Prof Ian Hann Response to Penrose Inquiry re "Blood Money" received 05/04/2011

I would like to respond to this request in note form :-

1. In 1975 I was a general and neonatal paediatric trainee in Liverpool

2. I do not recall seeing the World in Action programmes of Dec 1 and 8, 1975

3. I became fully engaged with the question of appropriate and available therapy for bleeding disorders in 1983. I do have a vague recollection of the UKHCDO meeting of that year and the conclusion of its expert members that there was no need to stop using commercial concentrates, a position that I believe

   (a) was supported by the patients' group on the grounds that treatment was necessary and could be life-saving,

   (b) proof of transmission of HIV was uncertain and

   (c) that local supplies were not yet certain.

4) The programme rightly emphasised the problems with Baxter Hemofil and the need to improve the donor pool and move towards unpaid donor self-sufficiency. I believe this was supported by the haemophilia treaters. It highlighted the potential unquantified increased risk from certain populations eg prisoners as used in Scotland I seem to remember, but the programme did not specify which type of hepatitis it was seeking to address, or the fact that testing for Hepatitis B (which had been a major issue in this donor population) was improving all the time and greatly reducing the risks to recipients. The commercial companies were the main drivers for increased safety with regard to heat treatment and the only drivers (including Baxter) to the ultimate goal of recombinant therapy.

5) When I joined the discussions from 1983, it was the constant theme that treaters wished to see UK self-sufficiency, for all of the reasons that were stated in the programme. We all recognised that a donor population of any type would never be free of risk from hepatitis viruses, unknown viruses – eg subsequently West Nile etc., unknown other agents eg subsequently the British prion problem. However for the reasons of sustained supply, economics and probable reduced risk, that is what we asked for in the interim until truly safe recombinant products became available.

6) My recollection is that we had many discussions about the increasing demand with figures of 10% annual growth being a memory of mine. However, it was pointed out that none of this took into account the dramatic gap which would still exist between supply and need for prophylaxis in children and subsequently adults. Manco-Johnson, Gringeri, myself and others pointed out that the average on-demand usage in a cohort of children would be about 113,000 units and that for prophylaxis about 352,000 units – more than triple.