Public Interest **Lawyers Limited**

Eight Hylton Street
Birmingham
B18 6HN
UK
Tel: 44 (0)121 515 5069
Fax: 44 (0)121 515 5129
Email: info@publicinterest lawyers.co.uk
Web: www.publicinterest lawyers.co.uk

Specialists in public, human rights, international, environmental and planning law

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27 July 2012

Dear Andy,

Advice on Gulf War Syndrome

1. I am writing to follow up my meeting with you in Chester on 27 June 2012. As you know, PIL are presently acting for you on a pro-bono basis. PIL is instructed to advise you as to whether there might now be sufficient prospects of success of a challenge to the MoD about its role in Gulf War Syndrome (GWS) to found a properly made application for a Certificate of Public Funding (CPF), (that is, a Legal Aid certificate).

2. I am providing my advice to you, as agreed, in writing. This is subject to solicitor-client confidentiality: this letter is your property and it is up to you as to whether you wish to share its contents with others including showing a copy of it to other Gulf War Veterans (GWVs) suffering with GWS.

Reading

3. In the preparation of this advice I have read all the materials you have sent me by post or email (including links to relevant documents) and in particular the following:
   i. *Independent public inquiry on Gulf War illnesses – the Lloyd Inquiry*;
   ii. *King's Centre for Military Health Research: a fifteen year report*, King's College London, University of London, September 2010;
   iii. *Gulf War illness and the heath of Gulf War veterans: scientific findings and recommendations – Research Advisory Committee of Gulf War Veterans' Illnesses* (the US Committee report);

iv. *Hospitalisations for unexplained illnesses among US veterans of the Persian Gulf War*, James D Knoke and Gregory C Gray, Emerging Infectious Diseases, Vol 4 no2, April-June 1998;
v. *Antibodies to Squalene in recipients of anthrax vaccine (2001)*, Pamela B Asa, Russell B Wilson and Robert F Garry, Experimental and Molecular Pathology, 73, 19-27 (2002);
vi. *Background to the use of medical counter measures to protect British Forces during the Gulf War (Operation Grandby)*, MoD internal document;
vii. *Implementation of the immunisation programme against biological warfare agents for UK Forces during the Gulf conflict 1990 – 1991*, MoD internal document;
viii. *Operation Grandby: the effect of co-administration of the pertussis vaccine on specific antibody titre development to the anthrax vaccine in man*, MoD report, October 1997; and
ix. MoD minutes of 16.08.90 with attachments (the so called "missing fax" referred to in the Lloyd report)

4. I have also read various newspaper articles and various websites.

5. I have also, as you know, asked for and received a copy of the 110 page opinion of Stephen Irwin QC and Christopher Hough, 26 March 2003. This opinion on behalf of those clients instructed at that time by Hodge Jones & Allen [1] was for the purposes of advising the Legal Services Commission (LSC) whether it was reasonable to continue to fund the GWS multiparty action (MPA) proceeding at that time. I understand that at this point the LSC had spent approximately £4 million of civil legal aid monies on this MPA. I refer to this opinion below as the Hodge Jones & Allen opinion.

Background

6. I am advised that there are approximately 10,000 UK GWS sufferers in receipt of a War Disablement Pension and approximately 1 in 4 GWVs have reported symptoms of GWS and a number have died. I understand that various GWV groups believe that many of those who died did so in circumstances where a relevant factor was that the deceased had GWS. I understand that as the MoD and other relevant authorities have made no attempt to collate information about these deaths, it is entirely guesswork as to how many of these deaths are relevant to the cause of surviving GWVs with GWS. In my view it does no harm to the cause of GWVs with GWS who survive, that an unknown number have died, and it certainly does not assist the MoD at all that this information has not been collated and properly analysed.

7. I proceed on the basis that there can be no sensible debate as to whether GWS is a phenomenon, illness, disease or some other nomenclature that exists and is to be taken seriously. It plainly is. I am fortified in this position by the knowledge that even those

[1] Hodge Jones & Allen are the legal firm based in London who represented the GWVs in the case which failed.

who have worked with the MoD on military issues accept that GWS exists. I also note the huge body of research that proceeds on the basis that GWS exists.

8. I proceed on the basis also on the huge body of work available to the US authorities. I refer in particular to the report of the Research Advisory Committee on Gulf War Veterans' Illnesses. This very impressive report, complete with 1,840 peer-reviewed scientific or medical journal references, makes very clear that the US authorities, dealing with over 100,000 GWVs with GWS, have taken the challenge posed by GWS very seriously indeed.

9. I am acutely aware that a typical GWV with GWS is suffering from a range of illnesses or symptoms, any one of which would be serious on its own. In combination these various illnesses and/or symptoms render many GWVs with GWS with serious medical conditions. Most are, as I understand, completely incapacitated, unable to work and, in very many cases, unable to function properly on a daily basis[2]. These GWVs with GWS do not want sympathy: they want accountability, action on research issues, appropriate treatment, damages and an apology from the MoD.

Potential Causative Factors

10. Those arising from the independent Public Inquiry on Gulf War Illnesses (the Lloyd Inquiry):

    - Vaccines
        - Yellow fever
        - Tetanus
        - Typhoid

[2] I note the US survey, referenced in Vaccination News, on Anthrax Vaccine risks (30.05.2012). Of 265 surveys sent out, 139 were returned and subjects were asked: *"from the time you receive your first Anthrax Vaccine, have you started to experience any of the following symptoms?"*. The numbers following the symptoms are affirmative responses:

- ringing the ears – 12
- significant hearing loss – 3
- skin rashes not near injection site – 17
- itchy skin – 21
- numbness/loss of sensation in body parts – 16
- joint and/or muscle pain including arthritis – 57
- loss of energy/constant tiredness – 41
- recurring headaches – 26
- difficulty sleeping -24
- nausea, loss of appetite or abdominal pain – 9
- severe hair loss – 8
- vertigo – 8
- balance problems/light-headedness – 15
- short-term memory loss – 34
- reduced concentration – 36
- chills and fever immediately following vaccine- 111
- other – 24

I note, of course, the limited number of respondents and that the questions focussed entirely on the Anthrax Vaccination.

- Poliomyelitis
- Cholera
- Hepatitis B
- Meningitis
- Hepatitis A
- Anthrax vaccine, and pertussis (used as an adjuvant to anthrax)

- Pesticides
  - Special concern to those containing organophosphates
  - Fenitrothion
- NAPS tablets
  - Pyridostigmine bromide
- Exposure to chemical weapons,
  - Sarin
  - Cyclosarin
- Depleted uranium
  - Depleted uranium aerosols
  - Retained depleted uranium shrapnel
- Exposure to fumes from burning oil wells
- Infections
  - Leishmaniasis
  - Mycoplasma
- Stress and psychological factors
  - Communality of post-war "syndromes"
  - Anxiety
  - Stress
  - Depression
  - Other psychiatric problems
- Media and social pressures

11. Those arising from the US Committee Report:

- Psychological stress
- Kuwaiti oil well fires
- Depleted uranium
- Vaccines
  - General
    - Adenovirus
    - Influenza
    - Measles
    - Menigococcal
    - Plague
    - Polio
    - Rabies

        - Rubella
        - Smallpox
        - Tetanus-diphtheria
        - Typhoid
        - Yellow fever
    - Specific to Gulf War deployment
        - Anthrax
        - Botulinum toxoid
        - Immune globulin
        - Meninococcal
        - Typhoid
        - Yellow fever
- Cholinergic and related neurotoxicants
    - Pyridostigmine bromide
    - Pesticides
        - Organophosphate pesticides
        - Carbamate pesticides
        - DEET insect repellent
        - Pyrethroid insecticides
        - Organochhlorine insecticide
    - Nerve agents
- Infectious diseases
    - Gastrointestinal infections in theatre
        - E. Coli
        - Shigella
    - Respiratory infections
        - Pneumonitis
            - Fine sand
            - Infectious agents
            - Pigeon droppings
    - Sandfly fever
    - Leishmaniasis
    - Diarrheal diseases
- Mycoplasma infection
    - Mycoplasma fermentanx (incognitus)
- Herpes virus
- Antibiotic treatment
    - Doxycycline
- Biological warfare
    - Iraqi biological weapons
        - Bacterial
        - Viral
        - Fungal
        - Toxins

        - Anthrax
        - Botulinum
        - Aflatoxin
        - Mustard gas
        - Trichothecene mycotoxin
        - Brucella abortus
    - Sand
    - Tent heaters
        - Jet fuel
        - Diesel fuel
        - Kerosene
    - Solvents
        - IOM panel have generated a list of 53 individual solvents
    - Jet fuel
    - Chemical Agent Resistant Coating (CARC)
        - Toluene
        - Benzene,
        - Crystalline silica
        - Ketones
        - Hexamethylene diisocyanate
    - Contaminated food and water
    - Sources of electromagnetic radiation
        - Radiowaves
        - Microwaves
        - Other
    - Industrial pollution
    - Chemical decontaminating agent
        - Contained ethylene glycolmonomethyl ether
    - Airplane hydraulic fluid

Causation

12. I will return to the Hodge Jones & Allen opinion below. However, at this stage it is helpful to repeat what is in my view a helpful exposition of the relative causative test which I get from the Hodge Jones & Allen opinion:

"Causation

3.10 The next legal principle which require to be clearly stated is that of causation. This principle applies to all cases of this kind. The first and simpler formulation of the law of causation is as follows: but for the breach of duty, would the damage probably have occurred? It may be helpful to give an illustration drawn from the facts of this case. Let us suppose, hypothetically, that a judge were to find it was

a breach of duty to give pertussis vaccine as adjuvant therapy to the anthrax vaccine and that the anthrax vaccine should have been given on its own. In those circumstances the Claimant would not automatically succeed in a negligence case, even though fault had been proved. The Claimant will have to go on to prove that the fault had caused some recognisable damage, in this case to the health of service personnel. The Claimant would have to prove that it was probable that some identifiable injury had been caused by the pertussis vaccine opposed to the administration of anthrax vaccine without pertussis vaccine". (My emphasis).

13. In the light of the above it seems to me that the MoD deliberately set out from the beginning to throw as many facts as is possible into the causation pot. Some of these are plainly not to be considered to be possibly relevant to any act or omission on their part: for example, the decision of the Iraqis to set fire to Kuwaiti oil wells or the decision of the US to destroy by explosion the chemical stockpiles at Khamisiyah. Others would never lead to any finding by a judge against the MoD: for example, the suggestion that GWVs with GWS may have suffered stress because of their rightful concerns that Iraq might use chemical or biological weapons (CBW) in the conflict, or the extra stress GWVs with GWS suffered in the UK because of the media attention on GWS. I also put in this category the ill-conceived argument that a relevant fact might be the sense of anger and outrage GWVs with GWS had with the MoD and its perceived failure to take seriously GWS and to provide appropriate support (financial and otherwise), medical research and thus medical treatment. In my view it is a hopeless argument (that a Judge would never accept) that the MoD should now pay massive damages to the whole cohort of GWVs with GWS because of the MoD's apparent failings on medical treatment. I make clear, of course, that I do not accept that the MoD's approach to appropriate medical treatment for GWVs with GWS has been anything other than woeful (and may be the subject of a judicial review in due course). It is that I do not believe that a judge would find the MoD had to pay damages on that basis.

Pre-deployment Causation Issues

14. We have discussed together the fact that there are some GWVs with GWS who were given vaccines and/or NAPS tablets and subsequently (and presumably fairly quickly) fell sick and accordingly were either: 1) never deployed to Kuwait or Iraq; or 2) were deployed to, say, Germany or even the Middle East region but had to be returned home before hostilities commenced or in other circumstances relevant to this matter I now discuss (I call these below categories 1 and 2). The $64,000 question raised by these GWVs with GWS focuses on the fact that as a matter of evidence all factors can be excluded except a) multiple vaccines, b) anthrax plus the pertussis adjuvant[3], c) NAPS, d) the so-called stress factor of being exposed potentially to CBW.

[3] I am proceeding on the basis that the documents I discuss below suggest it is pertussis not squalene that is the relevant adjuvant in the UK context.

15. I wish to exclude d) immediately. This is for three main reasons. First, arguably, it does not arise for the personnel too sick to be deployed at all; second, I do not consider it to be a tenable argument at all, as it is one conceived by academics with an MoD axe to grind and thus anxious to muddy the waters with as many factors as possible. This would ensure that they cannot lead to findings of MoD negligence; third, because if it has legs (which I doubt) it is one to be advanced by the MoD in a subsequent MPA which would follow a successful application for disclosure (I make clear that the point of this advice is to focus on disclosure rather than the subsequent MPA that would follow if that disclosure application was successful).

16. Thus, if there were GWVs with GWS who were in categories 1 or 2 above, I suggest a strategy focused on obtaining from the MoD all relevant disclosure as to vaccines, NAPS and in particular the use of the pertussis adjuvant. I wish to set out what I understand is a summary of the position on the pertussis adjuvant issue.

The Pertussis Adjuvant

17. It is a matter of record that in the run up to the first GW the international community were fully aware that Iraq had a CBW capacity, including weaponised Anthrax. The UN Security Council passed Resolution 678 on 29 November 1990. This was a resolution passed under Chapter VII UN Charter, authorising force to, in effect, remove Iraq from the territory of Kuwait, and to restore peace and stability in the region. It might be argued that those members of the international community taking up this authorisation to join the coalition as Troop Contributing Nations (TCNs) should have acted sooner to protect effectively their troops from Iraq's CBW capacity. I think it highly unlikely that a judge would entertain venturing into matters of such evident high foreign policy involving intelligence gathering over twenty years ago, and involving now judgments as to what politicians and others should, or should not, have done over twenty years ago. Thus, the facts are that the UK decided to join the coalition in circumstances where there was not time for the anthrax vaccine alone to be effective. The annex to the MoD minutes of 16 August 1990 notes that the current vaccine available to the MoD "*does not offer full protection against all the strains of anthrax*" and "*the protection that is given does not reach its peak until after the fourth dose at thirty two weeks*". Far less time was available. I leave to one side as irrelevant to my argument below on disclosure that the MoD should have acted sooner. The same document discusses the fact that "*the efficacy of the vaccine can be enhanced by the simultaneous administration of a licensed Whooping Cough Vaccine or an unlicensed adjuvant subject to availability of these items*". It is clear that a decision was taken to speed up the take up of the anthrax vaccine by the use of the Pertussis vaccine. However, it is equally clear that as time was of the essence there was no time to test effectively whether the anthrax and pertussis adjuvant together posed a risk to human health and, if so, on what basis. There is no question that the MoD were aware of the obvious risk as is made evident

from an attachment to the MoD 16 August 1990 minute which is a declassified document dated 8 February 1991 from which I quote:

> *"b. Operational Effectiveness in Vaccines*
> *There are worries that the third anthrax/pertussis together with the second plague vaccination will have a more severe pattern of side effects together with a larger number of side effects"* (there then follows a redacted sentence).

18. The same document discusses that *"the risk of vaccination side-effects must be balanced against the known threat from BW"*. A further document declassified from Porton Down of 3 January 1991 makes clear that in the context of the vaccination against plague as there was no time available, any work to establish the efficacy of the vaccine and its safety would not be undertaken. It is absolutely clear that given the huge relevance to causation of the documents I am referring to above, (a single document and its attachments which have come into the public domain), it is strongly arguable that there must be many such MoD documents which would shed useful light on what the MoD knew or did not know about the risks of these vaccines and their adjuvants and other highly relevant factors in the present context of establishing liability for the use of these vaccines. It is this type of document which is the focus of the legal action focusing on disclosure I believe should now be commenced in the High Court. In the context of a GWV with GWS in categories 1 or 2 above, the argument is that, having excluded all of the other factors as we may, and focusing on vaccines and the NAPS tablet, the obvious risk to personnel of using untried vaccines and adjuvants has an obvious resonance in legal causative terms.

The Hodge Jones & Allen Opinion

19. I turn now to discuss the Hodge Jones & Allen opinion. There are nine chapters to it as follows:

20. There is also a large document as Annex 1, Best Case Review.

21. As we discussed when we met, the most important chapters by far are chapters 3 – 5. I will briefly explain why. Before focusing on Chapters 3-5 I will clear out of the way the other chapters.

Chapter 1

22. As the title suggests, this does no more than introduce the opinion and at para 1.3. concludes:

> *"The underlying advice we give is that broadly based all generic legal action in respect of Gulf War Illness has no reasonable prospects of success, and that we cannot support further public funds being devoted to legal action at the present time".*

Chapter 2

23. As the title suggests, this gives the background to the decision that reacts to the invasion of Kuwait by Iraq by the deployment of coalition forces in 1990. It is helpful in drawing together some of potential causative factors of GWS as follows:
    - nerve agents (2.18 – 2.23)
    - pesticides (2.24 – 2.27)
    - combinations of therapies and prophylactic measures (2.28)
    - the extent of exposures (2.29 – 2.33)
    - the Khamisiyah incident (2.34 – 2.35)
    - oil-well fires (2.36 – 2.38)
    - depleted uranium (2.38 – 2.45)
    - overview of actual and potential exposures (2.46 – 2.47)

24. I have very few comments on this chapter and those I have include:

    - noting that "*the most controversy about the vaccine programme concerns the use of the anthrax vaccine over an accelerated timescale with the adjuvant pertussis [whooping cough] vaccine*" (2.11). This paragraph goes on to explain why it is that the anthrax vaccine takes a significant time to elicit a protective response

and accordingly why the adjuvant was used in an attempt to make the body's immune system react more strongly and more swiftly to the anthrax vaccine.

- it is recorded at para 2.14 that "*there is no evidence to suggest that [the warning in the MoD fax of 21 December 1990] was ever attended to*". I would put it differently. In the absence of proper disclosure, which I do not think there has ever been, we have no idea as to what steps were taken, if any, in the light of the warning as to the risks of the use of the adjuvant. I find it highly significant that this paragraph concludes as follows:

  > "*Without access to all the relevant information, it is not possible to reach a final outcome of the conclusion of such a proper decision making process*".

25. The process counsel were considering is whether the MoD properly balanced the risk that humans would react badly to the combined vaccine as against the risk that without the use of the adjuvant the programme of immunisation against anthrax would be likely to be ineffective. One could also add that there should have been a full and proper consideration as to whether the pertussis adjuvant was necessary at all bearing in mind that other members of the coalition, for example the French, did not consider that the intelligence on Iraq's possession of CBW justified the risk to French personnel of such therapy.

    Para 2.15 again records that in respect of the Department of Health (DoH) warning the opinion has to proceed on the basis that there was a failure but "*that we are unable to show without full disclosure what the eventual decision would have been if the warning had been followed up. Our suspicion is that the decision would have been as it was*". With the greatest of respect to the authors of this opinion, I do not consider that position was correctly held. I have no idea why Hodge Jones & Allen and counsel did not push for full disclosure from the MoD which would have, presumably, shed full light on what might have been highly embarrassing, that is, that the DoH warning was ignored; or worse that it was not ignored and that when it was followed up it appeared that the warning was fully justified but nevertheless the MoD still ignored the evidence that emerged in following up the DoH warning. Either way we are simply in the dark and, as I say, full disclosure seems to me to have been an absolute minimum requirement before there could have been a conclusive opinion to the LSC at all in these circumstances. I return to disclosure below.

- In para 2.16 the authors return to whether or not there might have been a different outcome if there had been proper attendance to the DoH warning. They conclude on the material they had that they presume that the failure to attend to the DoH warning was a clear failure but conclude "*we do not on balance believe the Claimants could prove that it would have altered the outcome*". Again, I find

that to be a surprising conclusion against the Claimants and repeat what I say above regarding looking very carefully at whether the Pertussis adjuvant was needed at all in the light of what other coalition forces were intending to do. One of the areas that I think we would need careful consideration of in due course, if we got full disclosure, is exactly what the MoD knew, or ought to have known, of the approaches to be taken to anthrax by the other TCNs within the coalition. We would also need to look very carefully at the incidence of GWS within veterans from other TCNs. I note in particular the compelling evidence from France which suggests that there are no French sufferers of GWS at all[4]. I find that to be very striking in these circumstances. I explain why below.

- In para 2.28 there is consideration of the combinations of therapies and prophylactic measures. The MoD were asserting that the advice they were receiving was that no significant adverse reactions should be expected and that in the context of NAPS and the conditions in the Middle East, the advice the MoD received was "*that no significant different effects should be expected because of the weather conditions unless the soldier had "severe dehydration (and heat stress)….."*". The opinion then goes on to say as follows:

> "*Without full disclosure it is not possible to test the veracity of these assertions against the underlying documentation. It is worth pointing out that it would be in the highest degree unlikely that the MoD would make such public assertions unless they were able to back them up with primary documentation. This does not mean that we "trust" the MoD but rather is a judgment as to how extremely foolish it would be for them to make these claims were they not capable of at least ostensible support form documentation".* (my emphasis)

26. Again, I do not think it reflects well on me to be appearing now, with the benefit of hindsight, to be having a go at other lawyers. However, I can say that I would never have given the MoD the benefit of the doubt in the manner that counsel are doing here. I think, from my own work, that the MoD are more than capable of making this type of assertion without having any evidence to back those assertions up hoping and keeping their fingers crossed that they will get away with it. Sadly, on this occasion, because the legal team did not push for full disclosure, they did get away with it. Whether they continue to get away with it depends on the reaction to this letter. However, again I have to say, I find it extremely odd that the team did not push for full disclosure before a conclusive advice was given to the LSC in these circumstances.

- Para 2.29 refers to "*the absence of preservation of individual records by the soldier or airman concerned to know whether individuals received all of the*

[4] *Health consequences of the first Persian Gulf War on French troops*, Salamon, R.et al [2006] International Journal of Epidemiology, Vol.35, no.2 479-487

injectates or some of them". Again, I find this odd. I am aware that there is a huge controversy which suggests that critically important forms such as F/Med/5S were lost and you have briefed me on the very suspicious circumstances in which critically important medical records were somehow burnt and lost. I think that the emphasis should have been on obtaining all existing medical records from the MoD together with a full explanation as to where the others were rather than an assumption that it was for individual personnel to keep their individual medical records. I think that was the wrong approach and again points to the need to push extremely hard on disclosure.

27. I return to chapters 3-5 below.

Chapter 6

28. Chapter 6 deals with product liability and I think it can be quickly disposed of. It concerns a potential approach to liability against the MoD for its negligent breach of duty by relying upon the provisions of the Consumer Protection Act 1987. It also considers the interface with Employers' Liability under the Employers' Liability (Defective Equipment) Act 1969 (ELDA). The conclusion to this chapter is worth setting out as follows:

> *"6.43 In conclusion, neither of these Acts advance the veterans' claims, nor can they deal with the essential evidential problems which arise when the case is considered in the more obvious and conventional legal context of breach of duty".*

29. I completely agree with these conclusions and, from my understanding of the law, we can put to one side product liability and the issue of Employers' Liability under the ELDA.

Chapter 7

30. Chapter 7 deals with the Pilot Study and expert opinion received. As you may or may not be aware, there was in the first instance opinions of Augustus Ullstein QC on 4 October 1995 and 15 May 1997. Following those opinions and the consultation that went with them, the legal team at the time designed what came to be called "the Pilot Study". As the opinion notes, the Pilot Study "*arose from the thinking of lawyers rather than scientists".* Unfortunately, once the Pilot Study findings had been reviewed by Professor O.F.W.James, Head of the School of Clinical Medical Sciences at the University of Newcastle, it became clear that the Pilot Study was fundamentally flawed and could not be relied upon in any useful way. Professor James concluded, for instance, that:

- *"There are many potential confounding factors weakening possible associations in the Pilot Study"*
- *"There appeared to be no obvious overall correlation between symptoms and reported severity of exposures or pattern of exposures in individuals"*
- *"There were very limited correlations between the reported neuro-psychological investigations and any other investigations within the Pilot Study"*
- *"The neurological investigations in relation to the autonomic nerve system are not conventional and are difficult to interpret"*
- *"There was a complete lack of evidence for persisting inflammatory, immune or auto-immune disorders in the Pilot Study group."*
- *".....with the wisdom of hindsight, my conclusion is that this Pilot Study fell at the first fence – in other words no convincing connection between groups of symptoms and unequivocally and understandably abnormal investigations could be made" (para 4.2.3)*
- *"I do not think the investigations of the central nervous system carried out in the Pilot Study could provide nearly enough evidence that "on the balance of probability" central nervous system damage was caused by any particular agent or exposure during the Gulf War, still less that this was due to negligence on the part of the Ministry of Defence" (para 4.2.2)*

31. Thus, counsel had to record that *"we have found it difficult to place any reliance on the Pilot Study results"* (para 7.10) and *"it has always seemed to us inherently unlikely that the Pilot Study would alter the overall pattern of conclusions to be drawn from that great research endeavour"* (para 7.11).

32. It seems to me highly unfortunate, without making any criticism of those involved in the design of the Pilot Study, that it was carried out at all. It must have cost a great deal of money and must have added to the great pressure upon the LSC given that it had spent something in the region of £4 million on this litigation. Again, I bear in mind that it is relatively easy sometimes to say things with the benefit of hindsight. However, it is striking that once Stephen Irwin QC and Christopher Hough were instructed, they were obviously extremely sceptical about the use of public funds involved in the Pilot Study and wanted it to be brought to a conclusion. They make that clear by the following:

> *"It is for that reason that, from the moment we were instructed and got to grips with this case, we reviewed the methodology of the Pilot Study and suggested that there should be no prolongation or extension of the Pilot Study unless and until we were told that it promised the prospects of real assistance to the case and was therefore justifiable in terms of cost and further demand upon the veteran Pilot Study subjects".* (para 7.11)

Chapter 8

33. This deals with the Gulf Veterans Medical Assessment Programme (GVMAP) and the so called Treatment Case, that is, whether or not a cause of action arose in respect of the MoD's breach of the duty of care it owed to veterans in respect of medical treatment. I deal below with a separate suggestion made by Hodge Jones & Allen which was that *"the MoD have, through a lack of care, fostered a sense of grievance amongst the veterans which form part of the cause of their problems"* (para 8.2). As is known the GVMAP, which was set up in 1993, was established as a clinical programme to assess individual veterans and, if necessary, to refer them on for specialist help. As the opinion records *"later, it was realised that a more systematic research programme was needed"* (para 8.5). The opinion makes clear that they have not engaged in an exhaustive examination of the history of GVMAP because they did not consider it was necessary or appropriate to do so. On this aspect of a potential case against the MoD, that is considering legal actions for damages for failure to treat, the opinion records

> *"8.18 The veterans would face an accumulation of problems":*
>
> *[1] The focus on CFS/Fibromyalgia as an analogy for GWS is uncertain and quite new.*
>
> *[2] The regimes of treatments for these conditions are also relatively new.*
>
> *[3] Any campaign for such treatment might have problems of acceptance which would produce a breach problem and a causation problem in any litigation.*
>
> *[4] The developing knowledge in this area has arisen long after the war and long after the discharge of a great number of the relevant veterans.*
>
> *[5] Particularly in the light of [1] – [4] above, a legal duty of care on the part of the MoD which extended far enough so as to give rise to an obligation to organise, stimulate or provide treatment is legally problematic. We think in the end we would be likely to lose such an argument.*
>
> *[6] The prospects for success from such treatment are limited, which would introduce a very significant causation problem".*
>
> *8.19 Taking all these matters together, we cannot say that legal action on this basis has any reasonable prospect of success".*

34. It goes without saying from the overall thrust and content of this advice that I have not considered that these conclusions can be challenged. As my focus is on disclosure to feed a potential MPA that would follow that disclosure application, for my part I would like to put this question of the GVMAP and treatment case to one side. I am content to leave those conclusions as they stand.

Chapter 9

35. The conclusions chapter is helpful in outlining the essential points arising from the opinion. These are as follows:

> *"the essential ingredients of any case like this are that the Claimants must prove [1] the Defendants owe them a duty of care, not just morally but legally, in respect of the matters which led to injury [2] there was a failure of care and [3] that it was the failure of care which led to their injury"* (para 9.2). (I do not think any lawyer in this field would disagree with this assessment of the essential ingredients).

36. An essential conclusion on part 3 of these essential ingredients is to be found at para 9.5 as follows:

> *"even if and when a judge found there was an actionable breach of duty, say hypothetically in respect of the cocktail of vaccines – and we stress this is hypothetical: the judge would be quite likely not to do so when looking at the perceived risks of vaccinating against the perceived risks of not vaccinating – then the Claimants would still have to prove it was the vaccines which made the difference between illness and not illness..." (para 9.5)*

37. Thus we return again to the huge unanswered question in the absence of disclosure as to whether there was another course of action that might reasonably have been taken by the MoD dealing with the threat of anthrax, that is, for example to go down the French route of not using the adjuvant at all.

38. Finally, para 9.9 is worth setting out in full:

> *"We would have wished to pursue a case for the veterans if we could justifiably have done so. However, the evidence is against the case. Such a case costs many millions of money, whether public or private, and we cannot advise that it is begun without a firm basis....."*

39. Thus it is in the light of those findings in the conclusions chapter that I can now turn to consider the main chapters, that is, chapters 3-5.

Chapter 3

40. Chapter 3 is a very interesting and helpful review of the law. Counsel advise that they are looking at the system of decision making which was maintained by the Crown (para 3.4) and pose the question *"Did the Ministry of Defence fail in its duty to service personnel by taking less than reasonable care in those circumstances?"* (para 3.7).

41. At para 3.9 counsel pose the question: *"Was it reasonable to take the risk of giving the pertussis vaccine as an attempt to avoid the risk that soldiers would be effected by anthrax, given that biological attack might well take place before the normal timescale in*

which anthrax vaccine administered alone would induce effective protection?". As I have made clear above I do not think this is the question. I believe that the question to be answered is: "was it reasonable, faced with the knowledge there was a risk, to take the pertussis adjuvant (or at least that the question of real risk had not been explored and answered in the negative) in circumstances where the MoD appears to have made no attempt to minimise it or to take another approach as other members of the coalition did faced with the same anthrax threat?"

42. On the question of causation, counsel note that the application of that principle can be difficult *"particularly where many factors have come into play"* (para 3.10). I agree with that advice insofar as the focus of my approach in this letter is to eliminate those other factors by concentrating on those who received the vaccine and the adjuvant but were not actually deployed to the Middle East Region.

43. At para 3.11 – 3.16, counsel discuss what I believe to be a very important line of authority on the question of causation in circumstances where it is not entirely clear which particular employer is responsible for a precise amount of damage to an injured person. Counsel note that in some cases of industrial disease the courts have been willing to be more relaxed as to the rules of proving causation. They note:

> *"within this category of case, where an injury has more than one concurrent or consecutive cause, which combined to produce the injury, and scientific knowledge does not permit a finding whether the injury would have been avoided but for the breach of duty, the Claimant can succeed in proving causation provided the breach of duty led to some "material contribution" to the damage. On this line of authority, that is so even though the effects of that "material contribution" are not identifiable or divisible. See* McGhee v National Coal Board *[1973] 1 WLR 1. We should be careful to emphasise that this line of authority (1) requires there to be proof of some material contribution to the injury derived from the fault, (2) has been applied very sparingly indeed historically, and only to industrial disease cases where there was a continuous exposure to a substance or agent causing the disease and where is was not possible to identify the point when the agent caused disease, and (3) the principle has recently been significantly confined or limited by the House of Lords in* Fairchild v Glenhaven Funeral Services Limited and others *[2002] UKHL 22".* (para3.13)

44. Counsel go on to note the six conditions set out in *Fairchild* by Lord Bingham, and without going into those conditions in detail here, I have considered them and consider that all six conditions are satisfied. Thus, the law as I understand it assists us if we are able to exclude all factors other than the vaccines and the NAPs by concentrating our focus on disclosure on behalf of non-deployed GWVs with GWS. My conclusion on this is very much fortified by counsel's advice on the point where they note:

"if hypothetically the court were to find the Defendants in breach of their duty concerning two or more of the risks of exposures with which the case is concerned – let us say (1) both the use of PB and the use of adjuvant pertussis vaccine; and (2) the evidence showed as a matter of probability that it was one or other of those two exposures which caused the injury, but (3) scientific knowledge had not developed so as to show which of them was the cause: then we believe the court would be likely to apply an analogy to the Fairchild *principles" (para 3.15)*

45. Thus, in my view, if following a successful disclosure application potential Claimants suffering with GWS were able to show as a matter of probability that their illness derived from failures on the part of the Defendant, they would succeed, notwithstanding that they may be unable to show precisely which failure was to blame. Thus, for example, if the Claimants were able to show on the balance of probabilities that the combination of, say, the pertussis adjuvant and NAPs had led to GWS they would succeed. I note in passing that there appears to have been no focus at all by the Hodge Jones & Allen legal team to eliminating virtually all of the other factors in the way I now suggest so that the *Fairchild* principles might have applied in this earlier litigation.

46. Paras 3.20 – 3.42 discuss *"battle immunity"* and the Limitation of the Duty of Care. There is no need for me to comment on this section because it is of historical interest only. As I discussed with you, the Court of Appeal have recently heard a case arising from the invasion and subsequent occupation of Iraq in the period 2003 – 2008 that will deal with combat immunity. In this case (*Smith & Others v Ministry of Defence*) judgment is due shortly.

Chapter 4

47. Chapter 4 deals with Hodge Jones & Allen's strategy report. Counsel make clear at the outset that some of the points that the strategy report raises to be dealt with are answered in other sections of their advice. They then go on to deal with the main points in one place since, as they say, *"this gives focus to some of the most important facets of the case".*

48. At paras. 4.2-4.7 counsel deal with the strategy report's suggestion that it might be an actionable breach of duty if, and insofar as, the British Military failed to anticipate chemical and/or biological conflict and to prepare for it, particularly in relation to Iraq. After concluding that the UK could not possibly have anticipated coming into conflict with Iraq at the end of the Cold War (this is not important but seems to me to be idle speculation) the opinion asserts that *"a court would not investigate diplomatic decisions and actions taken in response to this timetable"* (i.e. that imposed by Iraq once it had begun to threaten Kuwait). In essence counsel advise that it is *"quite inconceivable the courts would entertain an action based in that way not least because no fair judgment could be made concerning these questions without the disclosure of an enormous quantity of highly secret intelligence product"* (para 4.7). Whilst I note below the various

failings on disclosure (and it is no answer that disclosure involves secretive material) I would not argue anyway with this conclusion.

49. At paras 4.8-4.11 counsel deal with the strategy of report's suggestion that there should have been a routine policy of inoculating or vaccinating all UK military personnel or a very significant proportion of them against anthrax and/or the other known biological agents. If there had been such a programme then there might have been a prospect *"that a sufficient number of soldiers, sailors and airmen would have been protected against such an attack already without resort to a specific accelerated vaccination programme. This might also have allowed the MoD to dispense with the adjuvant pertussis therapy".* (para 4.8). The simple answer to this aspect is that counsel advise that such questions of policy are simply not justiciable. I would agree.

50. At paras. 4.12 -4.14 counsel deal with the use of unlicensed vaccines which they have dealt with earlier in the opinion. The suggestion made is that it was wrong to resort to unlicensed vaccines to make up the gap between the licensed stocks available and what was deemed necessary. Counsel conclude that this question of judgment probably is justiciable and say as follows:

> *"Thus we do think that the decision to provide unlicensed vaccines – or to use the adjuvant pertussis vaccine – could be examined by the Courts. If there* ***was*** *a breach of the legal duty of care because the decision was not a reasonable decision, then that could found the basis for action".* (para 4.12)

51. At para 4.13 they note *"we find it impossible to think the Court would make that finding".*

> *"4.14 We are aware that the French forces took a different judgment on this front, deciding not to vaccinate their personnel against anthrax but to rely on environmental protection alone. This is an example where, in our view, there may be more than one reasonable answer to a difficult question. We believe that it is certain, if we attempted to mount such an argument in Court, we would lose it. Apart from other considerations, we believe the Court would raise the hypothetical question which arises in our own minds: what if the war had gone differently? What if there had been significant biological attack using anthrax? The likelihood must then have been that far more French forces personnel would have been infected with this deadly disease than UK forces personnel. Would one anticipate that even the fullest investigation following disclosure of this question would be likely to bring home a case on behalf of the servicemen of breach of duty? We make it clear that, if there* ***were*** *clear evidence that the combination of anthrax vaccines delivered as they were and pertussis vaccine delivered as an adjuvant had caused identifiable injury to significant numbers of forces personnel, then we would wish to investigate the case on breach more thoroughly.* ***In those circumstances, we would be advising seeking detailed disclosure of such documents as we could***

obtain in the proceedings. *Even in those circumstances, we would be surprised to be able to bring home a case on breach, and we reasonably anticipate a very significant litigation risk were such an attempt to be made".* (para4.14)

52. I find the section I have emphasised above to be extraordinary. I fail to understand how in these precise circumstances counsel were not advising Hodge Jones & Allen to seek detailed disclosure of the documents. I also fail to understand why, in the light of that failure to seek disclosure counsel were anticipating *"a very significant litigation risk"* in these circumstances. I find myself quite literally scratching my head on disclosure and wondering why it was that disclosure was not pursued in the most rigorous manner possible. I return to disclosure below.

53. At paras 4.15 – 4.21 counsel advise on informed consent, that is, the question as to whether or not individual armed forces personnel knew exactly what they were letting themselves in for in the various vaccinations and as counsel put it: *"in the context of the Gulf War, this means that the individual soldier, sailor or airman would have to satisfy the Court that he or she would have refused the anthrax vaccination and/or the pertussis vaccination"* (para 4.18). Counsel conclude that this argument is *"very highly problematic"* (para 4.21) but for the reasons which should be clear I do not consider that this question of informed consent takes us further. Either we get disclosure in the manner that I suggest in this letter and that gives us the basis of a successful MPA or we do not. I do not think a question of informed consent adds a great deal if anything. I would note, in passing of course, that if a soldier sailor or airman had known that the pertussis adjuvant was entirely untested then perhaps they would have been less likely to have given their consent. As I say, at this stage the question in my view in entirely academic.

54. At paras. 4.22 – 4.24 counsel discuss the issue of medical notes. They note *"there was then a secondary failure to produce a consistent or sensible system for transferring what medical records had been created in the field to the long-term personal medical file, the F/Med/4"* (para 4.22). At para 4.23 they conclude that they would be *"optimistic about proving a breach of the duty of care to forces personnel in this regard"* (that is the failure to transfer field records). Then they advise as follows:

> *"4.24 The problem of running a case based on such breaches of record making and keeping, is the problem of causation. The failure of record keeping even if rectified would not have altered at all the exposure of forces personnel to the various agents which they believe may have affected their health. The failure of record keeping and record preservation has no doubt hampered research. If it could be demonstrated for any individual or any group of individuals that they failed to have subsequent treatment, which meant they were not successfully treated, then such a case might well lie. While we can see that there may be a number of such individuals, the point cannot be a general one*

in the context of this case. The point is also rather theoretical. Given that the records were not created in the first place, or were destroyed and thus not transferred to the long-term medical records of the individual, there is a very severe problem of proof as to what information has been lost and therefore as to its significance. We therefore are very pessimistic about the prospects of demonstrating a good causative case in relation to these failures".

55. Again, I find myself failing to understand the approach of counsel to this important issue. As I understand the position there is a significant question mark over whether the MoD are to be believed that vital medical records were simply destroyed in the field by fire or whatever other "accident" came to pass. Even if records were destroyed I would want to see on disclosure a clear believable record as to why it came about that these records were destroyed. I would also want to know that there were available to GWVs with GWS each and every relevant medical record. For my part it is obvious that medical records would be an important part of disclosure. It is equally obvious that many veterans with GWS must have had their treatment hampered simply because those now dealing with their long-term health needs cannot be sure which vaccines and other agents that may have interfered with the body's immune or auto-immune system have been taken by any particular GWVs with GWS.

56. At paras 4.25 – 4.32 there is a section entitled "The Comparison of French Forces Personnel, their Illness and Epidemiology with those of the US and the UK". For reasons that will be obvious to you and from what I have said above, I consider the question of the incidence of GWS within the personnel of other TCNs in the first Gulf War to be of critical importance. As is obvious it really cries out for an explanation if, say, the French have no known cases of GWS but the US and UK have over 100,000 of such cases notwithstanding that the UK used the pertussis vaccine as an adjuvant and it appears that the US used squalene as an adjuvant. Nevertheless, there is a serious question to be answered. Therefore, this section is of great importance.

57. Counsel note: *"from the figures set out in the strategy report (the* Hodge Jones & Allen *report) that of approximately 25,000 French military who served in the Gulf, it appears that by the year 2000 only some 300 people had requested a war pension, related to this service. About 120 or so of those requests had been accepted and only a fraction were related to illness rather than injury"* (para 4.26). I have already noted above the journal article by Salamon and others on the health consequences of the first Persian Gulf War on French Troops. Para 4.27 notes that the US, UK and France had differed in their assessments of the type of weapons of mass destruction that Iraq might deploy and notes: *"France did not identify an imminent biological warfare threat. All three countries agreed that the Iraqis might use some form of chemical warfare, but they drew different conclusions about the agents that Iraq might employ"* (para 4.27). Para 4.28 notes that France relied less on vaccines as a protection against CBW and more on protective equipment than either of the other major powers. They also note that: *"it appears that the French military did not take regular doses of PB. The French only took the drug for*

short periods during specific alerts" (para 4.28). Then counsel note the following: *"it certainly is curious that French veterans have had a markedly lower level of reported illness that those of other countries. Instructing solicitors will be aware that there have been significant levels of reported illness from more minor countries involved in the campaign, such as Denmark. Why should such a differential pattern be observed?"* (para 4.29). Pausing there, it seems to me essential that at some point we are able to point to a definitive study of the incidence of GWS within all the TCNs in the first Gulf War. Whether or not such a study exists I do not know but it is certainly an issue that I would like, in due course, to consider with great care. I also need to know whether or not there is any later research into the French position other than what I have noted from Salamon et al.

58. Para 4.30 notes that a number of reasonable explanations might be put forward and *"it might be that the difference is the absence of anthrax vaccine. It would seem unlikely that the difference can be explained by any differential exposure to oil well smoke, undetected chemical or biological attack, the effects of the Khamasiyah plume, the effect of heat, or stress, or the combination of those factors. All of those exposures would seem to be common to the French personnel as much as to the personnel of other countries"* (para 4.30). I find the following paragraph to be of serious importance and I quote from it in full:

> *4.31 If the pattern of illness or malaise* found *amongst British and American troops, but not amongst French troops, were clearly established – something in respect of which we are not aware of any thorough peer-reviewed research – and if there were a clear scientific explanation to show that the agents used by the British and Americans but not by the French were the cause of such long-term illness or* malaise, *we would regard this as a strong piece of evidence as to what caused the difficulty. However, even then, we would not regard the distinction as conclusive. As things are, we are far from that position."*

59. This paragraph is of great interest. First, before the qualification at the end of the paragraph, counsel regard the French position as *"a strong piece of evidence"*. As I say, I am not clear at this stage as to how, if at all, the French position has been made clearer by peer-reviewed research since the Hodge Jones & Allen opinion. However, it is plain that the apparent absence of GWS amongst French troops very much underscores the approach I now advocate regarding an application for disclosure on behalf of UK GWVs with GWS who were not deployed to the Middle East region at all. Such an application focuses on the vaccines and the fact that the French who did not have the vaccines do not suffer with GWS to my mind speaks volumes about a potential causative connection between the vaccines and GWS.

60. Paras 4.33 – 4.49 deal with what is termed *"The Biopsychosocial Model of Illness"*. Essentially, such a model draws attention to what might be broadly considered to be psychological or social factors as an explanation for GWS including the following factors:

- *"Heightened concern about risk determined by factors, such as their involuntary, uncontrolled nature*
- *Lack of scientific information: or particularly dreaded consequences*
- *Prevailing levels of trust (or mis-trust) relating to Government, industry and professional bodies*
- *Prevailing attitudes and beliefs about medicine and other health-related professions*
- *The current political agenda*
- *The current legal agenda*
- *The current social and political climate*
- *The current media and pressure group activity"* (Para 4.35).

61. Counsel clearly consider the so-called biopsychosocial model of illness to be completely wrong-headed and one that would be broadly accepted, as they say, by Professor Wessely and his team at King's College. Counsel note *"Professor Wessely's illness model is really a socially determined one. In the context of the PTSD litigation, he attempted to ascribe the psychological problems found amongst service personnel to social determination. His reported work would tend to converge with that, in respect of Gulf War Syndrome. We believe that he would be in broad agreement with the Spurgeon model and were we to introduce that model to any trial, the Defendants would seize it with both hands"* (para 4.36).[5]

62. The next paragraph of the opinion is worth quoting in full as it demonstrates clearly the complete wrong-headed nature of the biopsychosocial model.

> *"4.37 The next ensuing passage of the Strategy Report, reads as follows:* "Over the past ten years the most commonly held theories by various scientists and research groups include the following:
>
> (1) The vaccines given to the troops in a stressful environment.
> (2) The exposure to organophosphates.
> (3) The stress of going to war.
> (4) The exposure to depleted uranium.
>
> However, on a balance of probability the **most plausible explanation** [emphasis added] is the breakdown in the relationship between the MoD and the Gulf veterans"

[5] The Spurgeon model is a reference to work by Anne Spurgeon in her study (Spurgeon A. *Models of Unexplained Symptoms Associated with Occupation and Environmental Exposures.* Environmental Health Perspective. 2002 August 110 Suppl 4:601-5)

We have added the emphasis to that passage above because we find it remarkable".

63. I completely agree that this is a remarkable conclusion in the strategy report of Hodge Jones & Allen and counsel's reasons for that are set out below.

> *"4.38 If a court were to reach a conclusion which, taken broadly, meant that the general symptoms reported across this population, unsupported by signs of illness or any alerted mortality, was in fact evidence supportive of a biopsychosocial model of illness derived from a "breakdown in the relationship between the MoD and Gulf veterans" we would regard that as quite inconsistent with any litigation based on the events of the Gulf War themselves. If this explanation, or anything like it, is correct, then Gulf War Illness may be rooted in the understandable fears and stresses of the experience of war but compounded by grievances and resentments which post-date the war. This a quantum leap from the underlying assumption of the whole flood of research which has poured into the experience of Gulf War veterans over the last decade. The basis upon which that massive research endeavour has been founded has all along been that there may be a truly objective scientific physically determined cause of the symptoms sustained by the veterans. The research endeavour has been to identify what the cause and effects may be".*

64. I completely agree with this and that the implication of the biopyschosocial model of illness is that the principal origin of the illness is psychological. As counsel point out, all of the research would have proceeded on the basis of the wrong approach. Thus, if the biopsychosocial model is to be believed, the US 2008 report with its 1840 references and six years of work would have proceeded down completely the wrong path. I have no idea why Hodge Jones & Allen considered it sensible to advance the so called biopsychosocial model as an explanation but I do consider it to be an entirely misconceived approach and I say no more about it.

Chapter 5

65. Chapter 5 deals with exposures of the Gulf War: the science. It considers vaccines at para 5.8 – 5.19, organophosphates at 5.21 – 5.33, sarin at 5.33 – 5.43, depleted uranium at 5.44 – 5.54, PB/NAPS at 5.55 – 5.72, multiple exposures: the "toxic cocktail" at 5.73 – 5.82 and finally scientific conclusions at 5.83 – 5.85. For reasons which should by now be obvious regarding my focus on non-deployed GWVs with GWS, I do not intend to deal with the sections on organophosphates, sarin and depleted uranium. Sections on vaccines, NAPS and the toxic cocktail to my mind raise more questions that they provide answers. Given the length of this advise I do not consider it would be helpful to go into great length on this chapter because essentially I believe that a successful application for specific disclosure should provide answers one way or the

other to the questions posed in these sections. I will give you, however, a taste of what concerns me.

66. Para 5.9 notes as follows: *"the dominant findings (from various research including in the Lancet) were that Gulf veterans were twice as likely as other military cohorts to report chronic fatigue, irritability, headache and other symptoms. If this difference is attributable to vaccinations, the only credible explanation is the effect of the biological vaccinations".* I find myself asking why, in the light of this finding, did counsel not advise that this type of question was worth pursuing? Again, 5.11 notes as follows:

    - *"The British experience that multiple vaccinations before deployment had a weak correlation with ill-health was not found in Canadian troops[6] and has been challenged by Professor Hooper as factually incorrect[7]"*

67. Again, whether or not there is a weak correlation or otherwise between multiple vaccinations before deployment and ill-heath seems to be an obvious question which cried out for an answer. To give one more example, in the section on multiple exposures counsel note as follows:

    "5.74 Identifying which cocktail may be "culpable" is severely hampered by the very poor records of actual exposure during the Gulf War and the obvious difficulty in undertaking controlled post-conflict trials" (my emphasis)

68. Again, this question cries out to be answered and why it did not lead amongst other factors to a hard hitting disclosure application is beyond my understanding. The need to pin down what medical records were available within the MoD seems to me to have been of critical importance and I note that the absence of records cannot be a point in the MoD's favour. As I make clear in this advice, disclosure focusing amongst other things on medical records would now be the main focus of the approach I advocate.

Disclosure

69. I turn now to the central thrust of the strategy I advocate, namely, an application to the High Court for pre-action disclosure. I should set out at the outset the failures on disclosure which arise from the Hodge Jones & Allen opinion before I go on to deal with how such an application might proceed and be the basis of a properly made application for a CPF.

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[6] *Canada's Gulf War Vaccine experience* 7.7.00 Scott Letter

[7] *Vaccines and GWS Hooper* 19.7.00 Letter

Historical failures on disclosure

70. I have dealt above with a number of failings as they arise but I thought it would be helpful if I gathered some of these references from the Hodge Jones & Allen Opinion together in one place.

a) In the context of whether or not the DoH warning was ever attended to and how the MoD might have balanced the risk of proceeding without the use of the adjuvant pertussis injected, counsel note: *"Without access to all the relevant information. It is not possible to reach a final outcome of the conclusion of such a proper decision making process"* (para 2.14).

b) *"For the purposes of this opinion, we proceed on the basis that there was in fact a failure, whether justiciable or not, in not following up the DoH warning, but that we are unable to show without full disclosure what the eventual decision would have been if the warning had been followed up. Our suspicion is that the decision would have been as it was"* (para 2.15).

c) In the context of the MoD assertions about NAPs and conditions in the Middle East: *"Without full disclosure it is not possible to test the veracity of these assertions against the underlying documentation. It is worth pointing out that it would be in the highest degree unlikely that the MoD would make such public assertions unless they were able to back them up with primary documentation...."* (para 2.28) (I have dealt with this point above).

d) In the context of which UK personnel were vaccinated what: *"it is not possible in the absence of preservation of individual records by the soldier or airman concerned to know whether individuals received all of the injectates or some of them...."* (para 2.29) (I have dealt with this point above).

e) In the context of the test of reasonableness and what steps the MoD took to discover relevant information about the potential risks on vaccines: *"on that basis, did the Ministry of Defence fail in its duty to serve its personnel by taking less than reasonable care in those circumstances?"* (para3.7) [this begs the question that apart from the fax of August 1990, what other relevant disclosure might have shed light on this question?].

f) In the context of vaccines: *"in those circumstances, we would be advising seeking detailed disclosure of such documents as we could obtain in the proceedings. Even in those circumstances, we would be surprised to be able to bring home a case on breach, and we reasonably anticipate a very significant litigation risk were such an attempt to be made"* (para 4.14) (I have dealt with this point above).

g) In the context of medical notes: *"there was then a secondary failure to produce a consistent or sensible system for transferring what medical records had been created in the field to the long-term personal medical file, the F/MED/4"* (para 4.22). (See also 4.24, 5.10 and 5.26) (I have dealt with disclosure and medical records above).

h) In the context of vaccines: *"if this difference is attributable to vaccinations, the only credible explanation is the effect of the biological vaccinations"* (para 5.9) (I have dealt with this point above).

i) In the context of multiple vaccinations: *"the British experience that multiple vaccinations before deployment had a weak correlation with ill-health was not found in Canadian troops and has been challenged by Professor Hooper as factually incorrect"* (para 5.11) (I have dealt with this point above).

71. Thus, before considering what additional documentation might be made available bearing in mind the extra research that is to be considered post the Hodge Jones & Allen opinion, it is important to make this point. It seems clear from the Hodge Jones & Allen opinion that the Hodge Jones & Allen team had not obtained highly relevant disclosure and that accordingly the LSC were advised to cease funding the Hodge Jones & Allen action in circumstances where all the relevant disclosure was not available to the Hodge Jones & Allen team and accordingly to the LSC. Thus, at the very least, an application for pre-action disclosure should focus on all of the disclosure that should have been made available before the Hodge Jones & Allen opinion was produced. It would then focus on the additional disclosure which arises for consideration either from a reading of all of the Hodge Jones & Allen papers or by careful consideration of the evidence as it now is including, for example, the US Committee Report and its 1840 peer-reviewed references.

Pre-action disclosure

72. I should set out how an application for pre-action disclosure might now be made.

73. The relevant rule is Civil Procedure Rule 31.16 which I set out in full below[8]. You will see that an application to the High Court for disclosure may be made before proceedings have started. Such an application will be supported by evidence. We need to confirm that both the respondent and the applicant are likely to be a party to subsequent proceedings. The point of this exercise is that pre-action disclosure will ensure that anticipated proceedings will be disposed of fairly and potentially resolve the dispute without proceedings and save costs. The order must: (a) specify the documents or the classes of documents which the respondent (that is the MoD) must disclose; and (b) require the MoD, when making disclosure, to specify any of those documents:

    i. Which are no longer in his control;
    ii. In respect of which he claims a right or duty to withhold inspection.

74. The order may require the MoD to indicate what has happened to any documents which are no longer in his control and specify the time and place for disclosure and inspection. The first part of that sentence has an obvious resonance in the context of medical records and whether or not it is in fact the case that key medical records have been destroyed by accident or otherwise.

75. It should be clear from the rest of this letter that, in due course, if a legal team including PIL were in a position to review the Hodge Jones & Allen files and put in the relevant thinking time we should be able to construct a lengthy list of documents which we can reasonably assert are for the MoD to disclosure and are either in the control of the MoD or require a clear explanation as to what has happened to them (for example, medical records). I do not think it would be helpful at this stage to speculate as to what we might ask for if we had a CPF for eligible GWVs with GWS to pursue this issue of disclosure.

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[8] CPR Rule 31.16 states;

(1) This rule applies where an application is made to the court under any Act for disclosure before proceedings have started.
(2) The application must be supported by evidence.
(3) The court may make an order under this rule only where –
    (a) the respondent is likely to be a party to subsequent proceedings;
    (b) the applicant is also likely to be a party to those proceedings;
    (c) if proceedings had started, the respondent's duty by way of standard disclosure, set out in rule 31.6, would extend to the documents or classes of documents of which the applicant seeks disclosure; and
    (d) disclosure before proceedings have started is desirable in order to –
        (i) dispose fairly of the anticipated proceedings;
        (ii) assist the dispute to be resolved without proceedings; or
        (iii) save costs.
(4) An order under this rule must –
    (a) specify the documents or the classes of documents which the respondent must disclose; and
    (b) require him, when making disclosure, to specify any of those documents –
        (i) which are no longer in his control; or
        (ii) in respect of which he claims a right or duty to withhold inspection.
(5) Such an order may –
    (a) require the respondent to indicate what has happened to any documents which are no longer in his control; and
    (b) specify the time and place for disclosure and inspection.

76. I should also add that I would expect to work in close co-operation with GWVs with GWS who may well have their own ideas as to what documents might exist and should now be pushed for through pre-action disclosure.

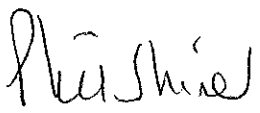
Next Steps

77. Thus, the thrust of this letter is that there should now be a hard hitting pre-action disclosure application made to the High Court in respect of relevant documents from the MoD relating to GWS. I would propose making an application to the LSC as soon as possible once I was instructed by GWVs with GWS who were eligible for CPFs. You are aware of the eligibility rules and I know that you have access to the LSC website and its online calculator as to financial eligibility. Thus, I do not address in this letter the question of whether or not any particular GWV with GWS is or is not financially eligible for a CPF. I stress that the applicants for disclosure must be GWVs with GWS who were not deployed to the Middle East region for the very obvious reasons set out above.

78. I would ask that you give this letter very careful consideration given the extremely serious context of so many UK GWVs with GWS who have not had accountability, suitable medical treatment, damages or an apology. As I hope I have made clear by the length of this letter – and the amount of time I have spent in reading into the subject – I am ready, willing and able with my team here at PIL to push a disclosure application forward if I am instructed to do so. I also make clear that I have access to the finest members of the bar specialising in this type of action in this context if we were to be successful in getting a CPF for pre-action disclosure. I also make clear that the potential costs of such an application for disclosure would be a very small percentage of the costs that the LSC invested historically in the Hodge Jones & Allen action which again may be something which makes such potential action much more attractive to the LSC.

I look forward to hearing from you in due course.

Yours sincerely,



Phil Shiner

Solicitor
Public Interest Lawyers