Infected Blood and the Civil Service

This paper summarises what the Infected Blood Inquiry Report says about the civil service and civil servants. As far as possible I quote directly from the report.

In short, the civil service failures that contributed to this scandal are very similar to those that led to Grenfell Tower.

There was institutional deafness and defensiveness exacerbated by the failure of senior officials properly to manage their department.

But first - here is a brief summary of ...

The history of this scandal

There were broadly three categories of patients who were infected by blood products. The first group were haemophiliacs who contracted HIV/AIDS. The second was a larger number of blood transfusion recipients had also been infected with HIV/AIDS. And then it was realised than another group had been infected with Hepatitis C and similar pathogens.

It all began 41 years ago ...

> ... on 6 May 1983 when [infectious disease expert] Dr Spence Galbraith telephoned Dr Sibellas at the DHSS to report that a Cardiff haemophilia patient had the right symptoms and signs for a diagnosis of AIDS, and to flag up three cases in Spain. He asked that the DHSS "consider the matter as a priority". Dr Galbraith's reasoning was impeccable. His views deserved to be given great weight and circulated widely [but] that did not happen.

This eventually led to the 'HIV Litigation'. In 1990 the trial judge took the unusual step of writing to the parties to set out his view that compromise was desirable because it was "cardinally important" that people should not die before knowing the outcome of the litigation:

> A government which takes upon itself the role of public provider of medical advice and clinical services is in a very different position to any commercial organisation. ... the public may be entitled to expect from government an appraisal of their position which is not confined solely to legal principles to be found in the law of negligence, or problems of proof.

This led to limited hardship funds being made available, and then ...

> In early February 1992, the Prime Minister was provided with a Department of Health briefing which maintained its support for the existing ring-fence around people with haemophilia. However, the cover note from William Chapman, the PM's Private Secretary, commented that the Government would have to give way and better to do that sooner. He questioned the logic of a ring-fence for people with haemophilia, and said that the "Government's position seems increasingly untenable."
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> (Mr Chapman was one of the few civil servants willing to challenge the Health Department policies.)

After further discussion it was announced in 1992 that limited financial support would be extended - but only to people infected with HIV. But ...

> The Government became so fixated on maintaining that ring fence that it lost sight of the desperate circumstances of those whose lives had been and were continuing to be devastated as a result of their treatment by the NHS. The question of moral responsibility, and the compelling need for a compassionate response, did not feature in the Government'sthinking ...
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> It took until 2003 for any form of payment to be announced for those with Hepatitis C and no payment was actually to be made until 2004. This deprived those individuals, and their families, of some valuable support before then. It prolonged and exacerbated the suffering of those who survived. And it further entrenched deep feelings of injustice.
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> The harms already done to [those infected and their families] were compounded by the refusal to accept responsibility and offer accountability, the refusal to give the answers that people fervently sought, the refusal to provide compensation, leaving people struggling and in desperate circumstances, the thoughtless repetition of unjustified and misleading lines to take, and the lack of any real recognition and of any meaningful apology."

What drove civil servants' (and ministers) thinking?

There seem to have been three key factors.

- They believed (wrongly) that those infected had received the best treatment available at the time.
- They feared that making payments to people infected with Hepatitis C would be a major step on the slippery slope to a general system of no-fault compensation.
- They believed that compensation would need to be diverted from funds currently allocated to patient care. (This was of course the firm Treasury line.)

These factors were exacerbated by ...

Institutional Defensiveness

This defensiveness took the form of ...

> ... a reluctance for the decisions, actions and omissions of both the NHS and government to be assessed and exposed – combined with a kind of "*memory illusion, but at a departmental level, where the people collectively try to remember things as they would like them to have been, rather than as they actually were.*" Jeremy Hunt (rightly) said that the State, including the Civil Service, "*didn't have an open mind to this issue. They basically had decided that the State in the 1970s and 80s had done the best it could in the circumstances: a very sad thing had happened; compensation had been put in place; matter closed.*"
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> The second and related reason was what Jeremy Hunt described as the "*massive institutional reluctance in the NHS to listen to the stories of ordinary people when things have gone wrong … there was certainly a very strong view that harm to patients is part of the cost of doing business. It's part of what happens.*" That description is equally applicable to government.

> The third was money and the fear of having to pay compensation. That too was the evidence of Jeremy Hunt. As he told this Inquiry, he (as Secretary of State for Health) knew, Number 10 knew, Number 11 knew that a public inquiry might well recommend large sums of compensation and for that reason did not want one. His evidence was consistent with that of another former Health Secretary. Andy Burnham told Parliament, "*To the extent that the public know anything much about this scandal, there is a vague sense that it is an argument about money. In my view, it is in the Government's interests to keep it there; ... Why is that? Just as with Hillsborough, if the Great British public knew the real story here, there would be such a wave of public support for the victims that demands for full and fair compensation simply would not be able to be resisted by the Government.*"

The Burgin Self-Sufficiency Report

In May 2002 Yvette Cooper commissioned a formal internal review on self-sufficiency; had it really been necessary for the UK to buy (infected) blood products from the US? She was concerned that the advice she has been given by officials, and that given to previous ministers, may not have been right.

In December that year, Peter Burgin emailed his draft report to Charles Lister. Parts of Peter Burgin's original draft would have been uncomfortable reading if anyone had taken the time to read it carefully. He in particular showed that the problems in achieving self-sufficiency were not simply a question of there being too few donations of blood or plasma. Mr Lister envisaged making the report widely available but thought it needed an executive summary, and references to the documents quoted and to back up statements which otherwise would remain unsubstantiated.

However, by June 2003, Mr Lister had not done any significant work on the report. His successor, Richard Gutowski was so busy (see below) that he eventually contracted out further work on the report to a set of consultants.

The Self-Sufficiency Report was not published until February 2006, four years after it had been commissioned and over three years since it had been substantially completed by Mr Burgin.

> In his statement to the Inquiry Mr Burgin said that the published report was "*materially different to my report.*" There had been a change of approach. The document became one intended for publication consistent with, indeed inclined towards, drawing conclusions in support of the line thus far taken, rather than asking any awkward questions about it. A particularly egregious example of this is that the very last words before the conclusions [refer to] an article which says what is effectively the opposite:
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> Ultimately, what started out as a project to inform ministers of materials that were available about self-sufficiency, so that they might consider for themselves whether the current line adopted by the Department of Health was properly justified, became itself a document the effect of which was to justify that line.

Dept of Health Management

Taken at face value, the above narrative suggests poor performance by Messrs Lister and Gutowski. But both were seriously over-worked and poorly supported, especially by their seniors.

> Both Charles Lister, and in turn Richard Gutowski, worked under strong pressures. Having received the draft report on Christmas Eve 2002 Charles Lister had done nothing with it before he departed his post in May 2003. He regrets that he "*simply had not been able to take the drafting forward* [between those dates] … *I can offer no justification for the delay, save that the Inquiry will be well aware … of the massive pressures on my team*."

Charles Lister had eight (!) major responsibilities

> I was Head of Blood Policy from October 1998 to May 2003. This involved a wide range of responsibilities which increased during my time in the role, including:
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> - Development of government policy on the safety and supply of blood and blood products to the NHS.
> - Sponsorship of the National Blood Authority (NBA) including business planning, ensuring Ministerial objectives were met, appointments to the Board, negotiations with the NHS on blood pricing etc.
> - The Better Blood Transfusion initiative.
> - Development of measures to reduce the risk of vCJD and HCV transmission through blood, including funding of measures introduced by the National Blood Service (NBS) and the provision of recombinant clotting factors for people with haemophilia.
> - Ensuring sufficiency of supplies of key blood products for UK patients, including sourcing of blood plasma supply from the US.
> - Negotiating and implementing a new EU Blood Directive on standards and quality of blood.
> - Drafting responses for Ministers on calls for compensation and a public inquiry into the contamination of blood with HCV.
> - Sponsorship of the Alliance House charities (AHOs), including DH funding and appointment of DH sponsored trustees.
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> The pressures on my team were recognised internally and externally. On 4 November 2002, Martin Gorham, the Chief Executive of the National Blood Authority, wrote to Nigel Crisp, Chief Executive of DH, to raise concerns about the impact these were having in delaying work, which the Authority wished to take forward, e.g. on capital projects and issues relating to blood testing. ... He went on say that, "Charles Lister ... has become completely overwhelmed by the amount of business that needs to be conducted.
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> The pressure on Richard Gutowski was just as great. He explained that "*speaking for 'my half' of 2003, this reflected I am afraid, the very great pressures that my team were under*."
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> The personnel in the team did not remain constant throughout my time in the position. DH was being restructured when I arrived and many positions were being cut. Shortly after my arrival, Jill Taylor took voluntary retirement. As part of the restructuring, her position was left vacant. In addition, the Administrative Assistant job was cut. Accordingly, the Team was reduced to [one] Higher Executive Officer, and me as Grade 6.

Comment

The whole saga is a terrible scandal dissected in impressive detail by Sir Brian Langstaff whose own closing comments I repeat below. As a former civil servant, however, I cannot help but be

struck by the similarities between what went wrong here and what appears to have gone wrong in the case of Grenfell Tower and the Post Office.

Part 6 of my report on the Grenfell Inquiry reads as follows:

> The failures were system-wide. "Single Point of Failure" Brian Martin made serious mistakes but he was a relatively junior specialist. He and his boss, Richard Harral, were working under huge pressure, knew that both ministers and senior staff had very little interest in their work, and knew that their fellow officials would oppose any changes to building regulation. And yet:-
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> · The Permanent Secretary and the rest of the Senior Civil Service (SCS) must have been aware, at least in general terms, of the workload and correspondence handling problems revealed by the Inquiry.
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> · The Secretary of State's Principal Private Secretary and the Permanent Secretary must have been aware of the very long paper-handling delays in and around Private Offices and Special Advisers' (Spads) offices. But no official, from the Permanent Secretary down, appears to have told ministers that these delays were unacceptable, nor told ministers that these problems were symptomatic of unacceptable wider problems in the department.
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> · Senior officials' own working practices seem also to have been sub-optimal, to put it mildly.
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> · There was little evidence that the SCS 'walked the corridors' so as to be informed about developing issues.

It looks to me as though much the same can be said of DoH, at least from 2000 onwards. Both Mr Lister and Mr Gutowski were middle-ranking officials (neither was in the Senior Civil Service) and I saw nothing in Sir Brian's report to suggest that their superiors were seriously concerned about their workload or the consequential delays in processing less time critical work such as the Self-Sufficiency Report.

I was also reminded of Gill Kernick's comments when comparing the Post Office and Grenfell Tower scandals:

> Then there was the **dismissal by those in power of other non-expert ways of knowing**. In every major disaster that Gill has studied, somebody has raised a concern. If it had been listened and responded to it could have prevented the disaster. In most of these cases, power and knowledge play a critical role in this silencing of voices. Typically it is those with less power such as front line workers or non-experts' views such as residents or the public that are not heard or taken seriously.

We can now add 'infected blood' to Gill's list. The Department of Health for far too many years persisted in parroting lines to take which had been contradicted by those outside the department, including Judges!

There is an echo, too, of the Post Office Inquiry. Marina Hyde in the Guardian:

> It’s easy, when you hear this level of corporate psychopathy, to think this inquiry was always an inevitability. But it wasn’t. This was a way of operating that Vennells and the organisation she ran got away with for so long because people couldn’t or wouldn’t believe what the victims were saying. You have to keep reminding yourself of this, even when you’re sitting in the middle of it.

Will Anyone Listen to Sir Brian?

If past performance is any guide, probably not. Let's consider the likely response of the civil service, Ministers and Parliament.

I have seen no evidence that the most senior **civil servants** are concerned about what has happened. Austerity and its consequences were ordained by Ministers and that, apparently, was the end of it. Speaking truth to power? Not on this watch.

I am not even sure if there will be a formal response to Sir Brian's report. It would certainly be interesting to see a thoughtful response to Sir Brian's proposals which *Civil Service World* nicely summarised in this way:

> Langstaff's proposals ... call on ministers to consider introducing statutory duties of candour for civil servants and ministers in their day-to-day work that would be in line with legal duties expected in evidence to courts. The move would effectively beef up non-statutory duties in the civil service code.
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> The report says that if ministers decide not to introduce a strengthened duty of candour across the whole civil service, senior civil servants should face new obligations. Langstaff said that in that situation, members of the SCS should be placed under a "statutory duty of accountability" for the "candour and completeness" of advice given to permanent secretaries and ministers, and the candour and completeness of "their response to concerns raised by members of the public and staff".

Future **Ministers** would be well advised to heed the advice of Current Secretary of State Mel Stride talking to Nick Robinson on the Today Programme on 21 May, the day after the report had been published:

> I think you have to test the advice that you receive when you feel that it's appropriate and dig deeper - and sometimes when you do that you discover things which at first blush you had one opinion about. By the time you've gone through that process you might end up with a very different opinion.
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> The only other thing I would add, Nick, of course is that - any Secretary of State - you're often at the top of a very large organisation which might be (as in the case of my department) interfacing with millions - I mean tens of millions - of people almost on a daily basis and you cannot of course be across absolutely everything to the Nth degree. But what you can, as I've described, is really be alert to what people are saying around you, what those outside of your department are saying and not fall into that trap of the kind of ivory tower in which an opinion or a cultural opinion emerges and nobody really challenges it.

Yvette Cooper did this, of course, back in 2002 but then ... nothing.

What about **Parliament**? I fear that David Allen Green was spot on in his recent blog:

> This inquiry is yet another example of an exercise in accountability that should and could have been undertaken by parliament and in real-time. Instead, and long after many of the key events, it has been left to an inquiry to show what happened at the material times - and what went wrong at the material times. As such, this is another example of failure by our parliamentary system to provide proper, real-time scrutiny.

I'll finish with these extracts from Sir Brian's closing comments:

> The best way ... to end this Report [is] as the Inquiry's hearings began – with the voices of people whose lives have been so irreparably and catastrophically damaged:
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> "*one emotion that has been building and growing for over 30 years is that of anger. The rage I feel at being lied to, dismissed and pushed aside, when all we asked for is recognition of our plight and meaningful recompense for the lives we have had so cruelly stolen from us. Instead, we have been treated with disrespect, disdain, and as if we are irrelevant … being multiply infected absolutely prevents a normal life being possible. Sufferers are consigned to the fringes of society, forever fearful of public reaction, without support from life or mortgage insurance and all the usual ways that people can protect themselves and their families from hardship through being unable to work. Desperately sick, exhausted and terrified about the future, this is the result of decisions made by those who were paid to do better. In the comfort of their offices, they pushed paper across desks, set aside the warnings and decided to gamble with people's lives for the goal of saving money. It is hard to avoid the conclusion that we were deemed expendable, collateral damage.*"
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> Those were the words of Richard Warwick, giving evidence to this Inquiry.
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> And finally, Mr AM in his evidence to the Inquiry:
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> "*what happened was the most egregious dereliction of duty by a country to its citizens in modern times. The government made us more vulnerable with deadly infections … the government's response was worse than mere apathy … Day after day, week after week, the Inquiry has heard accounts of people's personal battles with their viruses. In reality, we have been waging a war, not just against our viruses but against government. Government has tried to subdue us. They continue to ignore us and continue to do battle with us. Why? Where is their recognition of our struggle? ... We are tired of meaningless apologies. We are tired of platitudes in relation to this being something that should never have happened. As a community, in future we will judge you by what you do, not by what you say*".

Martin Stanley
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