Infected Blood Inquiry

Prof Brian Edwards
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The industry evidence

The resumed hearings begin with Counsel summarising the industry response to the slowly emerging evidence of the risk of AIDS for patients with haemophilia and their donor screening programmes.

Quite early on three donor groups had been defined by US scientists as high risk; intravenous drug users, gay men and people who came from a Haiti background. There were also known risks when blood was collected in high-risk cities such as San Francisco.

Restricting blood collection from high risk groups was one way forward but difficult questions remained…

The Inquiry will also look at what the companies did with old stock once the identity of an infected donor became known.

In 1982 the Centre for Disease Control [CDC] in the US had identified haemophiliacs as a high risk group for AIDS. They gave the companies notice of the possibility of transmission via blood products.

The evidence had been accumulating since June 1981. As Sir Brian Langstaff remarked *"It was there to be seen but was not picked up".*

The experts began to explore what could be done if a donor was diagnosed with Aids. Could their blood be quarantined. What if it had already been pooled?

Could the companies claim for reimbursement from their insurance companies?

Two months later the arguments still raged in the scientific community. Four more AIDS cases were identified. AIDS had a long incubation period so the evidence only trickling in.

However, by October 1983 the US National Haemophilia Foundation recommended that blood collection in high risk areas such as San Francisco should be halted.

Most companies stopped collections in these, but the US Blood Banks were slower to act.

There was much debate in expert circles as to whether city bans were as effective as a policy of educating all high risk donors. As one disclosed paper put it *"the drug users who sell plasma have no concern for others"*. The collection from prisons did however begin to stop as evidence about the number of infected prisoners began to accumulate.

In July 1983 the arguments had become public when the CDC was challenged about weak and anecdotal evidence. The critics included no less an organisation than the

American Red Cross. There was, said one expert, "not a shred of evidence that AIDS could be transmitted by blood". We now know how grievously wrong they were.

Meanwhile experts in the UK were following the US discussions very closely and in July 1983 the DHSS began to ask questions about the size of donor pools and donor screening.

Almost all companies were by now only collecting blood from FDA approved sites. The companies argued that "*A balance had to be struck between the theoretical risk of AIDS and the need for an uninterrupted supply to patients of a life sustaining therapy*".

In August 1883 the US congress gets involves and is told that "*the risk of acquiring AIDS from a blood transfusion is extremely small*".

The policy of stopping donations from at risk groups would decrease this risk claimed the expert witnesses.

In February 1984 we have evidence of a UK stocktake.

By this time 33 patients with haemophilia in the US and Europe had contracted AIDS including two from the UK.

Restricting blood collection from high risk groups was one way forward but difficult questions remained about what to do once an infected donor had been identified.

Testing for AIDS was still problematic and very expensive.

Heat treatment was just beginning to enter the market, but some clinicians were wary about its use.

Despite this by 1985 most companies had stopped manufacturing non heat-treated products.

They did however try to sell off old stocks at rock bottom prices to countries that had not yet made a decision to move to heat treatment.

There is no suggestion that this was illegal but was it ethically, right?

It also emerges that some companies were still accepting donations from prisons for use in manufacturing non coagulation products.

Next the Inquiry will cross examine some industry witnesses.