Witness Name: Andrew Michael March
Statement No: WITN1369014
Exhibits: WITN1369015-63
Dated: March 2020

INFECTED BLOOD INQUIRY

SECOND WRITTEN STATEMENT OF ANDREW MICHAEL MARCH

I, Andrew Michael March, will say as follows:-

1. I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 13 January 2020.

Section 1: Introduction

2. My name is stated above and the Inquiry is aware of my address and date of birth.

3. I have already provided a written statement to the Inquiry detailing my own infections and personal circumstances. However, I would like to add that, as I stated in my evidence to the Archer Inquiry, I feel that it is unacceptable that individuals like myself, and many others who have been infected or affected by the Contaminated Blood Scandal, had to become researchers and/or full time campaigners in order to try and establish what happened and in order to reach the point of finally achieving a Public Inquiry in 2017. Once I was aware of the unanswered questions I needed to become a campaigner – I could not return to the bliss of ignorance and again, like many others, my quest for the truth has adversely impacted my personal life and career ambitions.

Section 2: Organisations involved in campaigning activities

TAINTED BLOOD

1. Tainted Blood (TB) was formed as a way to post information and to share. At the start, it was very much just a website, which was not particularly intended as a campaign tool. It was Andy Evans and the late Gareth Lewis who came up with the idea together, and Andy built the website and handled the software to run it.

2. Although I wasn't part of the very earliest discussions, nor the first meeting that engendered the concept of TB, I had previously been involved in discussions on the MFT bulletin board regarding trying to coordinate some sort of initiative across the country and it was clear that there was a need for something to happen to move things on. There was an upsurge in media attention in relation to the Contaminated Blood Scandal around the time of April/May 2006 with renewed calls for a public inquiry and proper compensation.

3. It was during a meeting in Birmingham that I first heard about TB and I was very much drawn to this. I remember detailed discussions about what TB should be. The website was central to this.

4. TB formalised its aims; which were for a public inquiry into the events that led to thousands of British haemophiliacs being infected with HIV and Hep C and for proper compensation for victims and their families. Once the concept of TB had formed it rapidly morphed into a fully-fledged campaign group.

5. TB's first chairman was the late Gareth Lewis. The group also had a secretary and a treasurer. The current chairman is Andrew Evans; previously Sue Threakall. The members were initially contacted using the MFT database and which led to members being mandated. At the time of the Archer Inquiry TB had 249 members.

6. TB is now a support group as well as a campaign group. The support role increased as TB became more publicly visible through media attention and its website.

7. I joined the Committee of TB shortly after formation. However, I have not always been on the Committee, I would frequently retreat. Although, no official title was assigned to my role, I was one of the main people uploading information and making entries on the TB Timeline (discussed further below).

8. I remember being at the second meeting of TB in Birmingham (which was just after the Tiverton meeting where TB was more or less formed) and I made suggestions and requests to Andy Evans about the possible look and feel of the Timeline and he went away and brought it to life.

9. I recall many times how the late Haydn Lewis had said to me how he wished for something to help lay out the evidence and particulars of what had happened, to organise it in date order, and that it should be something searchable, and above all, to put the evidence in a safe place. The TaintedBlood Timeline, available on TB's website, was very much borne out of a desire to help Haydn.

10. I was involved in the creation of the TB Timeline almost from the start. Andy Evans designed the software to run the Timeline. Once the structure was in place, I made entries in conjunction with Haydn Lewis and Andy Evans. Haydn would often supply me with his thoughts on a new timeline entry and ask for me to add his commentary. I would sometime add my own observations too.

11. My main role within TB has been that of researcher. My involvement always seems to come back to that in one form or another. However, over the years, I have also contributed to the letter writing campaigns, often instigating a certain line of correspondence. Along with other Committee Members I would also often update the Committee News section of the TB website. I note from my email history that I was doing this in 2008.

12. As time went on I floated in and out of the TB Committee as needed according to my health, other demands and also managing my composing.

13. Like the Accusations Document, work on this was commenced prior to the inception of the Archer Inquiry. In 2006/2007 there was information coming out of Government via FOI requests (as discussed further below) and we (members of the TB Committee) found ourselves with a considerable amount of documentation to consider. We had to split up the reading of documents; the task was immense. We therefore designed a three tier system of different groups of people reading the information and filtering it for the most relevant material. I then made the Timeline entries from the key material that was identified through the reading process.

14. We kept a list of where we were at with reading the recovered solicitor FOI documents and this was circulated periodically. An example of one such list from 2007 is exhibited at **WITN1369015.**

15. There was a conversation with a small group from TB where Martin Harvey, then Chief Executive of the Macfarlane Trust, seeded an idea by suggesting that it was time to lay accusations. The French "J'accuse" document of the Dreyfus affair was referred to and I thought that was a wonderful idea so we decided to make it "We accuse" and we basically crafted 8 main accusations which covered the timespan involved and, from there, we built evidence around them to elaborate further and expand the document.

16. We wanted the Accusations Document to be something that would create a debate and that would provide responses. By the time it was presented at the Archer Inquiry (as discussed below) no real response had been received.

17. As part of the presentation Haydn and I discussed a number of issues we considered central to the Scandal. Some of these are covered under the heading "Research" below.

18. TB's Summary and Guidance on the expert group report (**WITN1369016**) was written on 23 February 2010. I believe it was prepared for Michelmores to help focus on the most important issues central to the case – I can only imagine that it must have been created as part of the work leading up to the Judicial Review in 2010 (discussed further below). At that stage the TB Committee was comprised of Andy Evans, Gareth Lewis, Haydn Lewis, Sue Threakall, Bruce Norval, Mark Ward and me but I believe that only 5 of us fed into this document.

19. In August 2006 I wrote to Sir Peter Maxwell Davies and John McLaren to ask him to sign TB's campaign petition for a full, independent inquiry into contaminated blood. I also asked my treating doctor, Geoff Savidge, to sign the petition.

20. On 29 March 2012 I produced a list of correspondence with Government Departments and Officials (exhibited at **WITN1369017**). The purpose of this was to demonstrate the wide range of contact that the TB campaign group had had with various government bodies and officials and to show that the issues of haemophilia and contaminated blood were well and truly on the Government's radar.

A. Early Day Motions (EDM)

21. A number of EDM's have been submitted as a result of TB's work. EDMs are motions submitted for debate in the House of Commons for which no date has been fixed.

22. The Contaminated Blood (Support for Infected and Bereaved Persons) Bill was presented to the House of Lords by Lord Morris of Manchester on 19 November 2009 and the Chairman of the APPG for Haemophilia then put down an EDM in Parliament regarding the same. My mother wrote to our local MP regarding the same and asked him to sign it (as he had the previous EDMs on this issue including 560 and 963).

23. Copies of the following EDMs are exhibited at **WITN1369018.**

    a. 756 – Contaminated Blood (Support for Infected and Bereaved Persons) Bill – Tabled 16 September 2010
    b. 1318 – TB Accusation Documents and the Contaminated Blood Public Inquiry – tabled 20 April 2007
    c. 2637 – TB Campaign – Tabled 24 July 2006

24. Haydn Lewis was involved in getting support for the EDM regarding the TB Campaign and encouraging people to sign the Petition.

B. Department of Health

25. Following the General Election on 7 May 2015 I kept a table of outbound and inbound correspondence between TB and the DOH. A copy of the same is exhibited at **WITN1369019.**

26. In January 2016 the DOH launched a consultation into "Infected blood: reform of financial and other support". To respond to the same Sue Threakall and I prepared an inventory of material relating to the DOH consultation that TB held dated July 2016. **WITN1369020.**

C. Correspondence with MPs and Ministers

27. In 2007 I wrote to Patricia Hewitt, the Secretary of State for Health, following comments made by Caroline Flint, Health Minister, on Question Time on 26 April 2007. I urged her to make an immediate statement followed by action in relation to this Scandal whether by way of a Government Inquiry, criminal prosecutions or other remedial matters.

28. On 14 July 2016 I wrote to Jeremy Hunt MP, Secretary of State for Health, regarding the newly proposed English and Scottish schemes. This letter followed previous correspondence about the consultation process.

29. TB wrote to the PM, Theresa May, on 18 July 2016 as soon as she came into office. One of David Cameron's final acts as PM was to unveil what we now know as EIBSS. TB immediately raised that the newly proposed scheme fell significantly below what had been identified as necessary. One of the primary points raised in the letter was why the English Scheme was not on a par with the Scheme already in place in Scotland which was more beneficial. The letter was signed by Sue Threakall as Co Chair and was copied to a number of other MPs including Diana Johnson and Peter Bottomley in their roles as Co Chairs of the APPG on Haemophilia and Contaminated Blood.

30. On 6 August 2016 I wrote to Nicola Blackwood MP, Parliamentary Under Secretary of State for Public Health & Innovation following the announcement of the new support scheme in Scotland on 18 march 2016 and in England on 13 July 2016. The purpose of the letter was to request copies of the economic modelling and/or financial costings undertaken in order to determine the projected costs of implementing Scottish levels of payments in England.

31. In August 2016 I sought legal advice from Counsel, Anita Davies, on the possibility of a legal challenge to the proposed English financial payment scheme for recipients of contaminated blood products (as published on 13 July 2016). A copy of the advice obtained is exhibited at **WITN1369021.**

32. TB were one of the groups invited to attend the meeting with Oliver Dowden, the then Minister for the Cabinet Office and Paymaster General, in January 2020. In preparation for the same TB prepared a Briefing Document **NOT RELEVANT**. This was a good example of the TB team working together. Most of the work that went into the document was already in place by the time I saw it. I believe Sue Threakall wrote and compiled most of the document but I did some proof reading and contributed to certain sections.

D. Scotland

33. In June 2016 Sue and I produced "The Scottish Project". This was an investigation of events leading up to an announcement by the Scottish Executive of a new support

scheme for haemophiliacs and others affected by NHS supplied contaminated blood products. The announcement was followed by a consultation launched by the DOH detailing their preferred "Option 2". This reflected an entirely different mind set which would result in much reduced levels of support for the future. It confirmed that we believed the disparity would lead to grave unfairness and included a legal summary to identify where we believed the Westminster response may be in breach of UK and EU laws. The questions of disparity in payments between the four UK nations of course remains a very live issue for this Inquiry to consider. A copy of the document is exhibited at **WITN1369023.**

34. TB's views on the Scottish Proposals had already been published on its website on 18 November 2015. **WITN1369024.**

35. A list of TB's correspondence with Government/Ministers regarding Scotland is exhibited at **WITN1369025.**

Section 3: Involvement in committees and/or working groups

36. My involvement with the APPG on Haemophilia and Contaminated Blood has largely been by proxy. I have regularly fed material into the APPG through various means, mostly through my MP, Andy Slaughter, who is one of the Vice-chairs, for example in December 2014. I would also raise concerns through Liz Carroll, Chief Executive of the Haemophilia Society which I did in June 2014.

Section 4: Research and investigations

A. Softly, Slowly Catchy Monkey

37. On 1 July 2008 I launched a website called "Softly, Slowly Catchy Monkey" (SSCM).

38. It was an information website set up to hold information to assist campaigning over the contaminated blood and blood products catastrophe. It was set up on the basis that it was going to take time and patience to get justice for what happened (hence the name of the website).

39. The website contained a number of documents which I prepared either alone or in conjunction with others and which are referred to further below.

40. One of these documents was entitled "The Ten Most Deplorable Acts Committed Against UK Haemophiliacs". I compiled this with Sue Threakall. Another was called "Unanswered Questions". **WITN1369026.**

B. Batch Numbers and Armour Recall

41. Throughout the majority of my life I have been treated with a wide range of blood products. I started with cryoprecipitate from 1974 – August 1977. Then I received my first FVIII concentrate which was manufactured by the NHS, Lister. On 3rd April 1979, as far as I can determine, I received my very first commercial blood product called "Factorate", manufactured by an American pharmaceuticals company.

42. The batch was R98806. I then received Lister FVIII again, until another commercial product, Kryobulin (made by Immuno) in October 1079. This batch number was 091712078.

43. From about 1980, I also received factor VIII from BPL Elstree, Profilate made by Abbott, Koate made by Cutter Laboratories, Oxford FVIII, BPL's 8SM. Throughout the 1980s whilst I was being given largely, NHS-manufactured Lister/BPL concentrate, there were intermittent doses of commercial Armour Factorate, and this continued right up until February 1988. These Armour doses included two batches which commenced with letter A and a letter B – which, as far as I understand from what I have read, should have been part of an international recall. The suspect batches were: A61190 and B59204.

44. My interest in batch numbers was borne out of my own batch number usage history. I seem to have reasonably comprehensive lists of batches administered. I realised that I had a comprehensive list after obtaining my medical notes for the US Litigation (Gullone case). I had obtained my medical records prior to September 2003, and I subsequently produced a table of my batch numbers which spanned some 8 pages.

45. On 27 March 2008, I sent a copy of the PDF of my own batch numbers to solicitor Laurence Vick at Michelmores. In the body of the email I discussed the how I was trying to narrow my products down to a likely culprit for my infection (primarily with HIV).

46. I made mention of a 'window of opportunity', which I took to be 1979-85, and went on to suggest that it looked very much like I could pin it down to a single manufacturer - which might help with the argument that we need to identify the particular U.S. Defendant whose products caused my infection. The email was suitably entitled: "Armour" was my main U.S. Product between 1979-85".

47. At some point prior to 2009, I had asked a haemophiliac friend, GRO-C, if he would share his batch numbers, and he did, which gave me something to compare to. Sue Threakall also kindly provided me with her late husband's batch number list. This formed the beginning of my work on correlating batch numbers. My interest in batch numbers increased over a number of years. As a former patient at Coventry and Warwickshire Hospital and Walsgrave Hospital, I was interested in which batches were used in the West Midlands area.

48. On 26 February 2019 I began work on a special list of "suspect" batch numbers - partly because I wanted to pursue this, but also because I was aware of a desperate need within my community for answers. The batch number project was very much an offshoot of a project Jason Evans was working on in relation to batch numbers; he had produced an extensive spread sheet detailing as many factor VIII batches as he could obtain release information on. Jason had done a series of FOIs to the MHRA and had been sent numerous pages of handwritten batch number lists. However, having closely studied Jason's spread sheet, and compared with the batches I had on my own lists, I could immediately see that the MHRA had not sent Jason information on all the batches ever released; the MHRA lists were in no way complete, and did not appear to cover the 1970s.

49. I frequently received requests for help when people were dealing with their batch numbers. The project developed into a table of some 32 pages. My table included multiple pathogens: Hepatitis (unspecified); Hepatitis B; NANBH; Hepatitis B, Non-B Hepatitis, AIDS/HTLV-III; CMV; vCJD-Implicated; Unknown Agents (including pyrogenic events) and Parvovirus B19.

50. I wanted to identify which batches were either recalled, known to be infective, or ones I could reasonably deem them suspect or highly suspect. I used red text to show which batches were highly suspect. As I worked on the "Suspect Batch" table, there seemed to be a trend of Armour batches coming up as suspect. I was disappointed

to see that Scottish "NY" batches were not looking too favourable in my table as there seemed to be quite a few recalls as well as a range of batches found retrospectively to be infective for HIV.

51. I gleaned information from wherever I could, from the Penrose Inquiry evidence, from the Lindsay Tribunal Report - where I learnt about the notorious Armour batch A28306 (released 27.09.85), which was made from untested plasma and went on to be associated with a case of HIV infection in the United Kingdom in February 1986. The same untested plasma was thought to be responsible for the Birmingham outbreak of late 1986.

52. It wasn't my intention to particularly delve into the background or origin of the batches, but this would depend on the batch, although, there were certain batches that I was always on the lookout for when I was reading at TNA. I would pay particular attention to Product License applications in the BN series as they could sometimes shed light on the origin of the source plasma from which the clotting factors were manufactured, but it usually did not go into very much detail.

53. My ultimate goal in the pursuit of batch numbers was to try and determine which ones were the infective batches; not just within the scope of my own treatment, but in a much wider sense. This turned out to be an extremely tough project.

C. Relevant Freedom of Information requests made to various public bodies

54. In June 2006 I wrote to WHO headquarters requesting a copy of the WHO letter dated 1974 warning Britain not to import blood from areas with high Hepatitis. I also wrote to the Haemophilia Society and asked them to write to the WHO to request the letter.

55. I wrote to the Royal Canadian Mounted Police (RCMP) on 11 July 2006 under the Access to Information Act to request information pertaining to the 1978-1980 RCMP investigation into the Canadian blood broker Continental Pharam Cryosan Ltd. They responded that they were unable to assist because I was not a Canadian citizen and, under the Act, rights of access were restricted to Canadian citizens or corporations in Canada.

56. Cryosan pleaded guilty in 1980 to falsely labelling blood intended for human beings as coming from Swedish donors when it had in fact been extracted from dead bodies in Russia.

57. This issue was flagged in the "Blood from Cadavers" article on the SSCM website which is exhibited at **WITN1369027** which I wrote in October 2011.

58. On 13 July 2007 I made a FOI request to the DOH for minutes of the meetings of the Advisory Committee on Transfusion Transmitted Diseases (ACTTD) from March 1989 to March 1993. This was at the time of the Archer Inquiry.

59. I received a response stating that these could not be located and that DOH did not believe ACTTD was a departmental committee. I was therefore referred to the National Blood Service (NBS).

60. I therefore proceeded to make the same FOI request to NBS but I did not receive a response.

61. At or about the same time I also wrote to Dr Elizabeth Lore, BBTS Honorary Secretary to request these documents and documents in relation to ACVSB (discussed further below) as I hoped that Dr Harold Gunson (who sat on ACVSB and ACTTD) might have retained copies in his personal effects.

62. I also wrote to Prof Zuckerman at the Royal Free seeing minutes from both ACVSB and ACTTD as he submitted papers to some of the meeting and I believed may have sat on the bodies.

63. I received a response stating that he was contacted by Carol Grayson in May 2007 and that, given his position as an advisor to the DOH, he was unable to participate in the "unofficial" Archer Inquiry unless the DOH would provide evidence.

64. Some of the ACTTD files and background papers (such as the 9th meeting) eventually turned up in HIM 22/7 Vol 5 which Jason Evans unearthed in May 2018. This categorially proves that some of the ACTTD minutes existed. I don't know why government wouldn't supply them.

65. I have made a number of FOI requests over the years to MHRA which can be summarised as follows:

a. May 2006 – minutes of Biologicals Subcommittee of the Committee on Safety of Medicines for July 1983, report of recommendations regarding the treat of AIDS to haemophiliacs prepared during the year of 1983 and a list of records being held for information regarding the work of MHRA between 1980 and 1985 with particular reference to blood products, haemophiliacs and blood borne pathogens. The minutes for July 1983 were provided on 5 July with a paper entitled "AIDS; A new hazard for haemophiliacs". A further response was received on 21 July which enclosed minutes for January, March, May and September 1983, January, March, July, September and November 1984.

b. July 2006 - minutes of the Biologicals Subcommittee of the CSM dated January, March, 11 May, 14 September and November 1983 and 4 January, 7 March, 2 May, 4 July, 5 September and 7 November 1984.

c. August 2009 – minutes of the Biologicals Subcommittee of the CSM for the final quarter of 1990, 1991, 1 November 1995, final quarter of 1995, first quarter of 1996. This request was partially successful on 21 September 2009.

d. September 2018 – information on batch NY 807. This request was not successful and I was referred to TNA for further information.

66. On 22 June 2009 I wrote to the MRC regarding the "Prevalence Studies in Haemophiliacs" research proposal submitted by Prof Lee in 2001 and querying whether the study was approved by MRC and whether the prevalence studies, surveillance and setting up of a confidential database was still current/active.

67. On 6 July I received a response confirming that I needed to contact the UK TSE Portfolio regarding my query.

68. I then wrote to Dr Latimer, UK TSE Portfolio at MRC about the same issue asking for confirmation of whether the research proposal was ethically approved by MRC even thought it was funded by DOH?

69. On 5 September 2018 I made a request under the Freedom of Information Act (FOI) 2005 to UK Research and Innovation for minutes of the Medical Research Council minutes dated 29 July 1983 and 10 October 1983.

70. I received a response on 5 October 2018 enclosing the draft minutes of an informal Meeting on AIDS dated 29 July 1983 and the minutes of the MRC Working Party on AIDS dated October 1983.

71. I subsequently found a copy of the final minutes of the meeting dated 29 July 1983 at TNA.

72. In July 2019 I made a further FOI request to UK Research and Innovation for copies of the papers that were circulated before the meeting on 29 July 1983. This was responded to on 21 and 30 August 2019. A copy of the response is exhibited at **WITN1369028** together with the relevant documents.

D. Number of mind maps showing relevant connections

73. I produced two Mindmaps after Jason Evans introduced me to the relevant software. He shared a couple of his own with me which inspired me to try and produce one of my own to try and link all the trailing tendrils of connectively up on the map in much the same way that I envisaged it in my mind.

74. My first Mindmap focused on the Medical Advisory Panel of the Haemophilia Society (1981-1989). A copy is exhibited at **WITN1369029** and it very much focuses on the physicians involved.

75. My second Mindmap (exhibited at **WITN1369030**) concentrated on the connections of Professor Bloom. I wanted to show how he was very much a central node, with tendrils reaching out in every direction to all manner of bodies. Professor Bloom very much had a finger in every pie such as the Haemophilia Society, advisory groups, organisations within the Department of Health structure or wider scope (NIBSC, CDSC, PHLS, CBLA). The Mindmap also included the proximity and link to the pharmaceutical companies; contact and impact on other physicians (through the UKHCDO, hospital proximity and advisory groups) and also to include the link to known incidences of non-consensual research.

E. Research into the Pharmaceutical Companies

76. Over the years I have kept my eyes peeled for material relating to pharmaceutical company involvement in the Contaminated Blood Scandal as this is an issue that no UK Inquiry has yet addressed.

77. On 9 July 2006 I wrote to the New York Times to request a copy of their article entitled "Aids Tainted Blood Killed Thousands of Hemophiliacs" published on 22 May

2003 because I was investigating developments in 1985 in relation to Dr Meyer and the FDA.

78. In 2006 I read the book *HIV and the Blood Supply: An Analysis of Crisis Decision Making (1995) Institute of Medicine*. Whilst reading this book, I noticed that there were a number of references to memoranda of various US pharmaceutical companies, such as Cutter Biologicals, Baxter Healthcare, Alpha Therapeutic and Armour Pharmaceuticals. There was one in particular that I was trying to obtain, Cutter Memorandum from Stephen Ojala dated 19th December 1983. I wrote to the Institute of Medicine because this body was mentioned in the title of the book, so I was just following a logical lead. There were 8 other memoranda of US pharmaceuticals that I also mentioned in that letter.

79. I also sent an email to the U.S. law firm, LCHB (Lieff Cabraser Heimann & Bernstein LLP), asking for copies of US pharmaceutical memoranda. I received an email reply on 18th July 2006 from paralegal Tammy Jenkins (Tamara D. Jenkins) stating that they were unable to accommodate my request, the reply went on to say: "*All defendants' documents in our possession are under court protective order and cannot be disclosed except for litigation purposes.*"

80. When I was at TNA I was reviewing a Cabinet File (CAB 174/2) which was tagged as "Review of Policy on Immunisation of Civil Servants" when I came across a letter dated 23 July 1984 from RK Rowntree (Senior Medical Officer) of Morson Pharmaceuticals to Mrs Haque of the British Council. The letter stated (in relation to the Hepatitis B vaccine) that *"the risk of AIDS transmission has now more or less been discounted in the Morson product HB vac which is used in the UK."* I understand that Morson were a branch of Merck Sharp and Dohme.

F. Porton Down – Molecular Genetics Lab, Centre of Applied Biology

81. Following Jason Evans locating further documents in TNA as part of his research in 2018 I noted that the Communicable Disease Report (CDR) weekly edition 83/05 referred to Dr RG Downing of the above location and stated that he was willing to carry out T-cell subset analysis on any Kaposi sarcoma or suspected AIDS cases.

82. I provided the Inquiry with a copy of the FOI response I got from TNA and the original request I made about file MH 166/1595 on 12 September 2019. This file was about the Centre for Applied Microbiology and Research (CAMR) at Porton Down and is a

closed file that will not be opened until 1 January 2065. I made the FOI request to see if any of the file could be made available because it was of interest due to the timeframe and contaminated blood products.

83. I had previously written to Porton Down in September 2011 about the possibility of a vCJD assay.

G. Chronologies

84. I have provided Collins Solicitors with a number of chronologies following my investigative work as follows:

a. AIDS/HIV infection in Haemophilia Patients – Historical Development (Chronology 1981-1986). I came across this when I was looking for material on the Haemophilia Society albeit I am not clear where the chronology itself came from. It is similar to the chronology that can be found in the legal papers from the 1990 HIV Litigation but it is definitely not the same chronology.

b. Chronology from the Krever Report.

c. Chronology from the Advice on Settlement for the HIV Litigation

d. BPL Chronology (which I prepared)

e. Chronology of Tainted Blood Press articles

f. Tainted Blood timeline (together with source documents)

g. Specialist Chronology of issues which I prepared in relation to matters I was concerned may be overlooked.

h. Chronology from the Review of Documentation Relating to the Safety of Blood Products 1970-1985 (pages 30 to 32).

i. Chronology – Blood Products/Haemostatic Agents and Hepatitis C/NANBH which was submitted to court in a "Hep B" case to assist the Judge. I believe that it was authored by the late Professor Geoffrey Savidge on 11 March 2007.

j. Chronology of events with relevance to self sufficiency, hepatitis C transmission and establishment of terminal dry heat-treatment for UK coagulation factor concentrates. This was in the evidence given to the Penrose Inquiry and, on the face of it, appears arise from litigation files maintained by BPL.

k. A chronology which accompanied a witness statement and other exhibits of Ben Cole (then of the Department of Health Blood Policy Unit) concerning the Inquiry into the death of a haemophilic friend of mine who was co-infected. This came before the Coroner's Court in or about 2014.

I. Master chronology – Ireland. This document was very much a joint project between me and Sue Threakall. We were working on it as far back as July 2009 when I emailed Haydn requesting a document for the project which essentially started as a challenge to the Government stance on Parity with Eire.

H. Research at the National Archives

85. I first became aware of the existence of the National Archives in Kew, London, at some point in April 2016, when fellow-campaigner, Jason Evans, sent links for 2 redacted piles of documents which had been made available through the online Archives system. I had not heard of The National Archives (TNA) before this time. I was slow on the uptake and didn't grasp the enormity of what Jason had tried to impart to me about the type and scale of material held there.

86. The first TNA catalogue series I came across was the JA series and, more precisely, the JA 418 subseries, which Jason had introduced me to by email. I remember saying to him: "*It's crazy, isn't it. Some of those PDFs starting with JA 418 have 150-230 pages in each. 3 out of 4 that I've downloaded so far have 230 pages in!*" To which Jason replied *"...it's like it's gone from having barely anything to more than I ever thought possible, one hell of a task ahead! It seems packs are being unlocked as I'm browsing, what the hell?"*

87. Little did I know back then, that what I had read online was but a sandcastle's worth on the beach's vast expanse of sand!

88. At that stage I had still not been to TNA in person, so I was only able to access material which TNA had made available online, usually in the form of PDFs. A lot of the material in the JA 418 sub-series consisted of documents that had been made available to the Penrose Inquiry. However, despite vigorously pursuing the wider evidence files associated with Penrose which I had been downloading for months from the Penrose website, after viewing the JA 418 files, it seemed to me that most of these JA 418 files were new and had not been made public in the wider Penrose Evidence. I wonder if perhaps they were only shared with the Penrose Inquiry team, not the public?

Introduction to TNA

89. On 6 November 2016 Jason Evans invited me to meet him in Kew at the Archives to view documents. He essentially showed me the ropes, and guided me through how to order documents and how the reading room operated. There were many rules with Draconian punishments.

90. I didn't return to TNA until 10 February 2018 - this time by myself - to start reading documents on a more regular basis. From this point I went quite often, at least every week (health permitting), and sometime a couple times a week. On 10 February 2018, I ordered my first files to read.

91. Over the new year and a half I ordered and read a total of 453 files. Of these files there were 255 documents which I deemed sufficiently relevant to grade A-C. I only took photographs of the relevant files. During the time I spent at TNA in person, I took at least 5,895 photographic images of relevant pages; each one being the approximate size of an A4 page.

92. There is now shown to me marked **WITN1369031** a copy of the files that I ordered during the course of my work at TNA.

My Inventory of Files Read

93. I found I needed a way to keep track of files which I had ordered, which had been read, and which had yielded relevant images. TNA kept the order history of a reader on their system, but I started keeping my own order lists because I needed them at home. For the first 6 months I had to correlate this with Jason's list, in order not to double up on the reading. I created the template for my Inventory on 8 March 2018. Over the months it grew to a 193-page document. It is not merely a list of files; there is a column for the file description, where I often added notes and comments. I tried where possible to make it clear which were my observations and opinions. One of my concerns was connectivity and how things, events, actions, policies all joined up.

94. I also have PDFs of screen prints which I took at TNA showing my order history (which are incomplete) spanning only 1 September 2018 to 9 May 2019. Many of the files ordered did not produce results, but these lists were important in helping me keep track of what I had ordered.

95. By the start of November 2018, the reading at TNA was becoming very stressful. I was going there by myself. As I became more aware of the many hundreds of thousands of files, I started to feel a crushing pressure bearing down on me - the task of reading had become a behemoth. This pressure was coming from the fact that there were simply so many documents, and it did not help when I realised from searching the TNA catalogue that some important series, such as JA, had subseries which had been designated: "Series Accruing"; the DOH were literally adding files to them every few weeks.

96. On 7 November, Andy Evans, Chair of TB, organised a conference call with Brian Stanton, Sam Green (the IBI information manager), and myself. During this conference call, the issue of what was happening at TNA was raised. Andy advocated for me, imploring the Inquiry for some kind of help with my reading. Thankfully, that help came. That same day, a paralegal working with the Inquiry, Damien, was copied in on an email about possibly meeting me at TNA on the Friday of that week (9 November 2018).

97. The night before the planned visit to TNA I spent several hours making a large plan (A2-size) of how the file-prefixes worked (according to my understanding at that point). I laid out the main prefixes that were yielding results. I believe there were 4 main prefixes: JA, MH, BN, FD and I grouped the others together into a miscellaneous group. I used a pentagon shape in the centre of the page to structure my diagram. I presented this to the IBI paralegals in the morning. They were suitably impressed. I drew the diagram to help convey the scale of the files at the Archives and how certain series were yielding results. You can see the number of potential files involved in each of the main series:

- MH series 30,235 files
- FD series 25,031 files
- BN series 25,368 files
- JA series 7,761+ files

Work with IBI Paralegals

98. On Friday 9 November 2018 I met Damian and his colleague, Barry, another IBI paralegal at TNA. They had applied for Reader's Tickets online and collected them that day. I told them about the document reading I had been doing there for the past few years.

99. Whilst at TNA, we made extensive efforts to search TNA's "Discovery Catalogue" at the computer terminals. I tried hard to demonstrate the problem with TNA's file tags and awkward cataloguing system and to convince the new paralegals that a 'broad sweep' acquisition of all the "apparently relevant" files simply wouldn't work. It would need a bespoke team, who were prepared to delve into the depths.

100. Whilst at TNA I noted that Barry was very interested in the area of informed consent, lack of consent and anonymous testing. When I got home, I searched my list of files and to see if there was anything pertinent that I could share with him. I mentioned it to him in an email dated 11 November 2018 **(WITN1369032)**. What motivated me to include this quote was that whilst we were at TNA, we had made several unsuccessful attempts to bring up search results on the subject of consent. This typified the problems with the search terms and the TNA catalogue. The respective quote that I sent the paralegals was from TNA file "FD 13/338", and reads as follows:

"The Committee on Epidemiological Studies of AIDS had concluded, on the basis of a variety of evidence that anonymous studies (without consent) using samples taken for other purposes would be necessary to obtain accurate estimates of the overall level of infection and in which groups infection is occurring. At the request of the Department of Health, the Committee had developed proposals for studying groups such as hospital inpatients, pregnant women and attenders at sexually transmitted disease clinics and drug abuse clinics..."

101. I thought it might be useful and I suggested that Barry might want to add this file to his future reading list.

102. During the course of my work at TNA one of the Inquiry paralegals found a file from 1953 which contained a Medical Defence Union document for the Prison Commission/Service. This contained the following statement:

"The consent thus obtained must be genuine consent; not merely an apathetic acquiescence but a real expressed willingness by the patient to undergo the treatment after he has had its nature, its risks, and its objective clearly explained."

My Grading System

103. During the course of my work at TNA I developed my own classification and banding system for the level of importance of files which I had viewed and/or downloaded. The system was as follows:

A: Critical find or item of game-changing significance
B: Contains important or useful items which fill in gaps
C: Some vaguely useful finds of potential relevance
D: File content not relevant. No images taken.

104. When I started to assist the IBI with their work at TNA they adopted my classification system.

Medical Research Council – FD Series

105. From quite early on, I had realised the FD series concerned the historic files of the Medical Research Council (MRC). There were some 35,000 files under the FD prefix. However, it was not clear from the catalogue which sub-prefixes would contain relevant files. It was obvious the Council Minutes could be important, but I discovered a number of sub-prefixes that yield critically important finds.

106. One of them was the FD 19 sub-series! I attach a PDF of a single page of an MRC grant application which aptly demonstrates the important and relevance of the FD 19 sub-series.

107. Another example, can be found in an Annex to a MRC research proposal made by Dr Craske in 1984 (from file FD 19/102):

"On March 13 1984, there were 29 cases of AIDS in haemophiliacs in the U.S.A. known to CDC. Eight of these had been reported since 1.1.84 Review of these cases has shown that the first occurred in September 1981 and that the rate of appearance of new cases is still increasing. One was diagnosed in 1981; eight in 1982; twelve in 1983 and eight to date in 1984. There was a 2 to 2 and a half year lag between the first appearance of cases in homosexuals in significant numbers and the appearance of cases in haemophiliacs. This could be accounted for by the incubation period of the disease plus the time taken for raw plasma to be processed into freeze dried factor VIII."

108. This was of importance to a line of investigation regarding what I would described as a "three year lag": the difference in the state of the epidemic in the UK as opposed to the USA which was some years ahead - back in the early 1980s. I became quite focussed this after reading about it in a set of minutes of the MRC Working Party on AIDS of 10th October 1983. The exact quote was:

"The Working Party sought to identify particular opportunities for research unique or special to the United Kingdom. The fact that the epidemic was lagging some three years behind that in the USA was considered an important factor in enabling the background against which AIDS develops to be delineated."

109. My thinking here was that if there was a three-year lag, then surely more could have been done in that time - by way of preventative action, adopting a cautionary approach, looking for alternative treatments, safer blood supplies, and learning from the American experience.

110. I discovered that the FD 23 sub-prefix was comprised of the Medical Research Councils "S-series" (Scientific Series) files. From studying these files, it was clear that the vast majority of the all-important 819 sub-series of the Scientific Series files were missing. I deduced that this 819 sub-series concerned AIDS and the MRC, with a possible timeframe of late 1982 to well into the late 1980s. To demonstrate the importance of the S819 sub-series, the above set of minutes [AIDS Working Party, 10 Oct 1983] should have been within it, but they never came from TNA.

111. One of the JA series files which I graded as an A-grade was JA 398/16. It contains a paragraph about the introduction of a product, which would require the "full co-operation of the Haemophilia Directors" since "a non-human primate testing facility is not available to BPL...". At first, I almost didn't see the significance of this. It almost requires a second read to comprehend what's being implied: that in the absence of a testing facility (at BPL) for non-human primates (probably chimpanzees), the authors (the CBLA) would need access to humans (us; haemophiliacs) through the cooperation of the Haemophilia Directors (the UKHCDO).

The MH Series

112. The MH series deals with the historic files of the Ministry of Health. An example of an important MH series would be TNA file: MH 168/143, which I graded A-star. The file concerns the manufacture and supply of blood products.

113. This file contains a report entitled: "Visit of Mr. Sydney M. Pugh (Cutter International) and Mr Carroll E. Jones (Cutter Laboratories Overseas Corporation), 9th March 1978, to Blood Products Laboratory".

114. On the second page of the report, there's a critically important comment about the preferred location of clinical trials:

"They mention the possibility of undertaking clinical trials in this country of new preparations of human blood and seemed to hint that such trials might be done here more easily than in the USA. I pointed out that clinical trials were controlled here as strictly as by FDA and that trials could be arranged no more easily in UK than in USA that an attempt {possible redaction} *to organise trials here on this supposition would cause great resentment."*

115. From this, I would deduce that the pharmaceutical companies in the USA believed that the United Kingdom was a soft target for clinical trials to be conducted in a less stringent way than the FDA would require. I have seen reference to this more than once and I believe this issue needs urgent investigation.

The BN Series

116. The BN series broadly comprises of files relating to the DHSS. The sub-prefix BN 116 comprises numerous sets of minutes of the Committee on Safety of Medicines (CSM).

117. Interspersed in the pages of these CSM minutes are product licences applications and the committee's reviews of these applications. TNA file: BN 116/4 is an important file because it contains what I believe to be the earliest Product Licence applications in the UK for imported commercial concentrates.

118. I was also sent 104 documents relating to Gallo by one of the Inquiry Team's paralegals.

I. Life Preserving Treatment

119. This is one of the issues Haydn and I presented on at the Archer Inquiry. When the first commercial products came into the UK they came in through an ethic committee and were allowed into the country on a research basis (either clinical trial or named patient). However, one of the hurdles that had to be cleared for the committee was that the products were for life support therapy. Whilst there may be an argument for stating that severe haemophiliacs required factor products as "life support therapy" or that a member of the public may require emergency treatment for a condition which was life threatening; we could not see that there was an argument for using such products on mild haemophiliacs.

120. Haydn felt particularly strongly about this as he was treated with commercial factor in 1974 having previously only been treated with cryoprecipitate. He was therefore a PUP (previously untreated patient). He was not consulted before he was given this product and he believed it was on some kind of trial because the MRHA data he received suggested that there were no product licences pre-1976. If this is correct the product he was given must have been under the heading of either named patient or clinical trial. At the time he had kicked his big toe so it was certainly not something that could be described as a life threatening situation.

121. I led the "named patient" part of the presentation. This related to pharmaceutical companies who wanted to get their unlicensed products used and, in order to do that, used what was called the "named patient" basis. In order to have their product evaluated it had to be distributed and included in human clinical trials in order to proceed to a licensed product. This system effectively allowed physicians to prescribe unlicensed treatment to a specific patient who is named and recorded. As part of this process a discussion is supposed to take place where the prescribing doctor informs the patient of the improvement benefits and that there might be risks. As I understand it in the majority of, if not all, cases these discussions did not take place.

J. Primates & Haemophiliacs

122. There has been a lot of publicity about the "Chimpanzee" letter sent to Haemophilia Centre Directors by Prof Bloom and Dr Rizza on 11 January 1982. However, this is not the only evidence that I have seen as to the attitude of the medical profession at the time to human trials to look at infectivity in relation to Hep C

(NANB as it was then) and the effect of heat treatment. I published a section on this on the SSCM website and the content is exhibited at **WITN1369033.**

123. I was provided with a copy of the "Chimpanzee" letter on 15 June 2006 by Oxford Haemophilia Centre following a successful FOIA request. I also asked for copies of any records relating to the 1982-1985 studies in administering Factor VIII concentrates to demonstrate infectivity in previously untreated haemophilia patients as carried out by the Plasma Fractionation Lab in Oxford. I was told that trial was carried out under the guidance of UKHCDO: the UK Hepatitis working party and that the following people were involved: Dr Bloom (the Chair), Dr Rizza (the secretary) and Dr Craske from the Public Health Lab. The letter also confirmed that PFL was a separate unit to the OHC and was an independent unit belonging to BPL. The results of the study were published in "Non A Non B Hepatitis after Transfusion of Factor VIII in unfrequently treated patients" BMG 1983.

124. At the time of the FOI request the information held in OHC relating to this trial was held in a 4 cm thick file relating to the activities of the Hepatitis working party from the 1970s to the early 1980s and including various notes, letters, correspondence and data relating to the working party.

K. Research into vCJD

125. I was exposed to vCJD between December 1995 and August 1997 when I was treated with 110 vials of BPL's Factor VIII "Replenate". These vials comprised of 2 batches (FHE4437 and FHF4625) which were subsequently deemed to be implicated for vCJD and recorded as being High Risk in the Health Protection Agency recall tables of September 2004.

126. Being designated "at risk" for Public Health Purposes has caused me great distress and, as a result, I have relentlessly pursued further information on the subject, researching wherever possible, writing to the Government and various scientists.

127. As part of my research I wrote to the vCJD Trust asking about the position of haemophiliacs. I made contact with Dr Stephen Dealler. I first heard his name mentioned in a positive vein during a conversation with campaigner GRO-A, the mother of vCJD victim GRO-A, in or about June 2008. I learnt that he had given evidence at the BSE Inquiry in 1999. I read a statement about what Dr Dealler

had found. I also read about a meeting he had given in 1994 where he tried to show that the risks must not be ignored. In September 1996 Dr Dealler published material in Transfusion Medicine on the potential risk to humans through blood transfusion. He had calculated a range of numbers for the potential infections in the UK.

128. I first tried to contact Dr Dealler on 10 September 2008 via the Pathology Laboratory in Burnley. I don't think I received a response. I then sent him an email on 8 June 2009 after GRO-A gave me his email address. I had also read that in January 1995 Dr Dealler made contact with the UK Haemophilia Society and advised them of the risk they may be taking over the level of infectivity in plasma and that it may be sufficient to transfer CJD. I do not know what form this contact took (ie. whether it was a letter, telephone call, email etc). When I contacted Dr Dealler the driving factor was to see whether he had retained any copies of his warning letters if indeed he had ever put them in writing.

129. Dr Dealler replied to my letter on 3 July 2009 and said: *"The problem was that we simply did not know the blood product risk and BPL may have a great problem. The difference being that, unlike the Ministry of Agriculture, Fisheries and Food (which had assumed the BSE risk to humans to be small until shown to be of significance), the Department of Health ethically should do the opposite."*

130. I believe he had his own website because he made some personal statements. An internet archive of the same can be found at: https://web.archive.org/web/20080214155027/http://bse.airtime.co.uk/deal.htm

131. I wrote to Dr Gascoign at BPL to find out more information about the batches I had been given. I relentlessly pursued access to the prototype v CJD test but to no avail. I wrote to many different places between 2008 and 2011 asking about the status of new assays for testing human blood for vCJD and, where possible, asking if I could be tested. In September 2008 I wrote to Alan Johnson making a formal request to be tested for vCJD.

132. Even in my letter to Dr Dealler in September 2008 I specifically raised the subject of the new vCJD assays for human blood. I wrote to my then haemophilia doctor, the late Dr Graeme Thomson, on 21 June 2008 specifically regarding vCJD testing. I formally requested to be tested for vCJD at the earliest opportunity. The next month, on 20 July 2008, I wrote to the Doctors Laboratory, London, explaining that I was a severe haemophiliac who had been exposed to vCJD. I asked if they could help me be tested with the new vCJD assay for human blood and even went as

far as to ask if there was any way in which the Canadian Life Science company Amorfix test, EP-vCJD could be obtained on a research basis so they could test it on me. The reply was disappointing; the Doctor's Laboratory explained that the NBS were not comfortable with the sensitivity and specificity of the kits available and that a positive or negative result would be hard to interpret.

133. I met George Adams, the President and CEO of Amorfix Life Sciences in person at a SaBTO meeting on 20 October 2008. Afterwards he sent an email to Dan Farthing at the Haemophilia Society on 24 November 2008 asking about a person who was at the meeting, whose name he did not get, who had stated they felt haemophiliac would want to be tested. That person was me. George Adams asked for an opportunity to discuss with the Haemophilia Society how they could best achieve this goal together. Chris James, the then Chief Executive of the Haemophilia Society, emailed me to suggest that George Adams come and meet with him and asked me if I would like to join them. I jumped at the chance. I asked if we could open the meeting out to other haemophiliacs who were interested in being tested and there followed a whole sequence of emails and correspondence with George Adams, cumulating in my email dated 9 March 2009 which confirmed I was more than willing to travel to Canada to be tested.

134. I also wrote to Dr Ralph Zahn at Allprion AG in Switzerland in August 2009 asking if there were any new developments in the area of vCJD testing of human blood and whether there was anything they could do to expedite testing for vCJD. I explained that a small number of haemophiliacs would be willing to travel to Switzerland for such a prototype test. You can see from this how determined and desperate I was back then to be tested.

135. There was another research aspect which has directly impacted me. It concerns my exposure to vCJD. In 2007 I stumbled across a transcript of America's Food and Drug Administration's TSE Advisory Committee, where they were discussing the testing of blood for new variant CJD. The meeting was attended by a leading member of Britain's National Institute for Biological Standards Control, Dr **GRO-D** **GRO-D**.

136. Dr **GRO-D** (NIBSC) made the following incredible comments during the FDA TSEAC meeting on 19 September 2006: *"Clearly, what you would really like is to have a test which works on humans which you validate on humans. The difficulty with doing that is that there are no human samples available which will do what you want them to do. The best way of doing this clearly would be to take a human,*

expose them to variant CJD and then follow what happens to them. It is very, very difficult to actually get samples which are relevant to that kind of set up."

137. *"Finally, we have some samples from hemophiliacs. This turns up just as a bit of serendipity, if you like. There was a study done at the Royal Free Hospital in London over the period of the late 1970s to the late 1990s. Samples were taken from hemophiliacs over the whole of that period, mainly to look at things like hepatitis seroconversions and HIV seroconversions. So, a lot of these things would actually be HIV and hepatitis C positive. Clearly, this is a period of great interest from the point of view of variant CJD as well."*

138. Making this discovery caused me a lot of anxiety. It was like it was happening all over again - a direct repeat of the past attitude to non-consensual testing. I was clearly their exclusive property and my tissue and blood samples were their property as well. I had recently been a patient at the Royal Free. I had been a patient there from 1992-2005. This would affect me directly. I did not want my blood being used for this "mad cow" analysis research without my consent.

139. I was staying with my Haemophiliac friend, the late Haydn Lewis, in Cardiff when we made the discovery. We quickly realised we needed to put a spanner in the works. All of this resulted in an exposé by Ned Temko of the Observer on Sunday 3rd June 2007. The scoop was aptly entitled: *"Patients' fury over blood test 'betrayal'.* The article bore the subtitled: "*Doctors at NHS hospital carry out 'mad cow' analysis without permission".*

140. In a letter of 3rd April 2008, Professor Edward Tuddenham, Director of the Royal Free Haemophilia Centre wrote to me confirming that they did have my samples: *"It is the case that we have samples of your blood stored here, in the form of frozen plasma from various dates between 1992 and 2002. These have not been sent out to anyone for any testing. As came out in the Press, I had been in discussion with Dr* GRO-D *to find out if there was interest. However, as we pointed out in the letter to all our patients, no steps in that direction would be taken without consulting with individual patients as to their preference."; "I would assure you that we are, certainly, not going to send your samples to anyone or carry out any further testing on the without your knowledge and agreement."*

141. In July 2008 I corresponded with Dr Thompson at the Haemophilia Reference Centre at St Thomas' in London regarding a possible vCJD assay.

142. In August 2008 I was already a client of Michelmores but I contacted them about vCJD. At that time they concluded that I would have to go down the clinical route regarding testing before getting lawyers involved. However, eventually, I progressed the idea with them and Mark Ward and I went on to instruct them (as discussed further below).

143. On 8 June 2009 I wrote to NHS Executive Leeds Medical Education Unit with a FOI request for a letter Ref "PL(CO)(98)1" regarding new variant CJD and patients who had received implicated blood products. The letter was dated 6 February 991.

144. I, together with another haemophiliac, became so concerned about vCJD exposure that we sought a referral to Professor John Collinge, Professor of Neurology, at the MRC Prion Unit at UCL. I was accepted as a patient. I provided blood as an exposed haemophiliac in order to help with their research. I was also given a genetic test to determine my relevant genotype in relation to vCJD. I am V-V (that is valine homozygosity at Codon 129 of the PRNP Human Prion Protein Gene).

145. On 12 September 2011 I wrote to Richard Vallance at FieldFisher regarding the vCJD Trust. I received a response from his colleague (as Richard had retired) dated 15 September 2011 which set out the details of the vCJD Compensation Scheme.

146. In June 2014 I became aware of the fact that the vCJD Trust appeared to be capped at just 250 cases, a ceiling on the number of potential applicants. I had to come to learn from a redacted document which mentioned the vCJD Trust and stated *"This Scheme provides for payments to be made in respect of up to 250 cases of vCJD up to a maximum of £67.5 million. If numbers exceed 250 cases the scheme will be reviewed."*

147. I then wrote to the vCJD Trust on 26 June 2014 because I was concerned that there was a glass ceiling and at what would potentially happen if a significant number of the 3,876 "at risk" haemophiliacs and others with bleeding disorders were to in fact qualify for help – the threshold would then quickly have been surpassed. I asked whether any review of the scheme would be able to allow for the potential increased number of "at risk" individuals making claims.

148. I acquired some additional medical notes some months ago from the Prion Clinic (UCL). However, after reading through them, I couldn't find anything in there about being tested for my vCJD genotype. I know that I most definitely was, and I know that I am a "V-V", as set out above. I was disappointed that they had either taken this info out, or not recorded it in the first place. I don't mind too much, because I can remember the lengths Prof Collinge went to explain things to me.

149. For example, Professor Collinge said that I was very special because I had the V-V genotype (homozygosity at Codon 129 of the Human Prion Protein Gene - PRNP). He explained that all mammals were M-Ms. He explained that the vast majority of vCJD cases were in humans who also had the M-M genotype, but that there had been one definite human case of an M-V genotype (which we heard about in the BBC documentary). He told me the breakdown of the three genotypes across the population: which were approximately 42% M-M, 46% M-V, and 12% V-V. Prof Collinge said that I was in the V-V group of a rare 12% of the population. He said that I had my parents to thank, as each of them must've had a "V" to give me, for me to have two sitting on Codon 129.

150. I naturally wanted to know whether this was good or bad, for me? He said that the V-V group would most likely have the longest of the possible incubation periods across the three genotypes, but that there was more to it than that. He explained that the M-V and V-V genotypes were polymorphisms unique to human beings (mammals, including bovines being M-Ms), and that they had been able to alter mice by giving them human characteristics, transgenically altered, so that there were in fact mice with the V-V genotype. He said that even when they inject vCJD (abnormal or misfolded prions) directly into said 'altered' mouse, that even at high levels, the scientists have found it hard to get the vCJD infection to take. He went on to tell me that I was very special and that even with the significant exposure to vCJD-implicated factor concentrates which I had had, that he truly believed that I would not succumb to vCJD due to my special genotype. I was now even keener to provide my special blood for research, and my offer was enthusiastically taken up!

151. There was a CJD and vCJD timeline on the SSCM website.

152. Unfortunately, the Timeline can no longer be accessed. The old passwords won't work because the server which held the vCJD Timeline and all it's files no longer exists the material and all the source files.

153. However, all the entries and content were largely what can be found in the "CJD and vCJD Chronological Timeline" the one compiled by myself, Mark Ward and Haydn Lewis with additional research and assistance from Carol Grayson of Haemophilia Action UK.

154. In February 2012 I prepared a document for the DOH, Blood Policy Division entitled "Submission to DH Re. "At Risk" Status" in relation to vCJD. A copy is exhibited at **WITN1369034.** This was sent to DOH on 13 February 2012.

L. National Institute for Biological Standards and Control

155. In July 2006, as part of preparation of the TB timeline, I wrote to NIBSC to request, under FOIA, details of batch numbers of virus implicated FVIII concentrates.

156. In February 2008 I wrote separately to GRO-D to request information held about tissues derived from me. In particular I wanted to know if any samples were held and, if so, if they had been used in any recent trials, blind panels or validation tests for any of the 7 labs prototype vCJD human tests. Also whether any samples had been offered to the FDA.

157. On 12 March 2008 it was confirmed that no such samples had ever been held.

158. This letter was written after publications in the Observer and the DOH website re vCJD.

159. Professor Edward Tuddenham of the Royal Free Hospital, wrote to me on 3 April 2008 saying that, as came out in the press, he had been in discussion with GRO-D GRO-D to find out if there was interest in some samples from the point of vCJD testing, but that no steps in that direction had actually been taken. I was not a patient at this point, but I received a letter a former patient. Essentially the letter provided some reassurance that my samples were not going to be sent to anyone for vCJD testing without my knowledge and agreement. Either way, these letters confirmed that there were indeed many haemophiliacs' samples, and they gave credence to the Observer exposé of June 2007 by Ned Temko, and that I was right to be concerned about a repeat of the non-consensual and secretive testing of my blood

M. Research into the Advisory Committee on the Virological Safety of Blood (ACVSB)

160. I started to research this area in or about June 2008 following discussions with the late Haydn Lewis. I only became aware of the existence of the ACVSB files because of the late Haydn Lewis. He was already well aware of them from having read the judgment from *A and Others v National Blood Authority and Another* (2001), where there was frequent reference made to the minutes. He told me that Westminster had destroyed their copies of these files and that he was trying to get hold of copies of the Destruction Dockets.

161. I would have been aware of both the ACVSB prior to sending my FOI request for the ACTTD minutes on 13 July 2007 where I had made the link to the sister committee (the ACTTD) and I had even made a list of the dates of meetings which I had extracted from the judgment of *A and Others*.

162. On 5 February 2008 Haydn forwarded an email from Ed Webber, Research for Jenny Willott MP (Haydn's MP), saying that he had managed to get hold of all the 'supposedly destroyed' ACVSB files through an FOI request to the Scottish Executive. This email was the first I had heard of them. It was some days before I was able to see the minutes which I did by downloading them in batches from the FOI Publications page of the ScotBlood website.

163. I do not know how I came into possession of the PDF of destruction dockets for the ACVSB files. From the file info, they appear to have converted into a PDF in September 2007. My sense it that I obtained them from the ScotBlood website, but the fact they were available there would have been directly to do with Haydn's pursuit of them through FOI throughout the whole of 2007, if not before.

164. I sent a reply by email on 18 June 2008 to Haydn and others in TB, where I discussed the idea of sharing the list of dockets with Dan Farthing of the Haemophilia Society and Mark Weaving.

165. In an email of 16th July 2008, Haydn was starting to make his own connections between the HCV litigation the dates of the other dockets which he thought were timed with the asking of questions in the House of Commons.

166. I printed every document from each of the 14 volumes and went through them, highlighting anything that interested me, and prepared summaries for each volume. The summaries are exhibited at **WITN1369035.**

167. At one point there was a discussion amongst some members of the TB community about working towards a publicity stunt whereby the 14 files would be printed out, boxed up and delivered to the Department of Health. The story, from our point of view, was that the Archer Inquiry claimed to be a full Inquiry but we had managed to locate 14 files of documents which the Government said had been destroyed. Whilst this never happened the documents are an example of how we have been lied to and drip fed information for over 30 years whilst we have campaigned for the truth.

168. I also made notes of the references to ACVSB in the judgment in *A v National Blood Authority*

169. By July 1989 a specific request was made for data of Haemophiliacs to be sent to Dr A Rejman (DHSS Haematologist). The nature of this data would have been in relation to Hep C infection rates. This is supported by the minutes of the Haemophilia Centre Directors' meeting in October 1989 exhibited at **WITN1369036** where Dr Mortimer of the Public Health Laboratory Services [PHLS] was willing to accept samples for HCV testing. It was said that the Working Party would be looking at HCV testing in haemophiliacs. By November 1989 it is clear that the ACVSB committee members and the Department of Health were aware that as many as 70-80% of haemophiliacs had tested positive for Hep C.

170. As part of my work with TB I was also trying to challenge the date of discovery and isolation of the Hepatitis C Virus because we believed it was nearly 2 years earlier than the accepted date of 1989 that was used by the Department of Health.

171. I wrote an email to Chiron to ask them for more information because it seemed odd to me from reading the documents that civil servants involved with ACVSB could have got things off the ground so quickly in 1989 if that was also the year that Hep C was isolated. It was directly as a result of my research into ACVSB that I became aware there was a discrepancy in respect of the 1989 date.

172. Due to the direct affect on the haemophilia community I wanted to ask Chiron Corp exactly how the development happened and when. It turned out that the US

patent for Chiron's HCV assay was filed as early as 18 November 1987 and the research went back to 1982. In May 1989 (Volume 2) there was clear knowledge of the Chiron HCV test and a desire was expressed to test without resource to Chiron. By July 1989 (Volume 3) there was evidence that the new Chiron HCV test had been used in first time recipients of Factor 8Y and further study of haemophiliac sera was advocated.

173. By April 1990 Dr Christine Lee (as she was then) submitted a paper to the ACVSB which stated *"The use of the Ortho Hepatitis C assay kit has confirmed anti-HCV seropositivity in all haemophiliacs with well documented NANB hepatitis."*

N. Ireland

Research into the Finlay Tribunal of Inquiry 1997 and the Lindsay Tribunal of Inquiry 2001

174. In July 2009 I wrote to the Director of Public Prosecutions (DPP) in Ireland as part of my investigation into the above.

175. At that stage, my understanding was that the DPP was approached in 1997 with seven instances of wrongdoing or allegations of potential criminal actions by the BTSB and I wanted to understand if this was correct and, if so, why no action was taken.

176. The confusion and ambiguity around understanding the Irish position was, in my view, impacting on the campaign in the UK because the British Government would not accept that the events in Ireland were similar to the UK and that the Irish Government decided to provide compensation, not on the basis of legal liability being established, but on compassionate grounds.

177. I received an acknowledgment on 27 August 2009.

178. I do not recall ever receiving a substantive response from the Director of Public Prosecutions (DPP) in Ireland. Having thoroughly checked all my physical files and letters and scanned PDF, etc., I can only find the holding acknowledgement of 27 August 2009.

179. I also wrote to the Department of Health and Children seeking confirmation that the Finlay Tribunal was a Judicial Tribunal and to Malcomson Law for further

information regarding their work with the Irish Haemophilia Society and the Lindsay Tribunal leading to the overturning of the 1991 settlement agreement.

Parity with Ireland

180. Following the Government's Response to the Archer Inquiry recommendations TB produced an information document entitled "Parity with Ireland: The Truth" A copy of the same is exhibited at **WITN1369037.**

181. In July 2009 I wrote to the Hepatitis C & HIV Compensation Tribunal in Dublin for further information about its operation. The response I received is exhibited at **WITN1369038.**

General Research

182. Whilst I don't have clear evidence that I, personally, was used in any kind of research, I have done a lot of reading on this subject, and I firmly believe that in relation to AIDS, the haemophiliac community were lined up as a high-risk research group from 1983, as were their wives and partners. I have read about the AIDS epidemic lagging some 3 years behind that of the USA. Instead of using those 3 years to take preventive action; such as looking for safer treatment options, the Government and MRC Scientists saw fit to line up their cross-hairs on the haemophiliac community and make absolutely sure that we were in the path of the infective products destined to come over from the USA to what they termed: "the virgin soil of the UK". I believe with all my heart that this is what they did. I made an FOI to the MRC last year to obtain a clearer, more legible copy of the minutes of the MRC Working Party on AIDS meeting of October 1983, which they kindly sent. So in the context of the above, I have indeed, been used for AIDS research, and I should stress that I was only 9 years old in October 1983. A copy of the minutes of that meeting are exhibited at **WITN1369039.**

Section 5: Individual campaigning activities

CPI Index-Linking Issue

183. On 20 November 2011 I wrote to Anne Milton MP regarding the front page that the Times published on 18 November 2011. From this article it appeared that

there were plans afoot to disengage the longstanding link between annual inflation and welfare benefit payment increases.

184. I also wrote to my MP, Andrew Slaughter, the Prime Minister, David Cameron MP and George Osbourne regarding the same issue.

185. I received a response from DOH on 9 December 2011 which confirmed that there were no plans to either cap or freeze the annual uprating of payments from MFET Ltd and the Skipton Fund.

186. At around the same time I contacted Unity Solicitors because of my concerns. A copy of my email setting out the issues is exhibited at **WITN1369040** together with the Legal Outline I prepared in relation to the issues.

187. In the Autumn Statement the Chancellor of the Exchequer confirmed that all working age benefits would be uprated in April 2012 in line with the expected CPI level of 5.2% which meant I then didn't have to take the matter any further.

Correspondence with my MP

188. My MP, Andy Slaughter, spoke about me in the debate on Contaminated Blood in 2010 following the Archer Inquiry. He then wrote to Anne Milton MP, Minister of State, DOH, to raise the issues that I had raised with him in a letter from TB

189. In 2013 he corresponded with Anna Soubry at the DOH regarding the MFT and financial support for those infected by contaminated blood.

190. I wrote to Andy again in April 2017 prior to the APPG meeting with Lord O'Shaughnessy on 18 April 2017 to raise a number of issues on TB's behalf regarding financial support.

191. I also prepared a briefing note for Andy dated 11 July 2017 (exhibited at **WITN1369041)** for him to use for the Emergency Debate on the need for an Inquiry on Contaminated Blood. I also wrote to him to outline the reasons why TB believed that there should be court intervention and/or criminal charges. A copy of the same is exhibited at **WITN1369042.**

192. In October 2017 I emailed him to ask him to support the EDM (no. 408) on the subject of the Inquiry into the Contaminated Blood Scandal.

193. I last wrote to him in February this year about the differences in the UK support schemes following the failed meeting with Oliver Dowden MP.

DWP Correspondence

194. On 15 September 2011 I wrote to Maria Miller MP, the Under-Parliamentary Secretary of State for Work and Pensions regarding the Welfare Reform Bill. I had read the Bill and noticed that there was no mention of the MFET or SF in it and the special provisions that applied to those schemes. I therefore asked for clarification of the status of the relevant Statutory Instruments which underpinned the Trusts/Schemes.

195. I sent chaser letters for a response on 30 September and 1 October 2011.

196. I finally received a response on 18 October 2011 which stated that there were powers within the Welfare Reform Bill to make consequential amendments (including to secondary legislation) and that these would normally be done after the Bill had gained Royal Assent.

197. In December 2017, following some correspondence, DWP confirmed that although my EIBSS regular payments were disregarded for calculating my Fortnightly ESA Income Related Entitlement, if my EIBSS payments were left to rest in a bank account and grew they would then be considered Savings/Capital for ESA purposes which would have to be taken into account on my ESA Income Related claim and I would have to notify ESA when my savings reached £6,000.

198. The letter that the DWP sent to me on 8th Dec 2017 gave what I suspected to be incorrect information which I then set about challenging and seeking confirmation. When I read it I immediately thought that there must be something wrong with this information. I had a sense that any funds that were EIBSS-derived payments could in fact accrue *ad infinitum*. It was funds from any other source that could not. So this needed challenging and correcting. If the information wasn't incorrect, then there would have to been a change in the law to tone of the Statutory Instruments or "Regulations", that I had somehow missed.

199. I raised the issue with NHSBSA (EIBSS) on 1st May 2018 by email.

200. On 9th May 2018, I emailed my MP, Andy Slaughter, with my concerns about the DWP ahead of the APPG on Haemophilia and Contaminated Blood meeting. I made the point that if the DWP were capable of making mistakes like this, then it was reasonable to see that it could greatly impact EIBSS beneficiaries.

201. I gave examples of how it could adversely affect us:

"... it could cause an increase in reviews, compliance checks, and the dreadful interviews under caution. It could also cause beneficiaries to unnecessarily dispose of / spend their precious support funds because they are wrongly under the impression that they must keep their EIBSS-related money under a £6,000 ceiling. Also, not being permitted to allow their EIBSS funds to accrue in any way, would clearly be a barrier to being able to save for anything from a deposit on a mobility vehicle to a deposit for a mortgage, etc., so this misinterpretation can only be viewed as detrimental."

202. On the evening of 9th May 2018, my MP emailed me with feedback from the APPG meeting. He clarified the ESA situation saying that someone from Department of Health who had been there at the meeting had said that what I had been told was wrong: *"...there is no requirement to stay below 6k to retain ESA – but that several DWP offices hadn't been told that!"*

203. I still felt this was not clear enough for EIBSS recipients. There was a £6,000 cap, but it only applied to non-EIBSS monies. Ideally I wanted something in writing from the DWP - by way of correction.

204. On 24th May 2018, I received a response from Nicholas Fish at the NHSBSA. He told me he had raised my query with the Department of Health and Social Care, who in turn raised it with the Department for Work and Pensions (DWP), and that he had received the following response:

"The Department for Work and Pensions (DWP) is aware of the difficulties some beneficiaries claiming Employment and Support Allowance (ESA) have experienced and has explained that this was caused by uncertainty amongst some of the processing staff as to how EIBSS payments should be treated. DWP colleagues have advised that an urgent internal communication is being issued to Operational staff reminding them of the correct procedures to be followed and of the sensitive nature of these cases."

205. It was not until 14th June 2018 that I received a substantive response from Jonny Hamilton (ESA Specialist Decision Making and Customer Service Manager)

where he apologised for the incorrect information I was given in their original letter of 8th December 2017.

"In this letter we wrongly stated that if payments made to you from the England Infected Blood Support Scheme (EIBSS) were to accrue in your bank account as capital over £6,000 then they would be treated as savings and taken into account as capital in your income-related ESA assessment. I can confirm that all payments from EIBSS (and formerly those from the Macfarlane Trust, Caxton Foundation, Eileen Trust, MFET and Skipton Fund) are fully disregarded, both as income and as capital. I can also confirm that if these payments are to accrue in your MetroBank account they will not be treated as savings/capital and therefore will not be taken into account in your ESA assessment."

206. This episode with the DWP is a clear example of how vigilant I have to be, as a victim of contaminated blood products. I cannot afford to take my eye off the ball for one moment where any branch of the Government is concerned.

207. In August 2019 I wrote a letter of concern to Justin Tomlinson MP, Minister of State and Minster for the Disabled, Health and Work about the number of DWP ESA reassessment and the DLA to PIP transfers. I was concerned about the number of haemophiliacs affected by this Scandal who suddenly were being asked for reassessments.

208. I was one such affected person and in the comment box on my ESA assessment form I made my views on the Government's approach quite clear. A copy of this box is exhibited at **WITN1369043.**

Media Work/Interview and contact with journalists

209. I have been involved on many occasions with the press in the form of television, radio and the printed press since 2007. Between 16 and 30 April 2010 there were at least 20 articles featuring the result of the Judicial Review, most of which mentioned me in some way. In addition to this exposure, I have helped behind-the-scenes by providing material to reports, seeding stories, researching aspects being reported on, and trying my best to help out where I could.

Television (2007-2015)

210. *GMTV – Wednesday 18 April, 2007* - My very first exposure as a multiply-infected haemophiliac came on morning of Wednesday 18th April, 2007, the first day

of the Archer Inquiry hearings. I appeared on GMTV with John Stapleton at 6:43 am. https://www.youtube.com/watch?v=O6gseMhkJ_g

211. When I was asked about my exposure to vCJD through, I said I was quite angry about that, because it came later, from blood donated in 1990 with the identification of vCJD in 1996, and that I felt it was wholly avoidable.

212. I made a strong point about the "multiple warnings" given from various sources "still in good time", eminent physicians in America, and from the Council of Europe.

213. When John Stapleton asked me if I subscribed to the view that we were perhaps guinea pigs, that they knew what they were doing and they wanted to see what the reaction might be in us, I replied:

"The haemophiliac community have almost certainly been used in place of rather expensive chimpanzees; where were £10,000 each becoming an endangered species; and now we're becoming an endangered species with only 300 or so of our numbers left..."

214. I was interviewed in the studio again for GMTV about 2 hours later (8:14am). I don't think there was anything held back, there was a note on the bottom of the screen whilst I was talking saying "Andrew March – Haemophiliac given contaminated blood".

Second studio interview: https://www.youtube.com/watch?v=gaQTXnMIIU0

215. *Sky News Channel - 18th April 2007* - I was interviewed at lunchtime live from College Green near to the Archer Inquiry. This was an unusual interview for me as there was no interviewer present, just a camera and sound equipment. I had an earpiece and was interviewed by Sky remotely.

216. *ITN - 18th April 2007 - "1970's conspiracy - Lord Owen has said he believes there was an official conspiracy to treat patients with blood that was known to be contaminated."* - On the first day of the Archer Inquiry hearings, 18th April 2007, I was filmed outside near College Green. I had the privilege to speak with Lord Owen, and one of the camera crew captured the footage, but not the audio. When I was interviewed on my own, I said that: *"May 1983 is a crucial time, after which, because the warnings were not heeded, I would allege that many haemophiliacs have got a valid medical negligence claim. The material should have been banned at that point.*

We got documented proof." Whilst I was speaking with Lord Owen, I made sure I told Lord Owen that I did not blame him, and thanked him for trying to save us. https://www.youtube.com/watch?v=FCiliHlJwtg

217. *BBC Newsnight Debate - Tuesday 24 February 2009 - "Debate: Whose fault is contaminated blood? Jeremy Paxman is joined by Andrew March, haemophiliac & Judith Willets from the Archer Inquiry. "* https://www.youtube.com/watch?v=RiE0fAVpMic - This was a live in-studio debate. It had come to my realisation whilst waiting to go on air, that Judith Willets (formerly an Archer Inquiry panel member) was not there to support me, she was there as an opposite. If memory serves, it was Judith that realised first when no-one else turned up – to provide the contrary view, as it were. This was awful for me, as I had been given no warning about how this would work, although I should have known, and since Judith had been my favourite panel member, often giving the human touch, it was all the more awkward for me. I was put on the spot a number of times by Paxman. The debate came to a crunch when the question was posed whether the inquiry had identified any wrong doing in the form of non-consensual research: Judith Willetts was adamant that they had not. When I said that some people are very distraught that they'd been exposed to non-consensual research, Judith Willetts came back saying:

"We found no evidence of that - of people being used as guinea pigs, as has been suggested. The evidence that we were presented with didn't bring that out at all".

218. I felt betrayed and let down. I was also shocked at the audacity of this statement. How she could sit through the devastating testimonies given over the course of the hearings and come out with that.

219. *BBC Newsnight – Thursday 21 May 2009 - "Tainted blood fight goes on Campaigners Carol Grayson and Andrew March tell Gavin Esler how they intend to fight on to get a better deal for haemophiliacs infected by contaminated blood from the US…"* https://www.youtube.com/watch?v=So45yfAxFco

This was an emotive joint interview with campaigner and widow Carol Grayson. I vehemently criticised the government support payments, especially their claim that they had already given out £150 million. I was asked what I would have received if I had been in the Republic of Ireland and the same had happened to me there, and I replied that it would have been really substantial, where the two figures combined for

both Hepatitis C and HIV would have awarded me somewhere in the region of £850,000. When Gavin Esler compared this to the UK government's disbursements of £12,800 annually, my disgust with the government really started to show, and I interjected: "...or a lump sum of £21,500 - for giving me HIV at the age of 9!" I wasn't very happy, and I had said that there were a lot of distraught people in our community that day.

220. I also talked about the way that warnings were ignored by Government. I firmly stated that "it was wholly avoidable", specifically, that if they had taken better action over the risk of hepatitis when warnings were given in 1975 and 1980, that it would have protected us.

221. *ITN News – Friday 16 April 2010 - "Haemophiliac wins compensation case against Government over contaminated blood products A haemophiliac who contracted HIV and hepatitis C from contaminated blood products has won his challenge against the Government's refusal to make adequate compensation payments. Andrew March was praised by the judge for his fight to have payments in the UK assessed on the same basis as those in Ireland…"*
http://www.youtube.com/watch?v=wTQQmWyQ7rU (Video: duration: 0:31)

222. *BBC Newsnight - 16 April 2010* - On Friday, 16th April 2010, I took part in another BBC Newsnight program which featured me very much as a composer as well as a multiply-infected haemophiliac. This part of the program opened with some BBC 2 footage from the BBC Proms, back in September 1998, where my orchestral piece, *Marine - à travers les arbres,* was performed at the Royal Albert Hall by the European Union Youth Orchestra (EUYO) under the world-renowned conductor, Vladimir Ashkenazy. The excerpt concludes with my walking on stage to take my bow. In the interview that followed, I talked openly about being HIV positive and having been infected with Hepatitis C. I mention the first confirmed case of vCJD in a haemophiliac found at post mortem and my own exposure to vCJD through blood products. I described it as a "third volley". This program also coincided with the result of the Judicial Review: "Haemophiliac wins compensation legal challenge".
https://www.youtube.com/watch?v=ukYyqsa_C-o

223. I would like to make an overall observation regarding the Newsnight features. The Department of Health all the way along kept stalling sending someone along to be interviewed, so no-one ever had to face me and give their side of this, nor did they

have to answer any questions from the interviewer. The Government just kept refusing to react. I take this as a sign that they've known all along that their actions were indefensible, including their handling of the scandal ever since.

224. Scottish Television [STV News], Wednesday, 25th March 2015. Media TV interview at culmination of Penrose, the National Museum of Scotland, Edinburgh. This was a group interview with two others: GRO-A and Richard Warwick. It was filmed on the day of the release of the final report of the Penrose Inquiry, whilst fires were burning in the streets outside - the fuel being the travesty of a final report, we were venting our frustration and anger inside the building. The interviewer and crew were from STV news. The theme of the questions was pretty much the usual: "What do you think about the findings of the report' and what's next for the victims and campaigners?". The interview was not a comfortable one by no means, as the filming was done under pressure: there was a frantic effort from the ushers to get us all to vacate the building as soon as possible. As far as I understand, the footage was aired, probably only in Scotland, because a friend of mine contacted me later that day saying they had seen it.

Printed Press (2007-2010)

225. *The Guardian – Wednesday 11 July 2007 - "HIV Case Study: 'I feel like I'm poisonous' Andrew March was 13 when he was told he had HIV…"* https://www.theguardian.com/uk/2007/jul/11/health.aids1

226. I believe this was the first time I had been featured in the printed press in relation to my health. (I had been in the press many times before due to my composing). This was a very difficult story for me, one of the most personal that I've done. It very much represented a "coming out" for me: in more than one respect, because I discussed relationship difficulties and how hard it was to meet people. I essentially made it known that I was single – at the age of 33 - as well as one of an unknown (but probably small number) of gay haemophiliacs. I also revealed that I had taken an Aspirin overdose whilst still at school. It was one of the worst times of my life. I was going through it almost alone, no counselling, nothing. However, on a more positive note, it also mentioned that I was a composer.

227. *Daily Mail 20 February 2009 - "Ministers accused of cover-up over... "Victim: Andrew March contracted HIV when he was 13 after receiving infected blood during treatment for haemophilia.""* https://www.dailymail.co.uk/news/article-1150978/Ministers-accused-cover-NHS-imported-blood-scandal.html

228. *Coventry Telegraph – Monday 25 May 2009* - "Tainted blood" victim pledges to fight on for friends Andrew March: "This year, I have lost two friends – one a haemophiliac and the other who received infected blood as a transfusion," … "I have to carry on campaigning for friends who no longer can." (Note: Only the first page is still available)

229. *Coventry Evening Telegraph – Thursday 25 March 2010 - "High Court compensation battle for transfusion scandal victims Andrew March: "The court cannot replace the government`s decision but we are hoping for a sympathetic judge who will quash it." We want the truth about why they refused to accept the inquiry's recommendations.""*

230. *Associated Press – Thursday 25 March 2010 "Top composer to fight tainted blood payout decision Haemophiliac Andrew March, 36, wants a judicial review of the Health Secretary`s May 2009 decision not fully to implement the recommendations of the Archer Report on supplies which were not adequately cleansed before use…"*

231. *BMJ 9th April 2010 - "UK ministers must "reconsider" decision on compensation to haemophiliacs:* "A British haemophiliac man who was infected with HIV and hepatitis C through contaminated blood products has won a legal challenge at the High Court in London over government compensation payments. Andrew March, 36, an award winning composer, won a judicial review of the government's decision not to increase ex gratia payments in line with much higher payments made by the Republic of Ireland…."" [See attachment for PDF screen capture: BMJ Article April 19th 2010]

Printed Press (2010 – following Judicial Review)

232. *The Guardian: -16 April 2010 - "Court ruling may help contaminated blood victims win higher payouts Government faces pressure to give more compensation, but judge warns campaigners against 'false optimism'"* https://www.theguardian.com/society/2010/apr/16/court-compensation-nhs-

contaminated-blood?utm_source=twitterfeed&utm_medium=twitter

233. *Independent – Friday 16 April 2010 - "Composer wins contaminated blood payout challenge Supporters of legally aided Mr March… …who attended London's High Court for the ruling – applauded as the judge said he was satisfied that the Government's approach "has been, and remains, infected by an error"."* https://www.independent.co.uk/news/uk/home-news/composer-wins-contaminated-blood-payout-challenge-1946889.html

234. *Telegraph – Friday 16 April 2010 "Composer wins compensation review over contaminated blood Outside court, Mr March said: "The judge's decision proves the flawed basis on which the Government made its decision not to implement the recommended compensation scheme…""* https://www.telegraph.co.uk/news/health/news/7597423/Composer-wins-compensation-review-over-contaminated-blood.html

235. *BBC News – Friday 16 April 2010 Campaigner wins tainted blood case: "A composer who contracted HIV and hepatitis C through an NHS blood transfusion has won a High Court challenge over compensation levels…"* http://news.bbc.co.uk/1/hi/health/8624879.stm

236. *Press Association – Friday 16 April 2010 "Composer wins blood payout challenge The Judge said: …they had not merely repeated that they could not afford it but given a reason which, in his view, contained an error and did not withstand scrutiny – that they continued to regard the Irish system as based on fault rather than on compensation…"*

237. *Channel 4 News – Friday 16 April 2010 - "Man wins infected blood payout case Haemophiliac Andrew March, 36, had sought a judicial review quashing the Health Secretary's May 2009 decision not to implement fully the recommendations of the Archer Report on supplies which were not adequately cleansed before use."*

238. *Belfast Telegraph – Friday 16 April 2010 - "Man wins infected blood payout case …the judge said he was satisfied that the Government's approach "has been, and remains, infected by an error".*
https://www.belfasttelegraph.co.uk/news/health/man-wins-infected-blood-payout-case-28529959.html#ixzz0qDkHxHWC

239. *Daily Mirror – Friday 16 April 2010 - "Man wins infected blood payout case Michael Fordham QC: "What we say is that the Secretary of State should reconsider this important aspect on a correct basis.""*

240. *Evening Standard (London) – Friday 16 April 2010 - "Man wins infected blood payout case An award-winning composer who contracted HIV and Hepatitis C through NHS treatment with contaminated blood products has won his legal challenge over compensation payments…"*
https://www.standard.co.uk/newsheadlines/man-wins-infected-blood-payout-case-6459893.html

241. ***Times Online – Friday 16 April 2010*** *"Composer who contracted HIV wins legal challenge …Ministers refused, promising those with HIV only £12,800 per year, while those with hepatitis C are paid separately… …But a High Court judge ruled today that the Government's approach "has been, and remains, infected by error", and the Department of Health may have to reconsider the compensation paid to victims of the scandal.""*

242. *Birmingham Mail – Friday 16 April 2010 "Man wins infected blood payout case Supporters of Mr March – who attended London's High Court for the ruling – applauded as the judge said he was satisfied that the Government's approach "has been, and remains, infected by an error"."*

243. *Herald de Paris – Friday 16 April 2010 - "Campaigner wins tainted blood case A composer who contracted HIV and hepatitis C through an NHS blood transfusion has won a High Court challenge over compensation levels…"*

244. *Daily Star – Friday 16 April 2010 - Man wins infected blood payout case: "The Government has refused to assess compensation on the same basis as in the Republic of Ireland…"*

245. *The Express – Friday 16 April 2010 - "Man wins infected blood payout case Haemophiliac Andrew March, 36, had sought a judicial review quashing the Health Secretary's May 2009 decision not to implement fully the recommendations of the Archer Report…"*
https://www.express.co.uk/news/uk/169691/Man-wins-infected-blood-payout-case

246. *Coventry Evening Telegraph (Nuneaton Edition), Saturday, 17th April 2010. "Victory for Man in HIV Blood Scandal - Haemophiliac wins payout backing from judge over 'error': "A Nuneaton-born composer who was given blood infected with HIV has won his legal battle against a ruling which limited victims' payouts." [See attachment for clipping: Coventry_Evening_Telegraph_Sat_17_April_2010]*

247. *The Scotsman – Saturday 17 April 2010 - "Composer who caught HIV from NHS blood wins court battle Haemophiliac Andrew March, 36, had criticised the government's refusal to match higher payouts in the Republic of Ireland…" "Mr Justice Holman said the way the government had reached its decision was flawed, though he said it was not up to him to rule on the amount paid…"*

248. *The Express – Saturday 17 April 2010 Victory in Blood Transfusion Scandal: "Yesterday at the High Court a judge said he was satisfied that the Government's approach to payments had been flawed… The ruling takes Mr March and thousands more sufferers closer to potentially billions of pounds in payments."*
http://www.express.co.uk/posts/view/169776/Victory-in-blood-transfusion-scandal

249. *Independent – Saturday 17 April 2010 Man gets review of blood payout: "Andrew March, 36, a haemophiliac who was infected with HIV and hepatitis C when he was nine, won a legal challenge against the Government's decision in May 2009 not to pay compensation to affected individuals at levels recommended by an official inquiry into the disaster…"*

https://www.independent.co.uk/life-style/health-and-families/health-news/man-gets-review-of-blood-payout-1947224.html

250. *TopNews USA – Saturday 17 April 2010 "Composer Wins Legal Dispute Over Impending Reimbursement Worth Thousands of Pounds Andrew March, a 36 year old, had sought a legal evaluation cancelling a governmental pronouncement, which stated not to honor reimbursement to victims of an impure blood scandal on the similar level as those in the Republic of Ireland…" "…A High Court judge ruled yesterday that the Government's declaration was full of errors".* https://topnews.us/content/217122-composer-wins-legal-dispute-over-impending-reimbursement-worth-thousands-pounds

251. *Daily Telegraph – Saturday 17 April 2010 - "Composer wins HIV blood case An award-winning composer who contracted HIV and hepatitis C through NHS blood products has won a legal challenge over "derisory" compensation…"*

252. *Private Eye 30 April 2010 - Andrew March (pictured) Re: Judicial Review "Bloody Good News". "Andrew March (pictured), a 36-year-old composer who was infected with HIV and hep C when he was still a child, has recently won a judicial review of the Government's decision last year not to increase its miserly payments to hep C sufferers."*

Radio Interview

253. Following the successful Judicial Review I was interviewed by BBC Radio 4 for the 6 pm news on Friday 16 April 2010.

254. "BBC Radio 4 interviews Andrew March, a haemophiliac who contracted HIV through contaminated blood has won a legal challenge against the Government over compensation…" https://web.archive.org/web/20160421135141/http://www.taintedblood.info/files/1271473897_BBC_Radio_4_News_6pm_16_Apr_2010.mp3

Contact with Journalists

255. On a number of occasions I have been involved with journalist behind-the-scene where the article itself is not to do with me, but I have played a critical part in

the background or made a significant contribution – such as seeding the idea or providing the source material for an article.

256. *BBC Newsnight – Tuesday 17 April 2007 (the first Newsnight to cover blood products) "Patients used for blood trials. "Newsnight has evidence some doctors effectively used haemophiliacs as guinea pigs for new blood products""*

257. This shocking story was the first Newsnight programme, as far as I can remember, to feature contaminated blood as a major focus. I was only involved in as much as I helped behind-the-scenes with this programme. The main way in which I helped was through giving comment by email, particularly on the points being raised in a draft letter to Dr John Craske which I had been sent by Susan Watts of Newsnight, in an email dated 29th March 2007. [See attachment: "Susan Watts BBC email of 29 Mar 2007"]. I've searched my email account for the original email, but there is no trace of it. I think it's simply too far back. This capture in the form of a Word document is all I have. What struck me about the email, is that Susan Watts has literally come up with a draft letter to go directly to Dr John Craske, where one can see all the questions that she was going to ask him. I don't know if the draft letter was actually sent.

258. This program caused quite a reaction from some UK physicians, where they clearly felt hard done by. I was privy to an email chain, dated 18 April 2007, where the top email was sent by Dr Brian Colvin, to multiple recipients, including Dr Mark Winter, Professor Christopher Ludlam. The email at the top of the chain stated: "*Charlie, It was as bad as we were fearing, you will agree*". The email goes on to refute the claims made in the Newsnight programme. I am not certain exactly how I came by this email, but I think Martin Harvey sent it to me.

259. In the days that followed the broadcast, there was a fairly active Blog, probably a BBC comments page. On or around 28th April 2007, I wrote this in response to a blog poster's claims that the Newsnight program had based entirely on hindsight:

260. *"The rather excellent Newsnight programme on Bad Blood was not based on hindsight. It was based upon what the medical profession and Government Ministers KNEW THEN. It's only ourselves that it seems new to now, since some crucial evidence documents have recently been unearthed and released.*

261. *We have to wonder what the Government are still withholding? Back in the 70s and 80s, every week, there were internal memoranda, telexes, group-letters and multiple copies of minutes flying around the United Kingdom concerning detailed knowledge on what they knew back then.*

262. *There were frequent meetings of up to 50 or 60 senior officials and consultant physicians and virologists, meetings on a scale only rivalled by Nazi German's Wannsee Conference.*

263. *Physicians and virologists conspired with one another, leaving dark and sinister coded phrases in their minutes. Sound familiar? They plotted as to how they would conduct unethical infectivity tests on infant haemophiliacs, how they would avoid warnings and ignore alternatives.*

264. *Don't be fooled, these so-called doctors and virologists were the very top of their class – they were the country's best minds and they were not stupid. They were utterly cognizant of the risks and the warnings about hepatitis, HIV and AIDS and they knew a great deal about safer alternatives. Visit www.taintedblood.info for a glimpse of some of the damning evidence"*

265. *The Observer – Sunday 3 June 2007 - "Patients' Fury over blood test 'betrayal' "Doctors at NHS hospital carry out 'mad cow' analysis without permission"" (Royal Free haemophiliac samples).*
https://www.theguardian.com/society/2007/jun/03/health.medicineandhealth2
The journalist I was working with in relation to this scoop was Ned Temko.

266. In February 2010, 16 pages of Department of Health memos came to me by way of chance. A music colleague, a songwriter and composer. He had a friend (John, now deceased) who was once unemployed and had no choice but to take a two-week placement at the DoH. The moment John arrived, he was "required" to sign the Official Secrets Act and then for two weeks, he did nothing but shred documents. He was working in a team of people and was asked to sort the documents into four piles according to given key words. As John was shredding certain documents, something told him to keep back 16 pages, despite the possible consequences if he did.

267. Many years later, he started to see things appearing in the press, post the Archer Inquiry, and near the time of the 2010 Judicial Review. He decided to share

what he had retained all those years and he saw to it that the pages were passed to me. One of the pages we already had in redacted form - the "Doomed Haemophiliacs" letter. This was important for several reasons – it sent a message to me immediately that we were dealing with genuine pages. Part of the revelation was that I finally got to see who had said such a dreadful thing (who had devalued the lives of haemophiliacs to just figures and cost savings), it was John H. James former Chief Commissioner of Kensington Chelsea & Westminster Health Authority.

268. When I received the "unearthed" documents as I call them, I worked with the late TaintedBlood campaigner Mike Dorricott and we made contact with Sarah Boseley at the Observer. She immediately saw the significance and wanted to do an article. Also, we helped coordinate this with Susan Watts at Newsnight, which resulted in a joint release of the information.

269. What is also important about this, is that these memos did not come my way through the usual FOI releases or requests. In fact, all but one of the pages were previously unseen. This provided me with enough of sample to suggest that the Government's repeated claims that all documentation was in the public domain that could be – simply wasn't true. I'm not sure exactly when they started making this claim, but looking back now, it was a total and utter lie. I can say with confidence, based on the memos themselves and all my wider reading, that these documents were ones which the Government ordered to be destroyed for fear of litigation. There was a TaintedBlood Press Release issued around the time of 11th March 2010 that makes clear why the documents were of such importance to myself and other campaigners.

270. The resulting article was : *The Observer - Tuesday 23 March 2010 - "Officials worried about saving money amid infected blood scandal" Leaked 1980s memos show concern with cost as HIV and hepatitis threatened lives of thousands of haemophiliacs."*
https://www.theguardian.com/society/2010/mar/23/infected-blood-hiv-hepatitis-history

Section 6: Complaints to the police, ombudsman or regulatory bodies matters reported to police or other regulatory bodies.

A. UKHCDO

271. On 15 May 2006 I wrote to UKHCDO to request documents.

272. I received a response on 12 June 2006 from Dr Charles Hay, Chairman of UKHCDO, which stated that, as a registered charity, the FOIA did not apply to UKHCDO and, furthermore, that as the FOIA discouraged "fishing expeditions of this sort" it was the UKHCDO's policy not the accede to such requests.

273. On 27 June 2006 I wrote to Dr Hay during the course of our ongoing correspondence regarding my request for documentation from UKHCDO. However, by this time, I had also become aware of Dr Hay's letter to William Connon at the DOH dated 17 November 2005 **(WITN1369044)** regarding recombinant treatment.

274. I do not believe that the UKHCDO themselves ever properly addressed my complaint.

275. At the same time, I wrote to the BMA, GMC and Healthcare Commission to raise my concerns about Dr Hay.

B. BMA

276. On 27 June 2006 I wrote to the BMA to make a complaint about Dr Charles Hay following correspondence that I had received from him in his role as Chairman of the UKHCDO.

277. The response I received on 2 August 2006 confirmed that the BMA was unable to investigate the conduct of doctors or charities at it fell outside their remit. I was referred to the Charity Commission (if my concern was about the conduct of a charity) or the GMC (if my concern was about a doctor's fitness to practice).

278. I had in fact already written to the GMC to highlight my concerns at the same time that I sent my original complaint to the BMA.

C. GMC

279. I received a response from the GMC on 7 July 2006 which stated that they had considered the information I had provided and decided that no further action was necessary.

280. The GMC concluded that the letters I had provided from Dr Hay did not appear to demonstrate any disregard towards the haemophilia community. They also said that there was no evidence that he had been involved with or condoned any experimentation which may or may not have taken place on haemophilia patients.

281. The letter suggested that I contact the Charity Commission or UKHCDO board direct if I had ongoing concerns regarding Dr Hay or the UKHCDO and that if I contact the Healthcare Commission if I had concerns about the overall healthcare provided to haemophilia patients.

D. Healthcare Commission

282. Again, I had already written to the Healthcare Commission on 27 June 2006.

283. I received a response on 5 July 2006 telling me that the issues raised regarding Dr Hay fell outside the Commission's remit.

284. This time I was referred on the Charity Commission and the National Institute for Health and Clinical Excellence.

E. Parliamentary Ombudsman

285. On 7 June 2006 I wrote to my local MP, Greg Hands, and asked him to consider making a complaint to the Parliamentary Ombudsman on my behalf in relation to the DOH's press statement that approximately 600 sensitive "Public Immunity" documents were destroyed by the DOH.

286. Questions answered in the House of Lords by Lord Warner mentioned that "current guidance states that decisions on retention or destruction should be made by 'whoever has best knowledge of the subject matter. The reviewer should be in Payband IP2 (Executive Officer Grade) or above'." I therefore wanted to know who had destroyed the documents, when they were destroyed etc.

287. Prior to this I had already attempted to contact the Parliamentary and Health Service Ombudsman by submitting a complaint form online but I subsequently realised that a complaint had to be registered through my MP.

F. CPS

288. When the Archer Inquiry opened in May 2007 a copy of Tainted Blood's Accusations Document was sent to all relevant officials and departments within the Government, including the CPS.

289. On 11 July 2007 the former Secretary of State for Health, Lord Owen, gave witness evidence to the Archer Inquiry and stated that he believed vital documents were selectively and with malice aforethought, destroyed in an attempt to avoid any criminal liability by the state or civil service.

290. As a result of this, on 19 July 2007 I wrote to the Chief Crown Prosecutor at the CPS on behalf of Tainted Blood enclosing a further copy of the Accusations Document and requesting that The Crown accept this as evidence that crimes had been committed and launch an investigation. The letter also raised the Right to Life pursuant to Article 2 of the ECHR.

Section 7: Litigation

A. HIV Litigation

291. The events set out under the ACVSB section above were all going on during the time of the HIV Haemophilia Civil Litigation which commenced in April 1989. The vast majority of haemophiliacs who were having samples taken for HCV testing were, at the same time, litigants in the HIV Haemophilia case but were unaware of the HCV testing or its results.

292. It seems clear to me that the testing of UK haemophiliacs for HCV was enacted over 1 year prior to the request for the waivers to be signed in relation to the HIV Litigation and that the Government were unlawfully gauging and trying to limit their liability for Hep C whilst we were already before the courts on the matter of HIV.

293. I was not aware that I was HCV positive at the time that I signed my waiver in the HIV Litigation.

294. This must either amount to material non disclosure by the defence in the HIV litigation or Misfeasance in Public Office. This of course forms the basis for

the current Contaminated Blood Group Litigation being brought on behalf of the haemophiliac community.

295. I wrote to Ann Milton (Parliamentary Under Secretary of State for Public Health) on 5 November 2010 following the debate and content of the Written Ministerial Statement on 14 October 2010. The statement was made following the outcome of the Judicial Review (which is discussed further below). Copies of the written statement and my letter are now exhibited at **WITN1369045.**

296. A copy of the Department of Health's response is exhibited at **WITN1369046.** This essentially stated that I had not provided any evidence that Ministers or Government officials ordered secret testing of all haemophiliac patients in order to gauge their liability for Hepatitis C during the HIV litigation.

297. I was very disappointed with this Department of Health reply, but it did not surprise me as I was not really expecting them to concede my claim, but I was not expecting them to quote the 20% chances for the original HIV Haemophilia Litigation. The only reason the chances at the time were 20%, was not due to liability being tested, but due to the vast majority of evidence that was kept back from the Plaintiffs at discovery – on the grounds of PII (Public Interest Immunity), and even when those documents were mostly released, they do not account for the vast wealth of material that has subsequently turned up at the TNA.

298. I wrote this letter because after reading the ACVSB minutes, I realised just how many events had taken place whilst I was a litigant in the HIV Haemophilia litigation, events and actions that should not have happened during the litigation as it gave a significant material advantage to the then Defence. I had spent time outlining how I saw things, but I had not actually sent the physical papers, where were the pertinent pages of the ACVSB minutes from which I had formed my opinion. It would not have been practical to attach all of the pages with this letter. I had made some serious allegations and claims in the letter.

299. *"As far as I'm concerned, there are countless examples of breach of duty and negligence. It is all the more insulting to the infected community when Government dwell on the fact that there has never been a Judicial Inquiry."*

300. I also wrote to Prof Napier under FOIA on 16 May 2006 to see if he had access pertaining to the 1987-1992 litigation because his firm, Pannone Napier, had been involved in the litigation on behalf of the Claimants. He was unable to respond because the FOI did not apply to private organisations.

301. In 2009 Haydn, Nick Sainsbury, Carol Grayson and Sue Threakall and I had a number of email exchanges regarding Haydn and Nick's continuing work to identify documents which were "missing" at the time of the HIV Litigation. Copies of these emails are exhibited at **WITN1369047.**

302. A FOI request was made for copies of the advice given by the Chief Medical Officer to the Secretary of State in August 1990. The Department of Health response dated June 2009 is exhibited at **WITN1369048.**

303. A number of documents were subsequently obtained including background papers relating to answers to Parliamentary Questions and a copy of the Chief Medical Officers advice to the Secretary of State dated 20 July 1990. These are exhibited at **WITN1369049.**

304. Contrary to the commonly-held misconception, there has never been any compensation, and certainly not restitution. In the early 1990s, I received a £21,500 one-off capital payment in respect of the HIV Litigation. In addition I believe there was a £20,000 one-off capital payment. The haemophiliacs, especially the healthier ones, were put under considerable moral pressure to accept this pitiful amount, being told that we should all accept it as time was of the essence because some of the haemophiliacs were very sick with AIDS and could easily not live to see the end of the trial. I wasn't even 18 years old. I now believe that the basis on which the amount was calculated was a mere 3-year life expectancy.

305. The worst part was the way the threat of the so-called waivers (termed "Deed of Undertaking" by the Department of Health) was used in order to coerce sick and dying haemophiliacs into accepting the derisory one-off amounts. I have no recollection of ever signing such a waiver. I would have been under the age of 18 at the time and I have also asked my parents about this and they do not recall ever signing one. The alleged waiver was said to indemnify the government against further legal action, but in reality it would have the effect of preventing haemophiliacs from taking any future legal action, particularly if they were to discover that they had been infected with another blood-borne virus. The timing of this waiver was

somewhat propitious for the Government since it turns out to be after the cloning and sequencing of Hepatitis C by the Chiron Corporation in 1987, and prototype tests were already in use prior to 3rd July 1989. Further testing of stored haemophiliac sera was being advocated by the ACVSB at this point: *"The Chiron test had been used in first time recipients of Factor 8Y. Preliminary results had shown no positives, while most recipients of earlier concentrates were Chiron positive. Further study of stored haemophiliac sera was advocated."*

306. The uncanny timing of this is simply too close for comfort as I believe that the then government knew during the HIV Haemophilia Litigation that the majority of multiply-transfused haemophiliacs also had HCV and that Government were trying to exclude our rights to legal remedies for something they already knew we had.

307. On 9 July 2006, I wrote to the then Secretary of State for Health, Patricia Hewitt MP, to ask if they could locate my signed 'waiver' of undertaking not to seek legal action regarding HIV and other pathogens from contaminated blood products. I stated that I have no recollection of signing such a document and that if I had, I would have been under the age of 18 at the time. I pointed out that the 'waiver' may have been signed by my parents (Mr Richard March and/or Mrs Gloria March), as I had not reached my 18th birthday at the time of the Macfarlane Trust Special Payment 2 (MFTSP2) in 1991. A copy of this letter is exhibited at **WITN1369050.**

308. I received a reply from Bilal Ghafoor of DOH Customer Services writing on behalf of the Secretary of State, dated 17 October 2006: *"We have carried out a search through the Department's files and we have not been able to trace your signed document. We believe that it may have been amongst several files which we know were inadvertently destroyed since that time. We have also approached the Macfarlane Trust for their copy of your waiver. Unfortunately, neither the Macfarlane Trust nor their legal representatives were able to find a copy of your waiver. "* A copy of this letter is exhibited at **WITN1369051.**

309. I also wrote to Martin Harvey at MFT to confirm that neither I nor my parents had any recollection of signing the waiver, that the DOH had no record of me signing it and that I had not received the MFTSP2 payment and requesting the payment as soon as possible.

310. I wrote to Michelmores LLP on 24 September 2007 enclosing copies of my correspondence with the DOH about the waiver.

311. It is clear from this that the DOH is not able to produce the alleged waiver of 1991, nor do they have any record of the MFTSP2 waiver. They even suggest that the waivers were among the destroyed files.

312. Bilal Ghafoor of DOH Customer Services went on to enclose a blank, unsigned example of a Deed of Undertaking that they claim was signed by other applicants in 1991. This bears little resemblance to an unsigned single-page fragment of what appears to be a waiver from the actual time that I have as a PDF. The example sent by the DOH in 2006 is clearly a modern version typed on a P.C., perhaps intended retrospectively but worded as I would expect them to today. The fragment is clearly a scan of an original typed document where the language used is of its time, for example, the use of the Crown. I was not convinced by this attempt to appease my request by sending a blank example waiver. Copies of both documents are exhibited at **WITN1369052.**

313. I believe that the waiver is now deemed rescinded, or null and void. I do, however, feel conned by the government over this, and what I can only describe as deception and immoral tactics by the Government of the day have done lasting damage to the haemophilia community.

314. In May 2006 I requested documents from the HIV Litigation from both J Keith Park Solicitors and the Royal Courts of Justice. J Keith Park confirmed that their documents had been returned to other solicitors. I do not recall ever receiving a response from the RCJ.

315. It is accepted that papers relating to the HIV were not adequately achieved and were destroyed in error. I collated information about this in "The Shredding Fiasco" section of the SSCM website. **WITN1369053.**

B. vCJD Litigation

316. In July 2009 I commenced a legal action regarding my exposure to vCJD. The case did not progress beyond the most embryonic stage.

317. I instructed Michelmores Solicitors. The potential claim was for psychological injury as a consequence of exposure to vCJD and for the stigma of my public health status (ie. "at risk").

318. As part of their investigations they wrote to Dr Bevan, my treating doctors, for details of my condition and prognosis. Dr Bevan was also in correspondence with Prof Tuddenham at the Royal Free at the same time to check whether they had retained any tissue samples.

319. An application was made for funding from the Legal Services Commission relating to the fact that I had been informed I was at risk of having contracted vCJD due to my confirmed receipt of blood products manufactured from blood taken from a donor who subsequently died of vCJD. The donor's vCJD infective status was confirmed by post mortem examination and the recipients of products made from his blood were all then informed of their "at risk" status.

320. The key question on breach of duty was whether any steps could have been taken at a strategic level to prevent or minimise the exposure and potential infection with vCJD. The details of the allegations are set out at pages 4 to 6 of the summary sent by Michelmores to the LSC which is exhibited at **WITN1369054.**

C. American Pharmaceutical Litigation

321. I instructed Lieff Cabraser Heimann & Bernstein LLP to represent me in the American Haemophilia Litigation. The claim was commenced against Bayer and other commercial fractionators in the UK from July 2003.

322. The Defendants were successful in having the claims dismissed on the basis of *forum non conveniens.*

323. In 2006 I asked for the memos of the pharmaceutical companies.

D. UK Bayer Litigation

324. On 23 July 2007 a small number of TB members (including me) went to Exeter with a number of other UK haemophiliacs and met with 2 representatives of Michelmores solicitors to discuss the possibility of further legal action in the UK. The TB Committee made it clear to its members that it could not make any recommendations following the meeting but we passed on the information so individual members could decide whether to contact Michelmores and we provided the relevant contact details.

325. Bayer were subsequently served with 5 sets of proceedings in December 2007. The Defendants position was set out in the Witness Statement of Mr Dodds-Smith dated 10 March 2008 and exhibited hereto at **WITN1369055**.

E. Judicial Review

326. I applied for a Judicial Review in 2010 to challenge the Government's decision not to implement recommendation 6H of Archer independent inquiry that victims of contaminated NHS blood products who contracted HIV and hepatitis C should be compensated at a level equivalent to the level at which such victims are compensated in Ireland *R (on the application of Andrew Michael March) v Secretary of State for Health* [2010] EWHC 765 (Admin). The Government's decision was quashed by Mr Justice Holman where he found that the Government's approach to this decision had been and remained infected with error.

327. I have already provided a copy of the Judicial Review papers to the Inquiry.

328. On 9 June 2010 the Secretary of State for Health confirmed that the successful JR would not be appealed and that the Government would go on to consider a full response to recommendation 6(h) of the Archer Inquiry.

F. Green Paper Challenge

329. In 2012 I commenced a second JR in respect of the Parliamentary Green Papers entitled "Justice and Security" because TB was concerned about the implications of the Government proposals (as set out in the Justice and Security Green Paper) for legislation to expand closed material procedures (CMPs) to all civil proceedings. This was of particular concern given the use of public interest immunity in the original HIV Litigation and the fact that it proved difficult to secure full

disclosure from the Government. Public Law Solicitors were instructed in these proceedings.

330. The Ministry of Justice consultation on the Green Paper closed on 6 January 2012 but TB did not become aware of the consultation until 29 February 2012. Following that I prepared a response to the same with Sue Threakall. The response document was dated 17 March 2012 and is exhibited at **WITN1369056.**

331. I also corresponded with Lynn Fraser at Thompsons about this to see whether there had been any issues regarding Public Interest Immunity during the course of the Penrose Inquiry.

332. In July 2012 an agreement was reached between the parties and I withdrew the claim for judicial review following confirmation from the Secretary of State for Justice that the clauses in the proposed Bill to introduce CMPs in ordinary civil proceedings would only apply to cases in which the disclosure of information would be damaging to the interests of national security. A copy of the Order is exhibited at **WITN1369057.**

G. Gullone Complaint

333. On 17th April 2003, I used a contact form with U.S. Law firm, LCHB. The Auto-Reply came back from Attorney Heather Foster. I am not entirely certain whether I was already a client at this point, although I would have been aware that a legal case was getting off the ground in the USA, because I had had contact with Anderson Eden who were handling transfer of medical notes in the UK from at least as early as 2002.

334. In June 2004, I became aware of the existence of a document comprising the full allegations of the Plaintiffs' in the *Gullone et al* case in the USA. I had been in conversation with a paralegal at LCHB by the name of Kathlyn Querubin, when she mentioned the complaint. I then emailed her about it on 30 June 2004 and asked if she would be willing to provide me with a copy. Kathlyn replied saying that she had put a copy in the post for me, but that she had attached a Word doc. version to the email.

335. I naturally requested a copy of the complaint document because it comprised the grounds of the US class action case. I was also trying to collect as many

articles/documents as possible that related to the litigation for future reference. Although the complaint document was rather verbose, I was surprised at how clear the allegations were and how detailed it was.

336. The principal allegations of the complaint are exhibited at **WITN1369058.**

H. Support Review

337. In February 2013 Adrian Goodyear was looking at a case in relation to the Support Review. The TB Committee were trying to provide answers to Karen Ashton, Solicitor at Public Law Solicitors Birmingham. After extensive research, we largely determined that the answers to her questions were not something we could lay our hands on. We produced "TaintedBlood's Answers to Questions 1 & 2:" in response. It appears that I created this document on 4 February 2013 but this would not have been solely my work. I would have been working in close conjunction with GRO-A, Sue Threakall, Mark Ward and the prospective claimant Adrian Goodyear.

338. I was already a client of Public Law Solicitors Birmingham due to the Green Paper challenge.

339. From early 2011, TB had wanted to challenge the legality of the Government's Support Review of January 2011, particularly whether the decisions that informed the Support Review were based on flawed evidence (because the Expert Group failed to consider the particular circumstances of those with haemophilia).

340. On 29 November 2012, an important meeting was held which was attended by campaigners, the then Minister, Anna Soubry, the Department of Health and the Expert Group on Hepatitis.

341. Before the meeting, three reasons had been given as to the purpose. It was the third of these reasons that we were particularly focussed on:
"Any aspects of the evidence base which are identified at the meeting that are thought to merit further consideration can be put to the Advisory Group on Hepatitis for detailed consideration and advice."

342. We took this to be a legal promise made specifically to us. Also, there had been some new information which came to light during the meeting with the Minister on 29 November 2012; information which cast doubt on the soundness of the evidence used by Government and their scientific and clinical expert panel.

343. The TB Committee were particularly concerned to learn during the meeting that the expert evidence (which informed the government's Support Review) had relied on research drawn from those who had contracted Hepatitis C as a result of I.V. (intravenous) drug use and did not appear to take into account the very special, unique position of those with haemophilia; particularly in relation to our exposure to multi-contaminant infection.

344. So we approached Karen Ashton at Public Law Solicitors, Birmingham, at some point in the first week of December 2012, to discuss a challenge to the lawfulness of the DOH Support Review. However, it quickly became clear that we were many months out of time. It was during this meeting that we learnt that a case might be able to proceed on a different basis – the effect of the promise made in advance of the meeting, along with the new information that had transpired.

345. Adrian's valiant claim was quite drawn out and lasted over 3 years - until around August 2015. Over this time the case developed a great deal, however, the case never went to Court.

346. On 7th March 2017, TaintedBlood produced a detailed explanation entitled: "Adrian's Legal Action – The "Support Review" Case". (Attached)

Section 8: Other Inquiries

Archer Inquiry

347. Haydn Lewis and I were asked to give a presentation to the Archer Inquiry regarding Tainted Blood. A transcript of this is exhibited at **WITN1369059.**

348. TB's Accusations Document was presented to Lord Archer as part of the presentation. A copy of the same is exhibited at **WITN1369060.**

349. I prepared submissions to the Archer Inquiry on Secretive and Non Consensual Hepatitis C Testing dated 9 July 2008. I was also involved in preparing the TB Submissions.

350. In September 2008 I wrote to the Secretary of State for Health re vCJD testing and sent a copy of that letter to Lord Archer.

351. Following the Archer Inquiry I prepared a comparison document of the Government's Response as contrasted with Lord Archer's recommendations.

352. Following the recommendations of the Archer Inquiry I started a Petition asking the PM to "implement the recommendations of the Independent Public Inquiry Report into NHS Supplied Contaminated Blood and Blood Products, chaired by Lord Archer of Sandwell." The Petition closed on 6 June 2009 with 4,316 signatures.

353. I wrote to Andy Burnham on 5 June 2009 regarding the Government's Response to Lord Archer's report.

354. At the same time I also wrote to William Connon, Head of the Blood Policy Unit at the DOH and the Secretary of State for Health confirming that I would continue to campaign for full equality with Ireland and stressing that I did not consent to or accept the Government's proposed increase of the MFT post May 2009 funding.

355. I was so concerned about the MFT at that stage that I also wrote direct to Lord Archer about my concerns.

356. I received a response on 24 June 2009 from the DOH. This effectively sought to distinguish the UK's position from that in Ireland. A copy of the same is exhibited at **WITN1369061.**

357. It was this correspondence which effectively sowed the seed for the JR that followed as discussed above. I also sent copies of the JR papers to Lord Archer.

358. On 21st March 2012, I felt the need to start writing my own critique of the Independent Archer Inquiry. I entitled my document: *"How the Archer Inquiry failed to address the need for a judicial inquiry - A Cake Fight in a Tea Room"*. I felt that the Archer Inquiry had been very anaemic and totally shy in its questioning and lines

of investigation. This was in no way Lord Archer's fault, however, it was my opinion, at the time, that the Archer Inquiry was about as 'pointed' in its inquisitorial approach as a flying cream horn in a tea room – hence my subtitle. I went into considerable detail over 44 paragraphs.

359. Paragraph 13 from my document encapsulates the crux of my concerns:

"13. At each hearing, witnesses were placed under restrictions regarding the naming names; such as names of treating physicians, hospitals, names of Regional Transfusion Centers, even researcher's names and published works could not be referred to. It all added to the feeling of it being a farce. Lord Archer who would remain silent when important connections needed to be made or pointed out would cut in decisively and prevent any physician or Minister's name from being mentioned. If the name was vocalized, then it would not appear in the transcript. In fact, on the publication of the Archer Report (23.02.09), the Associated Press reported that: "House of Lords member Peter Archer's report called the scandal a "horrific human tragedy" but did not name any specific medical workers or pharmaceutical companies as being responsible for the deaths of around 2,000 hemophiliacs since the 1970s."

Penrose

360. My involvement with the Penrose Inquiry was minimal, although I followed it remotely, as it were.

361. On 24 June 2011, I sent an email to Bruce Norvel in Scotland, asking him whether he was aware that buried deep within the 14 Volumes of the ACVSB, there was mention of the SNBTS and haemophiliacs in Glasgow. I made the claim that there was proof in the ACVSB minutes that the SNBTS tested 146 haemophiliacs in Glasgow for HCV using early tests and that the timing of this coincided with the Haemophilia HIV Civil Litigation which commenced in April 1989. I went on to state that the SNBTS found that 63% of the Glasgow haemophiliacs were positive for HCV using the new Chiron / Ortho ELISA test which was conducted between September and October 1989, which was over 1 year before the alleged waivers emerged.

362. My thoughts on this was that whilst the document didn't say that the testing was secretive, I had a strong hunch that the Scottish haemophiliacs being tested for

HCV would not have known. I was concerned that the Penrose Inquiry may have overlooked this.

363. In August 2011, a request from Bruce Norval in Scotland was relayed to me via my haemophiliac friend Mark Ward, asking whether I would be willing to speak to Lynn Frazer at Thompsons solicitors. I believe it was my email to Bruce of 24 June that precipitated this.

364. After discussing the ACVSB papers with Lynn Frazer at Thompsons Solicitors, it became clear that they needed the material I had. I then sent 110 files on a small data-stick by special delivery on or around 24 August 2011.

365. Around 2 years later, I had been reviewing some Department of Health correspondence from 2010. I felt that it was important the Thompsons knew about the content of the correspondence, so I emailed Patrick McGuire on 27 August 2013. I attached two PDFs to the email: my outbound letter to Anne Milton of 5th November 2010 and the DOH customer service centre reply of 19 November 2010 at **WITN1369062**.

366. I knew it was very late in the day as the Penrose final report was being drafted, but I still sent the email because I felt that the two letters were a strong reminder of the involvement of Ministers from London in what appeared to be a nationwide drive to garner samples from haemophiliacs and secretly test them over a year before the HCV test became widely available and the fact that this happened smack bang in the middle of our HIV litigation. This enabled Government to gauge their liability for another virus, one which I didn't know about at the time, but because knew, they were able to unfairly protect their position using the waivers. I believe these actions to be unconscionable.

367. I don't recall ever receiving an email reply or acknowledgement to my email of 27 August 2013.

368. My only other involvement with Penrose was by attending the final press conference on the day the Final Report was released. I've mentioned this awful day in my account of media work I have been involved with above.

Section 9: Haemophilia Society

369. I had contact with Chris James, Chief Executive of the Haemophilia Society, from at least June 2010 and possibly earlier. He was keen to help bring the main campaign groups together so that our aims could be more streamlined. I sent an email to Chris James on 2 October 2012 explaining the outcome of the Closed Material Procedures case and included a copy of the final Sealed Order form the High Court.

370. The TB Committee worked very closely with the then Chief Executive of the Haemophilia Society, Chris James, on various pieces of work. For example, a draft Press Release of 20 January 2010, entitled "Draft Statement on Contaminated Blood Bill". I would best describe my involvement, as part of the TB Committee, as 'emergency proofreading'.

371. I was in correspondence with Liz Carroll, Chief Executive of the Haemophilia Society between June 2014 and September 2017. The reason for this could have been one of several: the APPG, requests for help with a media inquiry or my music. In 2014, Liz Carroll took a keen interest in one of my choral pieces "Your Eyes Fall Upon Us", which I composed as an anthem for remembrance. Sue Threakall helped with the words. Liz Carroll liaised with the organisers of the Annual Thanksgiving Service in London, to see if the Anthem could be included in the service. The piece has been part of the service each year since.

372. In late February 2018, I worked alongside Sue Threakall on a brief project to provide Collins Law Solicitors with as much historic file material as I could find that related to the Haemophilia Society. This was very much a team effort, but the material we each had varied considerably and very little of it doubled-up.

373. The material I supplied mainly took the form of items which I had collected over the years. The files included: Letters to and from the Haemophilia Society (including specific correspondence from 1983 and 1990), HS press releases, Haemofact pamphlets, internal memoranda, various solicitor's letters which mentioned the HS in some way, HS Bulletins and press cuttings. I also provided items from the Penrose Inquiry's wider body of evidence; such as two letters from Thompsons Solicitors to Mr Douglas Tullis, Solicitor to the Penrose Inquiry, 9th

November 2011. There was mention of the provision of funding to the Haemophilia Society by manufactures of blood products which caught my eye.

374. I kept an impromptu inventory of the material sent from both myself and Sue, which I entitled: "Items on H.S. Sent to Collins Solicitors (Feb 2018)". The main purpose of the inventory was to help prevent duplication of items being sent, but it also provided an opportunity for a certain amount of explanation on the items being sent, where we provided our take on it, and any personal background details which related to the material.

Section 10: Trusts and Schemes

375. I was a member of the Macfarlane Trust Partnership Group for a number of years, from at least 2004, but in all likelihood from a year or two before that. The Partnership Group would meet every few months or so with the staff of the Macfarlane Trust, where a number of beneficiaries would discuss their concerns with MFT leadership, the Chairman, Chief Executive and sometimes members of the Board of Trustees would be present. We acted as a sounding board, providing feedback on any plans they had, particularly before widening out any proposed changes to the rest of the community of care. The discussions would often concern issues with our regular pay (monthly support disbursements). The staff of the Trust were usually intransigent on pretty much anything we asked for or suggested. It was very hard work and it would usually take many months before they would come round to even considering our position, let alone any concessions. By December 2004, the Macfarlane Trust had created the NSSC (The National Support Services Committee). This panel was seen as controversial right from its inception. However, they did help me with a music recording project in 2012 for which I am very grateful. It goes without saying that the NSSC was not popular with beneficiaries and this is an example of how the Partnership Group's wishes could be simply overridden. I was still a keen member of the Partnership Group throughout 2008 and 2009.

376. In November 2011 I contacted Herbert Smith regarding both the MFT and the SF because it appeared that plans were afoot to uncouple the historic link between annual inflation increases and the April uprate in state benefits.

377. In June 2012 I obtained legal advice from Limbach Banham Charity Law Solicitors in relation to the MFT in conjunction with another MFT primary beneficiary because I got very cross about the interpretation of "charitable need". This initiative started because it seemed to me that my friend needed some legal advice so I suggested that he use the Law Society's "Find a Solicitor" page to look for a solicitor who specialised in charity law. I then offered to attend the appointment with him to offer support. The purpose of the advice was to look at whether the MFT's means-testing of support was lawful and to examine whether the MFT were still operating according to the provisions of the Trust Deeds (which had been amended on several occasions). In particular, we wanted to know whether the charitable need specifically had to be financial. From the advice we received (exhibited at **WITN1369063**) it seemed to us that it did not.

378. At around the same time I was in email correspondence with Martin Harvey (the then Chief Executive of MFT) regarding a number of matters. Copies of this correspondence are can be made available to the Inquiry if required.

379. In 2015, the Government committed to reform the support schemes through a consultation. The Department of Health decided to have a one-off meeting which was intended to help inform the development of the consultation. I took part in the ad hoc meeting of the Reference Group on Contaminated Blood held on 5 October 2015. This meeting was not directly with the Department of Health, but with an Independent Facilitator, Gerard Hennessy. Later in October 2015, I was also part of the team who reported back to TB members with what had taken place at the meeting. Along with TB and other campaign groups, I helped by providing feedback and suggestions on the Reference Group Draft Report. This was prior to the introduction of EIBSS.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed GRO-C

Dated 31 MARCH 2020