Irish blood bank "knowingly" risked using contaminated products, Dublin tribunal told

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The Irish Blood Transfusion Service (BTS) knowingly risked treating haemophiliacs with contaminated blood products during the early 1980s, the official Lindsay Tribunal sitting in Dublin has heard. More than 200 Irish haemophiliacs were infected with HIV and Hepatitis C as a result, including young children. Seventy-five of these people have since died.

Haemophilia is a hereditary condition in which the blood does not clot normally, causing severe bleeding from even a slight injury. In the early 1970s an injectable clotting agent was developed made from donations by donors who had not been tested for HIV. The blood product had also not been heat-treated to inactivate viruses.

The Irish Haemophilia Society (IHS) said that, as a result, 220 of its 400 members became infected, 57 subsequently dying from HIV-related diseases. On September 10, John Berry, 62, died from liver cancer caused by contracting Hepatitis C from a clotting agent. Mr. Berry was the third haemophiliac to die since the tribunal was established last year, but the first since the public hearings began in May. Mr. Berry had been given the contaminated clotting agent after being admitted to hospital suffering from a nosebleed.

The tribunal was convened under Chairwoman Judge Alison Lindsay to examine the sequence of events and to hear allegations against leading officials at the BTS. The Irish Haemophilia Society agreed to participate in the hearing after winning a dispute with the state over the funding of its legal team and access to all tribunal documents.

The inquiry began by hearing evidence from 22 witnesses, including parents whose children had died. Using the pseudonym “Felicity”, one mother told how three of her sons had become infected with Hepatitis C from contaminated blood products. Her children wished they had cancer, she said, because if they told their friends they had Hepatitis C they would probably not be able to play with them.

“Martin” testified that his son was tested for HIV at age four, but no information of the result was relayed to him. At a hospital meeting two years later a doctor had remarked that the family seemed to be coping well with their counselling. When “Martin” asked what counselling was being referred to they were told that their son had been diagnosed as HIV positive two years earlier. Their son's health had deteriorated from 1992, when he became thin and frail before dying. “I firmly believe mistakes were knowingly made and I want to see heads on a plate at the end of the tribunal,” the boy's father said.

A widow also told the tribunal how she was diagnosed as HIV positive three years after her husband died from an AIDS-related illness in 1993, having contracted HIV and Hepatitis C from contaminated blood products.

The tribunal has heard damning evidence of the disregard for public health shown by the BTS and the state that resulted in such fatalities. In testimony presented by former BTS executives and medical experts it has emerged that the blood bank continued to sell infected blood products to Irish hospitals even when concerns had been voiced as to their safety.

Before 1974 haemophiliacs used the clotting agent cyroprecipitate to stop bleeds. However, a concentrated agent produced by US-based Travenol Laboratories was found to enter the bloodstream faster and significantly reduce the time spent in hospital. A 1974 memo presented to the tribunal revealed that Jack O'Riordan, then BTS national director, had objected to the Travenol agent being given a license on the grounds that the product was derived from “skid-row types” paid for donating their blood.

However Travenol was granted a license and later that year Dr. O'Riordan began negotiations with the company for the blood bank to act as its wholesaler and distributor in Ireland.

A letter from April 1974 recorded an agreement that BTS would get a 10 percent return on all products it sold and would be able to mark up the units it sold to hospitals. The BTS continued to buy clotting agents from Travenol through the early 1980s, even when it became clear that the company was failing to implement standard heat-treating procedures.

It has been alleged that in the early 1980s BTS discontinued a drive to produce its own blood products because it could make larger profits using commercial products. The tribunal heard that BTS faced a major funding crisis at that time. Mr. McStay, a receiver hired by BTS to analyse its accounts, told the hearing that Pelican House (BTS headquarters) was effectively insolvent in 1981 and would have been liquidated if it was a commercial company.

Banks were refusing to honour Pelican House cheques and nearly £1 million was needed to avert a total financial breakdown. In the late 1980s, to cut costs, BTS had reduced the number of full-time medical consultants it employed by two-thirds—leaving just one consultant for the entire country. Over the same period, revenue from haemophiliac blood products grew steadily to account for 26 percent of Pelican House total income by 1990.

By 1984 there were strong indications that HIV was being transmitted to haemophiliacs through blood products. There had been a three-fold increase in the number of haemophiliacs contracting Hepatitis B, deemed to indicate the presence of HIV, for which no test then existed.

In January 1986 the Department of Health had issued a circular stressing that it was “imperative” that all blood products made from donations not tested for HIV be withdrawn. This followed an EEC directive that all blood banks were subject to product liability claims in the case of contamination from infected blood. BTS agreed to change the heating procedure for its Factor 9 clotting agent, but did not recall its old products from hospitals.

The tribunal also heard that in 1988 Armour Pharmaceuticals, another supplier of blood products, announced it would be changing its manufacturing procedures for safety reasons, with a consequent doubling of prices. However, Pelican House asked Armour to continue with the old method until the end of year and Mr O'Riordan's successor, Ted Keyes, signed a document indemnifying Armour. Although there is no evidence that any person was infected with hepatitis from the blood product following the indemnity, a Pelican House clotting agent made from a by-product of the Armour process infected two children from the same family with Hepatitis C.

Throughout the late 1980s BTS did not contact haemophiliacs who tested positive for HIV, even though it had “powerful evidence” that a blood product made by Pelican House was responsible, the tribunal was told. They had also dismissed IHS charges that BTS blood products had caused HIV infection even though they knew it to be true.

The tribunal also heard that Sean Hanratty, former Chief Technical Officer at the BTSB, was a director and beneficial shareholder with Accu-Science, a company that sold products to Pelican House throughout the 1980s. Hanratty had invested in Accu-science, whose subsidiary company Intrascience received the contract for the supply of blood packs to the board in 1990. Hanratty is said to have subsequently resigned his directorship and transferred his shares, but the hearing was told that Hanratty was held responsible for the destruction of 20 years of BTS records in 1993 that were crucial to efforts by infected haemophiliacs to sue the pharmaceutical firms.

However, the tribunal so far has shown no interest in pursuing the mainly US-based pharmaceutical firms. In her opening remarks Judge Lindsay made no inference as to what inquiries would be made into the companies' involvement, despite there being a considerable amount of material relating to this in the US following civil law suits.

The judge also ruled that three documentary *World In Action* programmes would not be viewed in public at the tribunal. The *World in Action* programmes, two of which were transmitted as part of a series in 1975, investigated how US blood companies screened blood donors who were being paid for donations and the risk of blood products being infected with hepatitis.

The programmes make serious charges against US blood companies, and were “clearly relevant”, John Trainor, senior counsel for the Haemophilia Society, had argued. The decision by BTS to continue dealing with Travenol even after the broadcasts was an act of “irresponsible madness”, he said. Judge Lindsay dismissed the application, ruling that the documentary comprised allegations rather than fact and that their viewing could “blur” issues. However, she did order that transcripts of the programme be made available and that the allegations could then be put to any witness.

Both Hanratty and O'Riardon are now deceased. An earlier public hearing, the Finlay Tribunal, had held O'Riardon primarily responsible for the fact that a number of women had become infected with Hepatitis C from anti-D, a contaminated blood product produced by the BTS. An estimated 1,600 people were infected in the 1980s, the majority of them women who required the anti-D immunoglobulin during pregnancy. Others infected included haemophiliacs, those who received blood transfusions, and people with kidney problems.

The tribunal is continuing.