The Infected Blood Public Inquiry NEWSLETTER

THE HAEMOPHILIA SOCIETY

A summary of inquiry hearings

Two men at the heart of decision-making in blood services during the 1980s have been the subject of this week's inquiry presentations.

Professor John Cash was national medical director of the Scottish National Blood Transfusion Service 1979 to 1988 and Dr Harold Gunson was director of the North Western Regional Transfusion Centre 1980 to 1988 as well as adviser to the chief medical officer from 1981 to 1994.

The National Blood Transfusion Service (NBTS) covering England and Wales was formed in 1946 and made up of 14 autonomous centres. Scotland's service has five centres, Northern Ireland, one. Much of the evidence focused on the difficulties of getting nationwide policies agreed in the absence of a central organisation which had direct control over the regional centres. In 1987 Dr Cash described the NBTS as a "fragmented and disorganised shambles". It was not until 1994 that the National Blood Authority became responsible for the regional transfusion centres. A restructure in Scotland led to a national approach in 1998-9. Wales did not have a unified blood service until 2016.

Prof Cash complained of the 'ultimate dominance' of political considerations in blood service decision making.

Inquiry in focus: hepatitis blood screening

By 1986 debate was underway in the UK's blood services about whether to follow the lead of US commercial companies and start donor screening for hepatitis markers. There were concerns about the reliability of the tests, but in July 1987 Prof Cash caused "consternation" among colleagues by publicising his view that testing was "virtually inescapable". The Department of Health and Social Services (DHSS) wanted any testing to be adopted nationally and was concerned Prof Cash was about to introduce it in Scotland. This didn't happen, but with the identification of hepatitis C in 1988/9 the debate re-opened. Clinicians had concerns over the first generation hepatitis C tests, including the number of false positive results, but Prof Cash believed this testing should be introduced by June 1990. Nothing happened until a second generation test was approved, which was introduced UK-wide in September 1991. Dr Lloyd, Director of Newcastle Regional Transfusion Centre, felt this delay was "indefensible" and unilaterally started testing in April 1991. Dr Cash was furious at this "disgraceful" breaking of ranks within the National Blood Transfusion Service.

Quotes of the week

"The import into the UK of factor VIII concentrates derived from external sources, however well screened for hepatitis viruses, represents an unequivocal pathway by which the level of a potentially lethal virus into the whole community is being deliberately increased ."

Prof Cash, January 1976

"I have a feeling that as the drums are beating louder in other parts of the world on this topic, the Brits remain fast asleep."

Prof Cash on testing blood donors for non-A non-B hepatitis, 1986

"The follow-up we were doing 18 months ago of this incident was bedevilled at that time by the reluctance of haemophilia centre directors to cause what they considered to be an unnecessary worry to their patents, so that the follow-up of the recipients who received this product has not been carried out in the formal sense."

Dr Craske, of the Public Health Laboratory, in 1988 about an HTLV-III infected blood donation

"I fear...if there is a delay in the introduction of anti-HCV testing we will be exposing patients to preventable viral infection".

Dr Ludlam, of Edinburgh Royal Infirmary on using "imperfect" hepatitis C tests, in Dec 1989

"I do not think BPL could change to freeze-dried cryo[precipitate] rapidly and the logistic problems would be considerable."

Dr Gunson, May 1983

"My personal view is that not to test now that we have the ability to test would be indefensible under the current Product Liability Legislation."

Dr Lloyd, Director of Newcastle Regional Transfusion Centre, May 1991.