22. The Government's reasoning for rejecting recommendation 6(h) has been publicly articulated. This was by Gillian Merron, the Minister of State at the Department of Health, in Parliament on 23rd June 2009 (Hansard Vol 494, c. 656), in response to a question by Lord Morris of Manchester, as follows:

"I cannot accept the comparison with Ireland, because the Irish blood transfusion service was found to be at fault, and that was not the case here."

23. That reason was reiterated, and further explained, in a Westminster Hall Debate on 1 July 2009. In response to the question "Will [Minister] admit today that the Irish paid out without liability and before any tribunal had met to discuss the position? In addition, Crown immunity applied to the health services in Britain at that time." Gillian Merron stated:

'I stand by the points that I made. Furthermore, a judicial inquiry in Ireland found failures of responsibility by the Irish blood transfusion service and concluded that wrongful acts had been committed. As a result, the Government of the Republic of

Ireland decided to make significant payments to those affected. As I will explain, that was not the case with the blood transfusion service here

I turn to the recommendations on financial relief our responses to which have come under the closest scrutiny. In the UK, such payments are not compensation but ex gratia payments. That is an important distinction. Lord Archer made recommendations on the payments and made comparisons with Ireland. However, it is important to restate that the position in Ireland is very different. The independent inquiry in Ireland found the transfusion service to be at fault because it had not followed its own official guidelines on protecting the blood supply from contamination. That is not the case in the UK Comparable levels of payment are therefore not appropriate."

Correct

Grounds of Review

24. The Claimant recognizes that judicial review is not a merits review and that proper latitude is to be afforded to Governmental decision-making, including in a context such as the present. But even such decisions are not immune from substantive challenge when something has gone badly wrong with the logic and foundation of the critical reasoning. Here, it has. The Claimant accordingly seeks Judicial Review of the Government's decision not to implement recommendation 6(h) of the Archer Report, on the following grounds. They overlap, and indeed are perhaps different characterizations of the same fundamental flaw, but that is nothing new: see Boddington [1999] 2 AC 143, 170E.

Legal colleagues to comment, please

Error of Material Fact

25. The Government's decision not to implement recommendation 6(h) is based on a purported contrast between the Irish scheme (which is characterized as

a fault-based, compensatory scheme, set up in response to judicial findings of fault on the part of the Irish Blood Transfusion Service), and the UK payment scheme, which is characterized as an ex gratia scheme set up in the absence of findings of fault (paragraphs 22 to 23 above).

26. However, the Government's characterization of the Irish scheme as a compensatory, fault-based scheme, set up in acknowledgment of judicial findings of fault, is unsustainable. This is evident by reference to the order of relevant events, the subject matter of the judicial inquiries on which the Government relies, the nature and operation of the Irish scheme, and explicit statements made by the Irish Government

(1) The Irish scheme was not set up in response to judicial findings of fault

See separate background briefing already supplied on the Irish situation. The judicial findings ratified the findings of the earlier expert group and led to the compensation scheme being put on a statutory footing. It was this earlier expert group that first identified the "wrongful acts" that led to the Irish Government setting up the compensation scheme.

27. The relevant history of the Irish scheme is as follows:

a. The first manifestation of the scheme was the Haemophilia HIV Trust, which was set up in 1989 along similar lines to the Macfarlane Trust;

b. In 1991 the Trust was reformed to provide for lump sum payments to victims of HIV on the basis set out in paragraph 17.b) above;

c. In December 1995, the Irish Government set up a Compensation Tribunal, on a non-statutory basis, to assess compensation to be paid, ex gratia, to women who had been infected with Hepatitis C from contaminated Anti-D. Justice TA Finlay's Report of the Tribunal of Inquiry into the Blood Transfusion Service Board explained the origins of the Compensation Tribunal as follows:

"The Government by a declaration of policy issued in December 1994, committed itself to fair compensation for women infected by Hepatitis C virus from Anti-D.

A decision was taken in April 1995 to establish as a matter of urgency a Tribunal which would assess compensation on an ex gratia basis in respect of Anti-D recipients who were infected with Hepatitis C and partners and children of theirs who were also infected.

In September 1995 the scheme was extended to include

persons who had contracted Hepatitis C from a blood transfusion

or other blood products.

...Further negotiations took place, including negotiations between lawyers representing the State• and those representing the Groups involved and eventually amendments were made and an amended compensation scheme was approved in December 1995. A Compensation Tribunal was established on the 1 December 1995 Evidence was given that the Compensation

Tribunal has to date received 1,653 applications, it commenced regular hearings on 11th March 1996 and has heard 233 cases. The awards made range from £15,200 to £453,904 and a sum of approximately £25.9m has been awarded in compensation so far (pp 117-118);

d. In 1997 the Compensation Tribunal was placed on a statutory footing by the Hepatitis C Compensation Tribunal Act That Act contains the following provisions:

4.—(1) The following persons may make a claim for compensation to the Tribunal —

(a) a person who has been diagnosed positive for Hepatitis C resulting from the use of Human Immunoglobulin Anti-D within the State,

(b) a person who has been diagnosed positive for Hepatitis C as a result of receiving a blood transfitsion or blood product within the State,

(c) children or any spouse of a person referred to in paragraph (a) or a person referred to in paragraph (b), who have been diagnosed positive for Hepatitis C,

(d) any person who is responsible for the care of a person referred to in paragraph (a), (b) or (c), and who has incurred financial loss or expenses as a direct result of providing such care arising from the person being cared for having contracted Hepatits C,

(e) where a person referred to in paragraph (a), (b) or (c) has died as a result of having contracted Hepatitis C or where Hepatitis C was a significant contributory factor to the cause of death, any dependant of such person, and

(f) a person referred to in section 9 in accordance with that section

(7) Subject to section 5(3), a claimant shall not be required to produce to the Tribunal any evidence of negligence on the part of a relevant agency or other person in respect of her or his claim.

(8) A claimant shall, as the case may be, establish to the satisfaction of the Tribunal, on the balance of probabilities, that the Hepatitis C-

(a) in respect of which the claimant has been diagnosed positive resulted from the use of Human Immunoglobulin Anti-D within the State,

(b) in respect of which the claimant has been diagnosed positive resulted from a blood transfusion or a blood product received by the claimant within the State,

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(c) was transmitted to the claimant from a person referred to in paragraph (a) or (b) following such use, transfusion or receipt;, as the case may be, or

(d) where the claimant is a person referred to in subsection (1)(d) or (e), was contracted in a manner referred to in this subsection by a person being cared for or who has died leaving a dependant

(13) In making a claim for aggravated or exemplary damages, a claimant may rely on the facts found in the Report of the Tribunal of Inquiry into the Blood Transfusion Service Board or any other fact which the claimant establishes to the satisfaction of the Tribunal.

5.—(1) An award of the Tribunal to a claimant shall be made on the same basis as an award of the High Court calculated by reference to the principles which govern the measure of damages in the law of tort and any relevant statutory provisions...

(3) An award in respect of aggravated or exemplary damages may be made by the Tribunal where a claimant establishes a legal entitlement to such against a relevant agency or the Minister.

e. In April 2002, the remit of the Compensation Tribunal was extended by the Hepatitis C Compensation Tribunal (Amendment) Act to include vicims who had contracted HIV from contaminated blood products.

28. As to the subject matter and timings of the judicial Inquiries in Ireland on whose findings the Government relies:

a. There were indeed two publicly funded judicial Inquiries into the supply of contaminated blood: the Finlay Tribunal of Inquiry into the Blood Transfusion Board ("the Finlay Inquiry") and the Lindsay Tribunal of Inquiry into the Infection with HIV and Hepatitis C of Persons with Haemophilia and Related Matters ("the Lindsay Inquiry");

b. The Terms of Reference for the Finlay Inquiry are set out in Chapter 1 of the Inquiry's Report. They were concerned exclusively with matters relating to the infection of women with Hepatitis C by means of contaminated Anti-D, manufactured by the Irish Blood Transfusion Service Board ("BTSB"), and the implications of that contamination. Those Terms of Reference made no mention of the infection of

haemophiliacs with Hepatitis C or HIV by means of contaminated Factor ' and Factor IX;

c. The Finlay Inquiry commenced on 5th November 1996 and published its Report on 11 March 1997. The Report did indeed make a number of findings of fault in relation to the Blood Transfusion Service Board, which are summarized in Chapter 17. The principal findings were that:

i. The primary cause of the infection of Anti-D with Hepatitis C was the use of plasma from a particular patient, Patient X, who was undergoing therapeutic plasma exchange treatment;

ii. The use of this plasma was in breach of the BTSB's own standards for donor selection;

iii. The BTSB failed properly to react to reports made to them that recipients of the Anti-D made from the plasma of Patient X had suffered jaundice and/or hepatitis;

iv. The BTSB failed properly to investigate complaints by other recipients of Anti-D;

v. The BTSB failed to recall the contaminated batches which had been issued and to prevent the issue of further batches of plasma made from plasma obtained from Patient X;

vi. Responsibility for these failures rested to a major extent with three named officers of the BTSB;

vii. The BTSB acted unethically in obtaining and using the plasma from Patient X without consent;

viii. A further cause of the infection of Anti-D with Hepatitis C was the use of plasma from Donor Y;

ix. This occurred because the plasma had been used notwithstanding test results, and because of lack of a proper method of communication;

x. "The main reasons why these wrongful acts were committed" were "an undue emphasis on the necessity to use plasma from therapeutic plasma exchange patients so as to maintain the supply of plasma for the making of Anti-D; an undue and unsupported belief in the probability that the method of production ofAnti-D would inactivate any virus that existed; and

a reluctance to admit the possibility of having been wrong and the possibility of a failure of the production of Anti-D which would be involved in the recall of the product."

These findings of fault were therefore concerned exclusively with the BTSB's actions in relation to the contamination of Anti-D, and the "wrongful acts" referred to were those which resulted in this contamination.

d. The Report further concluded on p. 152 that "In general the provision for compensation by a Tribunal on a no fault basis, as an alternative to and not excluding the right to sue at the time at which it was introduced, constituted a reasonably

adequate and appropriate reaction to that particular problem by the Minister and Department"

e. The Lindsay Inquiry commenced in May 2000, and published its Report in September 2002. This Report made a number of findings of fault against the Blood Transfusion Board in relation to the infection with Hepatitis C and HIV of heamophiliacs by means of contaminated Factor VIII and Factor IX.

29. On the basis of the facts as set out above, it is clear that:

a. The Irish scheme was not set up in response to findings of the Lindsay Inquiry. That scheme in its final form was in place before the findings of the Lindsay Inquiry were even published. Indeed, this was acknowledged by Lord Warner in a letter to GRO C the spouse of a patient who died as a result of receiving infected blood products, of 26 May 2004; "Ifeel that the Lindsay Tribunal can have no bearing on the way in which payment schemes have been formulated in the Republic of Ireland — since it post dates the Hepatitis C Compensation Tribunal act by five years."

b. Insofar as it relates to haemophiliacs (and in any case) the Irish scheme was not set up in response to, or rationalized by reference to, findings of the Finlay Inquiry. This is because:

i. The Finlay Inquiry was not concerned with, nor did it make any findings in relation to, the contraction by haemophiliacs of HIV or Hepatitis C from contaminated clotting factors. Its principal investigations and findings related solely to the production of contaminated Anti-D;

ii. In any case, the Hepatitis C Compensation Tribunal was set up, albeit on a non-statutory footing, fifteen months before the

Finlay Report was published (in which Report it was referred to, and characterized, as an ex gratia scheme).

30. It is therefore demonstrably false that the Irish Government decided to make significant payments to victims "as a result" of the fact that "a judicial inquiry in Ireland found failures of responsibility by the Irish blood transfusion service and concluded that wrongful acts had been committed".

(2) The Irish scheme is not afault-based scheme

31. The Government has relied on a characterization of the Irish scheme as a "compensation" scheme, in contrast to the "ex gratia" payment scheme in

force in the UK. This characterization is erroneous.

32. It is evident from the central provisions of the Hepatitis C Compensation Tribunal Act 1997, set out in paragraph 26(d) above, that (other than in the case of a claim for aggravated or exemplary damages) payments made by way of compensation under the scheme therein enacted are not dependant on, nor do they make reference to, findings of liability, or negligence, or fault on the part of the state.

33. The scheme's status as a no-fault scheme was acknowledged by Justice Finlay

in the passage set out in paragraph 27.c) above. This was later confirmed by

a Brief prepared by the Irish Department of Health and Children and made

available to the UK Government at the time of Lord Warner's comments in

2004. That Brief makes the following assertions:

"The scheme of compensation for persons with haemophilia was put in place on compassionate grounds, without legal liability on the part of the State, because of the enormity of the tragedy which befell the citizens of the State whilst availing themselves of State health services." (para 1)

"The initial drive for compensation for persons with haemophilia who were infected with HIVstarted in the late 1980s and I understand that there were similar developments in the United Kingdom around the same time. An ex-gratia compensation scheme based on fiat-rate payments was finalized in 1991." (para 1)

"The original Scheme of Compensation announced by the then Government in June 1995 was confined to women who contracted Hepatitis C through the administration oftheAnti-D product; and to any infected partners and children of these women. The purpose of the scheme was to provide compensation on an ex-gratia basis, as legal advice to the Government was that the State itself was not liable. The same legal advice regarding liability would also pertain to the infection

o with haemophilia. but was not given specifically in that context" (para 3)

"Following further consideration and consultation during 1995, it was announced in September of that year that the compensation scheme was to be extended to cover all those who had contracted Hepatitis C from a blood transfusion or blood product administered within the State... the scheme of corn pensation was a no-fault scheme, there was a perception that any restrictions on access might be interpreted as an implicit admission of liability." (para 4)

34. Statements to these effects have since been repeated in letters from Anne McGrane (26th February 2005) and Lara Hynes (30 July 2009) of the Irish Department of Health and Children, to, respectively, Carol Grayson and the claimant

35. These statements make clear that the Irish scheme was explicitly designed, and has since always been conceived, and applied, as a no-fault ex gratia scheme, and is not a compensatory fault-based scheme.

We have no reason to doubt the validity of the facts quoted in Justice Finlay's tribunal report, or the quotes from the Hepatitis Compensation Tribunal Act, but if required, we could confirm this with Irish colleagues. It is important to remember again that the claimant makes no mention of the earlier expert group – whose findings set the compensation scheme in progress.

Unreasonableness

36. Further or alternatively, the Government's failure to implement recommendation 6(h) is unreasonable, applying that principled standard of substantive review. That is for the following reasons:

a. It is based on the demonstrably false premise that the compensation scheme in Ireland is a fault-based scheme, which acknowledges state liability. The Archer Report itself observed that this was a false premise by which the Government had been misled in the past, and formulated recommendation 6(h) in light of this observation;

b. It relies on the fact that there have been findings of fault directed at the Irish Blood Transfusion Service Board, but no such findings of fault in the UK. Since successive UK governments have declined to allow the question of fault to be ventilated by

means of a publicly funded Inquiry, the Government cannot reasonably rely on the absence of findings of fault in the UK as constituting a meaningful distinction between the cases of the UK and Ireland.

Faults were found in Ireland – see paras 28 c to e. Similar faults have not been found in the UK. **Rowena** – can you add anything more here?

In his summary, Lord Archer does say he thought a full public inquiry should have been held earlier, but he does not apportion blame (p. 101 of his report):

> *Without necessarily apportioning blame, the state needs to act responsibly in addressing the tragedy of patients being infected with potentially fatal diseases through NHS prescribed treatment.*

I cannot immediately find the reference they refer to as 'false premise' (**Rowena** – can you please double-check?), but pages 90 and 91 of Lord Archer's report do refer to liability:

> *Schemes to provide financial support for haemophilia patients who had suffered infections have been established in Canada, New Zealand, Hungary, Italy, Spain and Sweden. In Canada, payments ranged from $10 to $100,000. In Italy, monthly payments are made ranging between the equivalent of £600 and £900, and there has been a single payment of £465,000.*
>
> *It is not our function to decide issues of legal liability, and we do not presume to do so. But we are impressed by the arguments which have been presented to us for more generous assistance to mitigate the financial hardship endured by many victims. We have made certain criticisms of acts or omissions which, in the past, may have contributed to the disasters and the consequences, and which continue to blight the lives of victims and their families. But it is not on these observations that the arguments rest.*

Irrelevant Considerations

37. Put another way, the Government has erred in taking into account irrelevant considerations in deciding not to implement recommendation 6(h). This decision is based on the observations that (a) the Irish compensation scheme

operates in the context of findings of fault; whereas (b) there have been no such findings of fault in the UK context.

38. The presence of findings of fault in Ireland is irrelevant to the question whether parity with Ireland is appropriate, for the reason that the Irish scheme was not designed to acknowledge or respond to findings of fault, but was explicitly conceived of as an ex gratia scheme. The presence of findings of fault was thus incidental to, and did not rationalize, the Irish scheme. It is therefore irrelevant to the question whether a similar scheme is justified in the UK.

39. The absence of findings of fault in the UK is similarly irrelevant. This is because, to the extent that the question of fault could in principle have relevance to the question of the appropriate level of payments, it is not the presence or absence of findings of fault, but the presence or absence of fault itself that could reasonably be taken to have this relevance. In circumstances where there has been no Public Inquiry

into the question of fault, the absence of findings of fault does not demonstrate the absence of fault, and the absence of findings of fault is therefore irrelevant to the question whether parity with Ireland is appropriate.

We need legal advice on this. Ireland took their decisions on the basis of the expert group's findings and subsequent judicial inquiries ratifying problems unique to Ireland. You will see from the UK legal advice to potential HIV litigants in December 1990 (copy I circulated earlier) that the claimants were given a 20% chance of legal success. Do we need to go into detail as to why the Irish faults were unique to them (i.e didn't happen here)?

Conclusion

40. For the reasons set out above, the Claimant seeks permission to apply for judicial review, and thereafter seeks judicial review, of the decision not to implement recommendation 6(h). (The Claimant does not pursue the point originally canvassed, as to the Skipton Fund.)

41. The Claimant claims:

(1) a declaration that the Defendant's decision was contrary to law;

(2) such other declaratory relief as the Court thinks fit;

(3) costs.

MICHAEL FORDHAM QC

JESSICA BOYD

Blackstone Chambers

IN THE ADMINISTRATIVE COURT

R (ANDREW MICHAEL MARCH)

Claimant

V

SECRETARY OF STATE FOR HEALTH

Defendant

INDEX OF DOCUMENTS

1.

Grounds for Judicial Review

2.

The Report of the Archer Inquiry dated 23 February 2009

3.

Government Response to Lord Archers Report dated 20 May 2009

4.

Hansard entry for 23 June 2009 (volume 494; column 656; response of Gillian Merron MP to question from Dr Brian Iddon MP)

5.

Hansard entry for 1 July 2009 (Westminster Hall debate; column 124WH; further response of Gillian Merron MP to debate tabled by Jenny Willott

MP)

6.

Irish Statute: Hepatitis C Compensation Tribunal Act 1997 (dated 21 May 1997)

7.

Irish Statute: Hepatitis C Compensation Tribunal (Amendment) Act 2002 (dated 29 April 2002)

8.

Report of the Finlay Tribunal of Inquiry into the Blood Transfusion Service Board dated 6 March1997

9.

Report of the Lindsay Tribunal of Inquiry into the Infection with HIV and

Hepatitis C of Persons with Haemophilia and Related Matters dated 4

September 2002

10.

Brief prepared by the Irish Government on the Hepatitis C & HIV Compensation Tribunal in Ireland and provided to the UK Government in or around March 2004

11.

Letter from Ann McGrane (Irish Department of Health and Children) to Carol Grayson dated 26 February 2004

12.

Email from Ann McGrane to Hazel Bullock dated 3 March 2004

13.

Letter from the Lord Warner of Brockley (Department of Health) to Sue Threakall dated 26 May 2004

14.

Letter from Bob Stock (Scottish Executive Health Department) to Carol Grayson dated 21 June 2004

15.

Letter from Melanie Johnson MP (Parliamentary Under Secretary of State for Public Health) to the Lord Morris of Manchester dated 1 June 2004

16.

Letter from Dora East (Department of Health) to the Claimant dated 24 June 2009

17.

Letter from Lara Hynes (Irish Department of Health and Children) to Mark Ward dated 30 July 2009

18.

Letter from Lara Hynes to the Claimant dated 30 July 2009 (enclosing the Brief prepared by Irish Government and made available to UK Government in or around March 2004)

It is worth noting that Lara Hynes is our contact in the Irish Department of Health and Children. We do not disagree with her two letters dated 30 July (to Mr March and Mr Ward), but it is worth noting that Irish colleagues do present the 'no legal liability' front in such communications because this is a delicate issue for them and they try not to dwell on the issue of fault. However, it is worth noting that fourth paragraph of Mr Ward's letter does include mention of the Irish expert group, yet this is missing from the Claimants summary grounds.