**The ‘chilling cover-up’ of the U.K.’s contaminated blood scandal**

Fifty years on, an inquiry report has shed some light on a medical tragedy in the U.K. Between the 1970s and 1990s, more than 30,000 people were infected with HIV, Hepatitis C and Hepatitis B after receiving contaminated blood and blood products imported from the U.S. — making it the “worst treatment disaster” in the history of Britain’s state-funded National Health Service (NHS). “The disaster was not an accident,” said Inquiry chair Sir Brian Langstaff while announcing the report. Those in authority — doctors, the blood services, and governments — committed the ultimate folly in healthcare and healing: they “did not put patient safety first”.

The six-year-long inquiry is a dissection and diagnosis. It uncovers a coverup that was “more subtle, more pervasive, and more chilling in its implications” than an orchestrated conspiracy. It was undertaken “to save face and to save expense”. The calamity was made more catastrophic by the “defensiveness of government...and its refusal over decades to hold a public inquiry.”

“Affected individuals and families have been very stoic in their wait,” says Kate Khair, a nurse and Director of Research at Haemnet. “Many now feel that the report gives them vindication.”

The Infected Blood Inquiry

The public inquiry, the largest of its kind to be carried out in the U.K., was commissioned in 2017 to “examine the circumstances in which men, women, and children treated by National Health Services ... were given infected blood and infected blood products” since 1970. The affected included two groups: those with haemophilia (and similar blood disorders), and people who received blood transfusions during surgeries and childbirth. Between the decades in question, at least 3,000 people have died due to receiving infected blood. The Haemophilia Society estimates another 680 people have died since the inquiry began. An infected person still dies every four days in the U.K., per one estimate. Deaths and infections linked to tainted blood were also recorded in Australia, Canada, China, France, Ireland, Italy, Japan, Portugal, and the U.S.

Haemophilia is a rare genetic condition where the blood does not clot properly. Up until the 1970s, treatment options included administering the frozen blood product cryoprecipitate. It carried a low risk of passing on an infection since it was formulated from a single blood donation, but cryo was hard to store and harder to administer to patients. Enter Factor VIII, a revolutionary ‘wonder treatment’ made using concentrated pooled plasma from tens of thousands of donors. It was deemed to be a medical breakthrough. The caveat: Factor VIII had a high risk of infection. Even one blood sample, if infected with HIV or Hepatitis C, could contaminate the entire batch. Demand rose within the U.K., prompting the NHS to import supplies from the U.S. American blood products were often sourced from high-risk donors including prisoners, and drug addicts.

The infections were not fully understood and identified at the time: the agent for Hepatitis C was identified in 1988, and the first case of AIDS in the U.K. was recorded in 1981. Research as early as the 1940s shows transfusions or the use of plasma could transmit “serum hepatitis,” which could be fatal or lead to long-term diseases such as liver failure and cancer. By the 1970s, researchers had identified the virus responsible for Hepatitis B and became aware of the risks. The ‘unexplained Hepatitis’, as Hepatitis C was understood then, was known to be responsible for “the majority of post-transfusion hepatitis cases and that just as Hepatitis B could have serious long-term consequences, so too might non-A non-B Hepatitis”. The WHO warned in 1974 and 1975 against importing blood products from countries with high rates of hepatitis, such as the U.S.

By 1984, when HIV was identified as a cause, experts grew concerned that people receiving Factor VIII blood concentrate were at risk of HIV infection. Evidence was, however, discarded and authorities failed to switch to safer options, Sir Langstaff’s review found.

Why was tainted blood used?

The inquiry revealed how contaminated blood plasma products imported from the U.S. were used to treat people with haemophilia. In January 1982, leading expert Arthur Bloom wrote an infamous letter to haemophiliac centres, suggesting “the most clearcut way” of testing the infectivity of the new treatments was on patients previously unexposed to large-pool concentrates – including children. Sir Langstaff vivisects the events at Treolar’s College in Hampshire, a specialist school for people with haemophilia. Children were used as “objects of research” and treated “unnecessarily with concentrates (especially commercial ones) rather than choosing safer treatments”. A BBCinvestigation found that of the 122 pupils who attended Treloar’s between 1974 and 1987, 75 died of HIV and hepatitis C infections.

The inquiry estimates that of the 4,000–6,000 people with bleeding disorders in the U.K., about 1,250 developed both HIV and Hepatitis C. Of them, 380 were children. Three-quarters of these individuals have died. Those who received blood transfusions during surgeries also went on to develop infections. The inquiry estimates that between 80 and 100 of them were infected with HIV, and about 27,000 with Hepatitis C. Reports showed the death toll rose among people infected with Hepatitis B, Hepatitis C and HIV for two decades, and by the 1990s, almost 3,000 people had died. On multiple occasions, government officials decided not to suspend the importation of commercially produced blood products. They insisted, repeatedly, that people received the best available treatment and that blood donations were tested when technology became available. “Both claims were untrue,” the Inquiry found.

What did the report find?

The six-year-long inquiry reviewed evidence from the government, NHS, pharmaceutical companies, and national blood services. It also took into account over 4,000 oral and written statements from people and families affected; some 2,000 people were appointed as “core participants” who worked with the team to pose questions to an expert group. The picture that emerged showed people were “failed not once, but repeatedly”. Patient safety was ignored; decision-making was “slow and protracted”; people’s autonomy and privacy were neglected; clinical freedom was abused; governments and NHS officials were defensive; the lack of transparency and accountability amplified the injustice “to the people whose lives had been destroyed by infection”.

At a medical level, the opportunities to reduce risk were missed and new risks were created. There was a failure to achieve self-sufficiency in blood clot treatments in England and Wales; a failure to introduce surrogate screening for either HIV or Hepatitis C; delays in introducing screening for HIV and Hepatitis C despite mounting evidence. Doctors, haemophilia centres, pharma companies were guilty of “giving too many transfusions when they were not clinically needed, or when less would have sufficed, or overriding a patient’s wish not to be transfused”.

What next?

Mr. Langstaff has given the government a year to respond to its findings, noting that the inquiry is far from over. Its recommendations include immediate compensation, public memorials and for the learning to seep into medicine, government and civil services so that the tragedy is never repeated. Blood products should only be used when necessary, and should be regularly screened for known viruses. “We need to be sure that the products we use now are as safe as they can be”, Dr. Khair adds.

Chief among the Infected Blood Inquiry’s recommendations is to create an enabling environment where the “patient voice is heard”. Dr. Khair concurs. “We have to engage with and listen to patient opinions and concerns and act upon them,” she says. “We can, and should, learn from this — all care that we give needs to be assessed”.