

1 Tuesday, 19 July 2022

2 (10.00 am)

3 **SIR BRIAN LANGSTAFF:** Welcome, Mr Macniven.

4 **THE WITNESS:** Thank you very much.

5 **SIR BRIAN LANGSTAFF:** Let me explain the arrangements for  
6 today. They're slightly unusual because things don't  
7 always work out as you had planned. And on this  
8 occasion, although if you were in this room -- for those  
9 who are watching online -- you would see someone sitting  
10 at counsel's chair, in fact, you're going to be  
11 questioned online.

12 There is no accounting, really, for the way in  
13 which Covid works and, for reasons related to Covid,  
14 Mr Hill will not be with us today, just to make sure  
15 that we are all, if you like, as secure as we can be.

16 So the arrangement is that he will ask you the  
17 questions online. You, I'm very glad to say, are here.  
18 Thank you very much for coming down from Edinburgh to be  
19 here. Particularly, I think, you were -- last week you  
20 were in Australia. So --

21 **THE WITNESS:** I didn't come back especially for this!

22 **SIR BRIAN LANGSTAFF:** Oh, you shouldn't have said that.

23 Anyway, you're not just talking to the small  
24 audience you see here today, those in front of you are  
25 participants, those to the left are lawyers. At the

1

1 can say in your evidence to this Inquiry today?

2 **A.** I can think of none.

3 **Q.** Your career, if we may begin with that. You joined the  
4 Scottish Office as a graduate trainee in 1973. Is it  
5 right that you graduated in history?

6 **A.** Correct, yes.

7 **Q.** No medical background at all?

8 **A.** No.

9 **Q.** You had various roles before being promoted to Assistant  
10 Secretary in the Scottish Home and Health Department in  
11 1986 and is it right that you headed the division  
12 responsible for the Scottish Office's interests in the  
13 Blood Transfusion Service?

14 **A.** Yes, that's correct.

15 **Q.** Did that include both blood products, Factor VIII and  
16 Factor IX products, produced at the PFC, as well as  
17 blood transfusion?

18 **A.** Oh yes, it included all the Scottish Office's interest  
19 in the Blood Transfusion Service.

20 **Q.** We'll come on in a second to look at some of the  
21 structures and place you within the wider hierarchy,  
22 but, for now, can I just check this was your first post  
23 in a health department?

24 **A.** Yes, that's correct.

25 **Q.** Your written evidence to Lord Penrose was to the effect

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1 back there are representatives of the press and others.

2 Online, however, there will be a much larger audience  
3 numbering in three figures. They'll be watching on  
4 a mixture of live stream or YouTube and, in particular,  
5 I expect, given today's heat, there may be more watching  
6 indoors than might otherwise have been the case.

7 Mary will invite you to take the oath in a moment  
8 and then Mr Hill will ask you the questions.

9 Mary.

10 **DUNCAN MACNIVEN (sworn)**

11 **Questioned by MR HILL**

12 **SIR BRIAN LANGSTAFF:** Mr Hill?

13 **MR HILL:** Mr Macniven, can I just check that you can see me  
14 and you can hear me?

15 **A.** Yes, that's absolutely fine, thanks.

16 **Q.** You have given a witness statement to this Inquiry dated  
17 8 June 2022. You also provided three witness statements  
18 to Lord Penrose's Inquiry in September and October 2011  
19 and you appeared before his Inquiry three times in  
20 person in November and December 2011; is that correct?

21 **A.** Correct, yes.

22 **Q.** That evidence that you've given is accurate to the best  
23 of your knowledge and belief; is that right?

24 **A.** Yes, indeed.

25 **Q.** Other than memory, is there any inhibition on what you

2

1 that you joined in early May 1986; is that right?

2 **A.** Yes, that's right.

3 **Q.** And that you remained in the Scottish Home and Health  
4 Department until 1990 but, from the summer of 1989, you  
5 were working on the team responsible for the Scottish  
6 element of the NHS and Community Care Act, as it became?

7 **A.** That's correct.

8 **Q.** Does that mean that from summer of 1989 onwards you  
9 didn't have any involvement in blood policy and blood  
10 products policy, save where they interacted with the  
11 Act?

12 **A.** Yes, and they didn't interact to any extent that I can  
13 remember.

14 **Q.** In effect, then, we are looking at the period from  
15 May 1986 until summer '89 as the period in which you  
16 were directly involved in blood and blood products?

17 **A.** Yes.

18 **Q.** You had various other roles within the Civil Service  
19 that you set out in your witness statement, in  
20 particular the section 2. Is it right that you spent  
21 a full career as a civil servant in Scotland?

22 **A.** That's correct, except that my responsibilities as  
23 a forestry commissioner from '98 to 2003, or '99 to  
24 2003, extended to the whole of Great Britain.

25 **Q.** You retired in 2011 with your last post being Registrar

4

1 General for Scotland?

2 **A.** Yes.

3 **Q.** What level of Civil Service role was that final post?

4 **A.** It was what is, in modern parlance, called a "director",

5 "grade 3 undersecretary", there were various terms, but

6 "director" is the current term.

7 **Q.** Thank you.

8 Let's turn, then, to the structures of the

9 Scottish Office which are very helpfully set out in your

10 statement. I'm going to ask that this be brought up on

11 the screen. I'm not going to read through it, we'll

12 talk through it rather than read through it, but just so

13 people can have it as a point of reference, if we can

14 have on the screen please, WITN7064001 and if we can

15 just have page 1 first of all, just to orientate

16 ourselves. Can I just check that's come up on the

17 screen in front of you?

18 **A.** Page 1 is in front of me at the moment.

19 **Q.** Yes. We can see from that that it is the first page of

20 your written statement to this Inquiry, dated 8 June.

21 I'm going to take us, please, to page 5 of that document

22 and, in particular, paragraph 9.2.

23 **A.** That's fine.

24 **Q.** As I say, I won't read through it but let's instead talk

25 through it. We are dealing, it's important to remember,

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1 a minister of the Scottish Office and later the

2 Secretary of State for Scotland. In terms of the

3 Civil Service position, the Scottish Office had, at its

4 head, the Permanent Secretary. For simple parlance,

5 we'll call that "tier one". Then the Scottish Office

6 was broken up into four departments, is that right, or

7 a number of departments?

8 **A.** A number of departments. I think it was greater than

9 four. I think it was maybe five.

10 **Q.** The one we are concerned with is the Home and Health

11 Department --

12 **A.** That's correct.

13 **Q.** -- referred to sometimes, the SHHD, Scottish Office Home

14 and Health Department --

15 **A.** **(The witness nodded)**

16 **Q.** -- but internally, within the Scottish Office, often

17 referred to simply as HHD, for obvious reasons.

18 The Home and Health Department was headed by

19 a Secretary --

20 **A.** **(The witness nodded)**

21 **Q.** -- in the terminology at the time. That's, as it were,

22 the second tier of the Civil Service.

23 **A.** **(The witness nodded)**

24 **Q.** Then, within each department, there were groups of

25 divisions --

7

1 with the Scottish Office before devolution, the

2 Westminster department that covered matters concerning

3 Scotland; is that right?

4 **A.** Yes, but devolution has two aspects. What you're

5 talking about is legislative devolution which came with

6 the setting up of the Scottish Parliament in 1999.

7 Before then, as my statement brings out, there was

8 a very large measure of executive devolution to the

9 Scottish Office, so that it wasn't a question --

10 Parliament in London legislated but there was a great

11 deal of executive devolution to the Scottish Office.

12 **Q.** What areas -- it's perhaps easiest to ask what areas the

13 Scottish Office didn't cover than what they did cover?

14 **A.** Too complicated a question, I'm afraid. Because it was

15 rather similar -- the degree of executive devolution

16 before 1999 was rather similar, the subject areas were

17 rather similar to those that were legislatively devolved

18 from 1999, so things like foreign affairs, defence,

19 social security.

20 **Q.** Other matters including health were devolved --

21 **A.** Yes.

22 **Q.** -- executive form, to the Scottish Office. We'll look

23 at the range of topics in which you were involved in due

24 course. It's also something that we'll pick up with

25 Lord Forsyth tomorrow, from the perspective of both

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1 **A.** **(The witness nodded)**

2 **Q.** -- and they were headed by an Under-Secretary --

3 **A.** **(The witness nodded)**

4 **Q.** -- which was the third tier.

5 **A.** **(The witness nodded)**

6 **Q.** Then each of the divisions was headed by an Assistant

7 Secretary, which was the fourth tier, and that was your

8 role from 1986 to 1999; is that right?

9 **A.** That's correct. Strictly speaking, some divisions were

10 headed by a Senior Principal rather than an Assistant

11 Secretary but the difference was a marginal one.

12 **Q.** You were an Assistant Secretary throughout the period we

13 are dealing with?

14 **A.** Correct.

15 **Q.** Then below the divisions there were branches?

16 **A.** **(The witness nodded)**

17 **Q.** The one that -- the terminology changes, confusingly

18 over time, but often the relevant branch for us is

19 branch 3.

20 **A.** **(The witness nodded)**

21 **Q.** That would have been headed by a Senior Executive

22 Officer, an SEO?

23 **A.** Again, practice varied depending on the difficulty of

24 the command but it was normally -- a branch was normally

25 headed by a Principal -- grade 7 in current parlance

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1 I think -- and that was the case in my time or for most  
2 of my time there. But the difference between Principal  
3 and SEO was a trivial one.

4 **Q.** The tier that we're now looking at for that SEO is tier  
5 five, as we've gone down there.

6 **A.** (The witness nodded)

7 **Q.** So your division was known as 4D?

8 **A.** (The witness nodded)

9 **Q.** Often referred to by Roman numerals, so it appears  
10 sometimes as "IVD" but, actually, we should read that as  
11 "4D"; is that right?

12 **A.** Yes, that's right.

13 **Q.** Just to confuse us all a little.

14 **A.** Yes, so that's the fourth division in the fourth group  
15 in the Home and Health Department.

16 **Q.** That gives us an idea, doesn't it, of the range of  
17 topics that the Home and Health Department was covering?

18 **A.** (The witness nodded)

19 **Q.** It is perhaps important to note that it's not just the  
20 Health Department but the Home Department as well.

21 **A.** (The witness nodded)

22 **Q.** What kind of areas would the Home and Health Department  
23 have to cover?

24 **A.** On the home side, it covered police, for which I was  
25 later responsible, prisons, criminal justice, licensing,

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1 resources and the comparison with the Department of  
2 Health. Before we do, if we could bring up PRSE0000358,  
3 which was a document that was prepared for  
4 Lord Penrose's Inquiry, and helpfully shows the  
5 different tiers and helps us also to put some names to  
6 those the people in different areas.

7 If we start at the top, the "Secretary of State  
8 for Scotland", we can see three listed there, to 1995,  
9 so for most of your period it would have been  
10 Malcolm Rifkind as Secretary of State?

11 **A.** Correct.

12 **Q.** Then "Junior ... Ministers with responsibilities for  
13 Health", first of all John MacKay, then Lord Glenarthur,  
14 from whom the Inquiry has already heard, and  
15 Lord Glenarthur said that he was Minister of State of  
16 the Scottish Office from 10 September 1986 to  
17 13 June 1987, and so he would have come into post fairly  
18 shortly after you took up post in the SHHD.

19 **A.** And was in post only quite briefly.

20 **Q.** Indeed, quite briefly, handing over to Michael Forsyth,  
21 later Lord Forsyth, who was the Under-Secretary of State  
22 for Scotland for the rest of your time at the SHHD --

23 **A.** That's correct. I mean, the paper records him being  
24 first an Under-Secretary of State and then the slightly  
25 more elevated role of Minister of State, but his

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1 a range of what you might call, in Whitehall parlance,  
2 Home Office functions, and I think I'm right in saying  
3 that three of the groups dealt with these home affairs  
4 matters.

5 Then there were two groups, 4 and 5, which dealt  
6 with health matters. Group 4, essentially, dealt with  
7 the running of the Health Service, whereas group 5 dealt  
8 with health policy and services, which were not run by  
9 the health boards and Common Services Agency, which were  
10 responsible day to day for running the Health Service in  
11 Scotland. So group 4 was a more managerial group and  
12 group 5 was more health policy.

13 **Q.** Did that division cause any difficulties in the  
14 formulation of policy?

15 **A.** I can recall none. I mean, we weren't talking about  
16 a large number of people and it's important to remember  
17 that the Scottish Office culture, if you like, involved  
18 close liaison, almost friendship, between the senior  
19 civil servants responsible for a whole range of topics.  
20 And the strength of that was that if you had a question,  
21 a problem, across the whole range of the Scottish  
22 Office's activities, you knew the person who was  
23 responsible for that, and you could liaise simply and  
24 without fuss with that official.

25 **Q.** We'll come on in a little while to the question of

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1 functional responsibility for health was unaffected by  
2 that promotion.

3 **Q.** It's important to note, is it not, that these ministers  
4 were responsible for health and other matters as well,  
5 the junior ministers.

6 **A.** (The witness nodded)

7 **Q.** I see you're nodding there. For the transcript, it's  
8 helpful if you could verbalise your answers.

9 **A.** Yes, okay, I verbalise a nod.

10 **Q.** Thank you.

11 Again, that's something we will pick up with  
12 Lord Forsyth tomorrow, but it must be kept in mind that  
13 their concern was not simply health but a number of  
14 other matters as well.

15 **A.** Yes, and think about that at the level of the Secretary  
16 of State; *a fortiori*, it was true of the Secretary of  
17 State.

18 **Q.** The next heading is the "Permanent Secretary of the  
19 Scottish Office", and we see the two name there:  
20 Sir William Fraser and Sir Russell Hillhouse.

21 Then the "Secretary of the [Scottish Home and  
22 Health Department]", so this is the tier 2 that we were  
23 referring to earlier. In your period, William Reid  
24 would have been the Secretary.

25 Then the "Under Secretary", and then it explains

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1 there that this is the person who headed up the groups,  
 2 and again, for your period, Hugh Morison, 1984 to 1988,  
 3 and Hamish Hamill, 1988 to 1990, would have been the  
 4 Under-Secretary and, in effect, your boss; is that  
 5 right?  
 6 **A.** Yes, not in effect my boss, in actuality my boss.  
 7 **Q.** Then if we move down to the divisions, on the next page,  
 8 please, we can see, as you said, they were headed either  
 9 by an assistant secretary, as you were, or a senior  
 10 principal, and the relevant division was "IVD", and we  
 11 can see you are listed there between John Davies and  
 12 before George Tucker.  
 13 Then the tier below the principals or senior  
 14 executive officers, this is tier 5 now, that's headed  
 15 the branches, and the names of relevance to us perhaps  
 16 are Alexander Murray, 1983 to 1987 --  
 17 **A.** Who was always called Sandy.  
 18 **Q.** Always was called Sandy. Tom Macdonald, '87 to '88, and  
 19 Rab Panton, 1988 to 1992.  
 20 If we could go on to the next page, please,  
 21 that is the administrative side. As we have seen with  
 22 the Department of Health and the Department of Health  
 23 and Social Security in London, there was also a medical  
 24 side of the Civil Service, and we have the names of the  
 25 Chief Medical Officers. For your period, Dr Iain

13

1 **A.** (The witness nodded)  
 2 **Q.** And Dr Macdonald was a deputy before becoming the CMO,  
 3 before your time.  
 4 **A.** (The witness nodded)  
 5 **Q.** During your time, Dr Graham Scott was the Principal  
 6 Deputy Chief Medical Officer --  
 7 **A.** The Deputy Chief Medical Officer. A Principal Medical  
 8 Officer was a different person. Graham didn't have  
 9 "Principal" in his job title.  
 10 **Q.** Sorry, did I say "Principal?"  
 11 **A.** Yeah.  
 12 **Q.** I meant to say Deputy Chief Medical Officer.  
 13 Do you know what Dr Scott's specialism as a medic  
 14 had been?  
 15 **A.** I will have known at the time but I can no longer  
 16 recollect.  
 17 **Q.** Then below the "[DCMO]" is the "Principal Medical  
 18 Officer ...". Dr Archie McIntyre was in that post for  
 19 some 16 years and throughout your period of time.  
 20 Was Dr McIntyre somebody with whom you worked  
 21 closely?  
 22 **A.** Oh yes, absolutely. Archie was our very distinguished  
 23 and energetic medical -- and experienced -- principal  
 24 medical officer.  
 25 **Q.** Do you know what his specialism would be?

15

1 Macdonald, 1985 to 1988, and Professor Ken Calman, 1989  
 2 to 1991, were the CMOs.

3 You say in your statement -- it's  
 4 paragraph 20.1 -- that you didn't have a particularly  
 5 close relationship with the CMOs but instead worked  
 6 primarily with the Deputy Chief Medical Officers. Is  
 7 that fair?  
 8 **A.** Yes, that's correct. I mean, I knew who the Chief  
 9 Medical Officer was and -- we knew each other, we nodded  
 10 to each other in the corridor kind of thing, but on  
 11 blood transfusion I don't recall any direct contact with  
 12 the Chief Medical Officer.  
 13 **Q.** Was there any reason why you didn't have any contact on  
 14 that policy with the CMO?  
 15 **A.** Simply that the staff of the Chief Medical Officer were  
 16 perfectly capable of dealing with the subjects without  
 17 my being involved with him. They were clearly involved  
 18 with him frequently.  
 19 **Q.** Were you involved with the CMO directly on other topics?  
 20 **A.** My recollection is yes, because we -- they were very  
 21 similar faces and -- but I don't remember what these  
 22 topics were. Until I changed job in 1989 and I had  
 23 a closer relationship with Ken Calman on the policies  
 24 that were underlying the NHS and Community Care Bill.  
 25 **Q.** Deputy Chief Medical Officers are listed there as well.

14

1 **A.** No, I can't remember. Again, I will have known at the  
 2 time but it's 35 years ago.  
 3 **Q.** We can always look elsewhere to try to find the answers  
 4 to questions as well.  
 5 **A.** Indeed.  
 6 **Q.** Then below the "Principal Medical Officer ..." was the  
 7 "Senior Medical Officer ...", and the relevant name for  
 8 your period is Dr John Forrester, 1985 to 1988.  
 9 Again, somebody with whom you worked closely?  
 10 **A.** Oh yes, absolutely.  
 11 **Q.** The post was vacant from 1988 until Dr Skinner took over  
 12 in 1989. Do you recall why the post was vacant?  
 13 **A.** No, I don't I think it was just that John Forrester  
 14 retired and it took them a moment to find Ros.  
 15 I don't recall the vacancy being a long one, and  
 16 in that vacancy I would have referred to Archie McIntyre  
 17 if I'd required advice. In other words, there was not  
 18 a gap in the chain of advice. There may have been a gap  
 19 in the personality of the senior medical officer.  
 20 **Q.** Do you recall any difficulties being caused by that post  
 21 being left unfilled?  
 22 **A.** No, not at all. It would very much surprise me if there  
 23 were any such difficulties.  
 24 **Q.** Before Dr Forrester, and indeed before your time at the  
 25 SHHD, was Dr Bert Bell, Albert Bell, who was in post

16



1 from at least 1974, possibly earlier, until 1985. We  
2 can see from the papers that there is reference to  
3 Dr Bell's departure being an event which meant that  
4 a lot of institutional memory left at the same time.  
5 Was that something you were aware of when you joined the  
6 department in 1986?

7 **A.** Yes, Dr Bell, whom I never met, was a name to conjure  
8 with. He was clearly an influential figure. I didn't  
9 appreciate a lack of advice from his departure. Perhaps  
10 because Archie McIntyre was so steeped in the matter, in  
11 the matter of the Blood Transfusion Service.

12 **Q.** There wasn't then a sense that there had been a gap in  
13 the institutional memory or a gap in the capabilities of  
14 the Department with Dr Bell's departure?

15 **A.** Yes, there clearly was because, as you say, he had been  
16 around for a long time and there was a loss of  
17 institutional memory. There always is when people  
18 retire. But it wasn't something that was a significant  
19 handicap to the Department, because, as I say,  
20 Archie McIntyre, a particularly distinguished operator,  
21 was there to act as continuity person.

22 **Q.** Dr Forrester, you mentioned that in 1988 he retired.  
23 Just so that we have something of a picture in our head  
24 of him, he had an interesting career where he originally  
25 studied classics, I believe, and then served in the war

17

1 make liaison with other people and he came across as  
2 rather cold and distant. He was in fact a very warm and  
3 pleasant man.

4 **Q.** Thank you. We will come back to Dr Forrester in due  
5 course, but I just want to refer to couple of other  
6 people that you mentioned within your statement at  
7 paragraph 14.1 -- we needn't bring that up. There's the  
8 Chief Pharmacist, Graham Calder. From your statement,  
9 you believe that it was Dr Calder who was responsible  
10 for medical licensing. That's not a matter in which you  
11 were involved; is that right?

12 **A.** Whether he was responsible for medical licensing, I'm  
13 not quite sure, but medical licensing was certainly not  
14 part of my responsibilities.

15 **Q.** Then from the finance group you mention in particular  
16 Hamish Robertson and Norman Kernohan, were these people  
17 with whom you would deal when sorting out funding and  
18 bids and --

19 **A.** Yes, indeed. They were close colleagues.

20 **Q.** Then you also mentioned Dr John Cash who was the medical  
21 director of SNBTS and we will come back to Dr Cash in  
22 due course. Is it right that you had limited dealings  
23 with the people at the Protein Fractionation Centre and  
24 would instead generally work through Dr Cash?

25 **A.** Yes, that's correct but you -- in the last paragraph

19

1 before switching to medicine, and he subsequently  
2 entered the medical Civil Service.

3 I believe that he was in general practice before  
4 he ended the Civil Service. Do you have any  
5 recollection of that?

6 **A.** No, I don't. I knew John Forrester very well, but  
7 I don't recall his CV.

8 **Q.** But it's right, isn't it, that by the time that he was  
9 in that post as senior medical officer, he was coming  
10 towards the end of his career --

11 **A.** (The witness nodded)

12 **Q.** -- and had considerable experience as a civil servant  
13 behind him?

14 **A.** He was certainly reaching the end of his career. The  
15 length of his experience as a civil servant I can't  
16 recollect.

17 **Q.** Can you give us something of the character of  
18 Dr Forrester?

19 **A.** Well, I think that's a slightly difficult question for  
20 you to ask me. However -- well, how good am I at giving  
21 a character reference to you or to anyone else?

22 John Forrester -- so this is said with a certain  
23 amount of tentativeness. John Forrester was a very  
24 careful, intellectual, intellectually capable man who  
25 was an introvert. He did not find it straightforward to

18

1 you've changed from dealing with the Scottish Home and  
2 Health Department and its personalities to dealing with  
3 the Blood Transfusion Service, which was a different  
4 organisation. But you're correct to say --

5 **Q.** You're quite right.

6 **A.** -- that my dealings were mainly with John Cash. I think  
7 he didn't have line responsibility for the Protein  
8 Fractionation Centre, which was a sort of -- which was  
9 a separate division of the Blood Transfusion Service,  
10 and although it seems slightly odd to say it, John Cash,  
11 although national medical director was not chief  
12 executive. But the personality of John Cash was such  
13 that, in effect, he was chief executive and, in effect,  
14 Bob Perry, who was the director of the Protein  
15 Fractionation Centre, was in John Cash's shadow, even if  
16 he wasn't formally responsible to him. So I dealt with  
17 John Cash.

18 **Q.** Let's turn, then, to that separate structure and you're  
19 quite right that Dr Cash is not a civil servant within  
20 the Scottish Office, in that sense. The Common Service  
21 Agency. Now --

22 **A.** Common Services Agency. It had more than one service.

23 **Q.** Let's bring up WITN7064001, page 6, please. This is  
24 again your statement. Again, I won't read through it,  
25 but we can discuss the matters raised in that

20

1 paragraph -- it's helpful for others to have it on the  
2 screen.

3 So the Common Services Agency was not part of the  
4 Scottish Office, and you describe it as being  
5 a statutory body that was, in essence, a holding company  
6 providing wide variety of services to a territorial  
7 Health Board. Could you just take us through that and  
8 explain the distinct roles between the health boards,  
9 the Scottish Home and Health Department, and the Common  
10 Services Agency?

11 **A.** Okay. The delivery of the Health Service to the public  
12 in Scotland was through the Territorial health boards,  
13 of which I think there were 14 or something -- 15,  
14 indeed, I say it in the statement --

15 **Q.** (Unclear: simultaneous speakers)

16 **A.** -- there are 14 now but there were 15 then. So they  
17 were the public facing element of NHS. It was to them  
18 that -- it was they that operated the hospitals, for  
19 which the general practices operated under contract.  
20 They delivered the Health Service locally. And the  
21 Common Services Agency, like the territorial health  
22 boards a creature of the 1978 NHS Scotland Act, was  
23 responsible for delivering services which it made sense  
24 to deliver at the Scotland level, rather than at the  
25 level of the 15 local health boards.

21

1 Blood Transfusion Service --

2 **A.** I'm sorry, I didn't catch the opening of the question.

3 **Q.** Sorry. If we think just about the relationship between  
4 the SHHD and the Scottish National Blood Transfusion  
5 Service, you've said that you worked with Dr Cash --

6 **A.** (The witness nodded)

7 **Q.** -- who was SNBTS.

8 **A.** (The witness nodded)

9 **Q.** You are SHHD.

10 **A.** (The witness nodded)

11 **Q.** What would the CSA bring in to that relationship?

12 **A.** It varied, from topic to topic. Although the Scottish  
13 National Blood Transfusion Service was part of the CSA  
14 and the CSA was responsible to the Scottish Office, the  
15 SHHD, in practice there was a great deal of direct  
16 contact between the SNBTS and SHHD on almost all  
17 matters. In other words, it was unnecessary to follow  
18 the hierarchical route through the CSA. One could  
19 shortcut.

20 But, formally, the SNBTS was part of the CSA. The  
21 general manager of the CSA, Jim Donald, was John Cash's  
22 boss, and was helpful in resolving some of the problems  
23 that inevitably arose between the SNBTS and the  
24 Department.

25 **Q.** Of course, we must remember that the CSA covered many

23

1 **Q.** Did that include the Scottish National Blood Transfusion  
2 Service?

3 **A.** Yes, the -- I described the Common Services Agency as  
4 a holding company, one of the -- one of its  
5 "subsidiaries" was the Scottish National Blood  
6 Transfusion Service.

7 **Q.** In contrast to England and Wales, which the Inquiry has  
8 heard about, you have a Scotland-wide Blood Transfusion  
9 Service, which also includes the fractionation centre as  
10 well?

11 **A.** Yes, that's correct. The Protein Fractionation Centre  
12 and the Regional Blood Transfusion Services were part of  
13 the Scottish National Blood Transfusion Service. And  
14 I should explain really, going back to your last  
15 question, that the 1978 Act, and indeed its predecessor  
16 legislation -- the predecessor legislation, because the  
17 1978 Act was a consolidation Act -- the Act made the  
18 territorial health boards and the Common Services Agency  
19 responsible to the Secretary of State.

20 It was the Secretary of State who was responsible  
21 for the Health Service in Scotland and for the  
22 appointments to and guidance for the territorial health  
23 boards and the Common Services Agency.

24 **Q.** If we think just about the relationship between the  
25 Scottish Office, the SHHD, and the Scottish National

22

1 other areas as well. Did they play more of a role in  
2 those areas in liaising between the SHHD and those  
3 providing the services?

4 **A.** I'm not sure that they did. The other major CSA service  
5 that I had responsibility for was the Scottish Ambulance  
6 Service, and I recall a similar direct relationship  
7 between me and the director of the Scottish Ambulance  
8 Service, John Wilby, as I recollect between me and  
9 John Cash in the Blood Transfusion Service.

10 **Q.** That does rather beg the question what was the point of  
11 the CSA?

12 **A.** I think the point of the CSA was less in the kind of  
13 delivery of the service, which was the sort of area  
14 we've been talking about and no doubt will talk about on  
15 the Blood Transfusion Service, and more about the  
16 governance of the CSA, because the board of the CSA --  
17 its management committee, I think it was called, but it  
18 was essentially its non-executive board -- comprised  
19 people from -- comprised external lay people but also  
20 people from the territorial health boards. It was  
21 always chaired, or in my time it was chaired, by a very  
22 distinguished former chairman of a territorial Health  
23 Board, the largest territorial Health Board, in fact.

24 So in governance terms, the important point was  
25 that it was offering a service to the territorial health

24

1 boards, and they were involved directly in its  
2 governance, whereas the previous arrangement before the  
3 reorganisation of the Health Service in 1973, I think,  
4 was that the Blood Transfusion Service -- there wasn't  
5 that layer of governance responsibility giving power to  
6 the territorial health boards in the oversight of the  
7 Common Services Agency's functions.

8 **Q.** Just for completeness, the chair you're referring to, is  
9 that Donald Macquaker?

10 **A.** Yes.

11 **Q.** Your role in this, if we may turn to that now. It's  
12 page 4 of your witness statement, paragraph 8.1. Again,  
13 if we bring that up. I think it is helpful perhaps just  
14 for me to read out the list of matters for which you  
15 have responsibility. You say:

16 "From 1986 to 1989, I headed the Division of the  
17 Department which discharged the Secretary of State for  
18 Scotland's responsibilities for the following subjects  
19 (in addition to blood transfusion services): health  
20 service land and property; health service building  
21 procedures and standards; procedures for the procurement  
22 of goods and services; emergency planning; oversight of  
23 the Common Services Agency; the ambulance service; and  
24 services for physically disabled people."

25 You then say that you had over 40 staff but your

25

1 Could I just ask you to expand on what you meant  
2 by that?

3 **A.** Yes, as you can imagine -- I mean you have concentrated  
4 on the past two years on the Scottish National Blood  
5 Transfusion Service, on blood transfusion, one of the  
6 topics that I was responsible for. And you can  
7 appreciate that, on that subject, quite a number of  
8 difficult issues arose during the three years.

9 Consider the next -- the other Common Services  
10 Agency service that I was responsible for, the Ambulance  
11 Service. We were facing a number of difficulties with  
12 the Ambulance Service, for example many ambulances in  
13 rural areas were staffed only by one person. So  
14 an ambulance would turn up, there would be its driver,  
15 and nobody else, which, as you can imagine, was  
16 suboptimal and we were very keen to find a way of  
17 staffing the Ambulance Service to eliminate that kind of  
18 work.

19 I use that as an illustration of the sort of issue  
20 that can come up in the other subjects which I was  
21 responsible for. On Health Service building,  
22 Legionnaire's Disease was a major threat and avoiding  
23 the transmission of Legionnaire's Disease by, for  
24 example, hospital air conditioning plant, was major  
25 issue.

27

1 role:

2 "... broadly speaking, was to provide leadership,  
3 purpose and direction to my staff, to contribute to  
4 policy-making and advice to ministers, to liaise with  
5 the relevant external parties and to resolve difficult  
6 issues."

7 The first point to note from that, Mr Macniven, is  
8 that is an extremely broad range of responsibilities for  
9 you; is that right?

10 **A.** It certainly seemed so at the time.

11 **Q.** Was that characteristic of the Scottish Office and the  
12 fact that it is covering so many different areas within  
13 one department?

14 **A.** Yes, not a universal characteristic because, remember,  
15 I moved to a job where I concentrated on one task, the  
16 passage of a Bill through Parliament, but it was -- but  
17 that post was perhaps atypical and more typical was what  
18 you've just read out, that every assistant secretary --  
19 you're talking about somebody that is at a fairly  
20 elevated position in the Civil Service, every assistant  
21 secretary had had a wide range of responsibilities.

22 **Q.** You say at paragraph 9.3 -- I won't bring this up but  
23 you wrote that, and I quote:

24 "The main problem was the volume and diversity of  
25 business."

26

1 On Health Service Procurement, we were very  
2 anxious to take advantage of the scope for value for  
3 money savings by getting the Health Service to purchase  
4 more efficiently.

5 Now, these fascinating topics are of less interest  
6 perhaps to the Inquiry than they were to me at the time  
7 but you can imagine that each of these kind of topics  
8 came across my desk in a bewildering variety and what --  
9 I had five branches working for me, the 40 staff were  
10 organised in five branches, and what you had to hope  
11 didn't happen -- and, fortunately, in the three years it  
12 rarely happened -- was a crisis happening on all five  
13 branches at the one time, so there was a huge variety of  
14 issues which were not entirely easy to resolve.

15 **Q.** Did your colleagues on the medical side, Dr McIntyre,  
16 Dr Forrester, did they have more of an opportunity to  
17 specialise in particular fields or did they have  
18 a similarly diverse range of topics with which they had  
19 to deal?

20 **A.** I don't think they had quite the diversity of topics  
21 with which I dealt. And on each of my -- I dealt with  
22 Archie and John, only on Blood Transfusion Service. On  
23 other matters, for example the Ambulance Service,  
24 I dealt with a different senior officer, whose name was  
25 David Drummond, and on Building Services, I dealt with

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1 a different medical officer. I can't remember what the  
2 precise boundaries of Archie's and John's work was, but  
3 they certainly were not responsible solely for advice on  
4 the Blood Transfusion Service.

5 I think they, and particularly Archie, who had  
6 been there for so long, had the opportunity to build up  
7 an experience and knowledge of the Blood Transfusion  
8 Service which was quite profound. So I don't think that  
9 you should get the idea that they were dilettante. They  
10 were, however, inevitably, greatly inferior in their  
11 theory or knowledge of blood transfusion practice and  
12 theory to our colleagues in the Scottish National Blood  
13 Transfusion Service who had spent a career in the  
14 specialty.

15 **Q.** "In the SNBTS, we had the greatest expertise", and  
16 the -- Dr McIntyre and Dr Forrester would have more of  
17 an opportunity to immerse themselves in that topic than  
18 you did but they wouldn't have as much as the SNBTS; is  
19 that right?

20 **A.** Absolutely, and could not possibly have achieved that,  
21 because they didn't have day-to-day responsibility for  
22 running the service.

23 **Q.** The range of topics that you had responsibility for  
24 plainly led, as you have described, to an immense press  
25 of business on you at points. Did that require, then,

29

1 about should there be a Blood Transfusion Service;  
2 should it be locally organised in the way you were  
3 characterising in England? No. That the kind of policy  
4 was established. There was no evidence that it was  
5 broken. It was unnecessary to fix it.

6 At a lower level of policy -- I can perhaps  
7 illustrate it by the Ambulance Service example that  
8 I gave -- there was a very strong ability to effect  
9 policy, in that case to adopt a policy of eliminating  
10 single-crewed ambulances.

11 **Q.** In the DHSS, we've seen -- or, sorry, the Department of  
12 Health, as it subsequently became, saw an element of  
13 Blood Policy Unit, bespoke to that area of policy. Was  
14 there any equivalent in the Home and Health Department  
15 or did the size of the Department not allow for that?

16 **A.** Yes, there was certainly nothing with a highfalutin  
17 title of that kind. It was perhaps unnecessary in the  
18 more compact circumstances of Scotland to set up  
19 a separate unit, but Blood Transfusion Services policy  
20 could be considered by a small room full of people, viz  
21 Graham Scott, Deputy Chief Medical Officer, Archie  
22 and/or John -- Archie McIntyre and/or John Forrester, my  
23 boss, myself, and John Cash. You could gather together  
24 six or seven people and discuss policy matters and, from  
25 time to time, that was done. And it depends what you

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1 a need for quick and efficient decision making on those  
2 topics?

3 **A.** Well, I would like to think so. I don't -- it's  
4 35 years ago. I don't remember, I don't have an abiding  
5 memory of inefficiency and incompetence.

6 **Q.** Did you have an opportunity to take a step back from  
7 this press of business and take a wider perspective,  
8 a more strategic perspective, or was it a case of having  
9 to deal with whichever fire had started at that time?

10 **A.** It wasn't quite as bad as firefighting all the time.  
11 The nasty times, which I was describing, fires in  
12 a number of branches at the one time, were the exception  
13 rather than the rule. But I think it would be correct  
14 to say that I was often tied up with the day-to-day at  
15 the expense of the strategic. There wasn't a lot of  
16 time to draw breath in this post, and think about  
17 strategy.

18 **Q.** The Inquiry has heard various people speak about the  
19 importance of an institutional memory and the momentum  
20 that goes with it, that the policy continues because it  
21 has been in place before. In your case, when you were  
22 there for three years and Dr McIntyre had been there for  
23 so much longer, do you feel that you were in a position  
24 to challenge or to change the existing policy?

25 **A.** It depends what you mean by "policy". If you're talking

30

1 mean, again, I come back to this question of "What do  
2 you mean by 'policy'?" But if -- I've drawn attention  
3 in my evidence to meetings which I think  
4 I initiated with the Blood Transfusion Service and the  
5 CSA, so tripartite meetings, involving also Jim Donald  
6 as a seventh member of that little unit, Blood Policy  
7 Unit.

8 And we convened, from time to time, to consider  
9 issues in the Blood Transfusion Service. Now, as I say,  
10 were these issues "policy" or not? It's up to you to  
11 define. But we could certainly do the necessary  
12 thinking to resolve matters in the Blood Transfusion  
13 Service by gathering together a small number of people.

14 **Q.** Let's turn to the role of ministers. You say in your  
15 statement --

16 Lawrence, we can take the statement off the screen  
17 now, thank you.

18 It's paragraph 11.1 but I won't bring it up. You  
19 say the most difficult and politically contentious  
20 matters would be decided by ministers but more  
21 day-to-day matters would be determined by those working  
22 within the Home and Health Department; is that a fair  
23 characterisation?

24 **A.** Yes, that's correct.

25 **Q.** How would a decision be made on what should go to

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1 a minister?

2 **A.** That was, throughout the Scottish Office, a very

3 difficult question, and the skill of the senior

4 officials of the Department was to identify issues which

5 needed to go to ministers because there was no rulebook.

6 You couldn't get an algorithm that gave you an

7 authoritative answer. It was a question of judgement

8 and people that had been around for a long time

9 developed that feeling and, of course, that feeling

10 varied from minister to minister. The advent of

11 Michael Forsyth, a particularly energetic and involved

12 minister, allowed us to put more matters to the minister

13 than we had previously been used to, and Michael Forsyth

14 expected to take decisions on a wider range of issues

15 than his predecessors had.

16 So it was a matter of judgement, with a certain

17 amount of iteration with the minister that you had at

18 the time. You can ask Michael Forsyth about that

19 tomorrow.

20 So it was a difficult decision, that, and it

21 varied with the subject and with the minister.

22 **Q.** Was the difficulty greater as a result of the very wide

23 range of issues that Scottish Office ministers had to

24 deal with?

25 **A.** Oh, yes, absolutely. And, nowadays, post-legislative

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1 goes to the minister?

2 **A.** It varied from time -- from circumstance to

3 circumstance. Normally, I would decide, as the

4 assistant secretary, what to put to ministers and what

5 not to put to ministers. You can ask Michael Forsyth

6 about this tomorrow but I would say, generally speaking,

7 no. Almost without exception, I got that judgement call

8 right, but I will have referred in difficult cases to my

9 boss and perhaps my bosses boss, to guide me with their

10 greater experience.

11 **Q.** Were their doors always open to you if you sought such

12 guidance?

13 **A.** Oh yes! Goodness me, yes. What, your boss's door open

14 to you? Yes, absolutely. And my door was entirely open

15 to my five direct reportees and, indeed, to folk like

16 Archie and John -- Archie McIntyre and John Forrester.

17 We operated in cellular offices. Very different from

18 the open plan today.

19 Literally, our doors were closed because people

20 talked as they walked along the corridor, which was ill

21 disciplined of them, and you didn't want noise drift in

22 either direction. But, metaphorically speaking, doors

23 were very much open, and all I had to do was to pop

24 along to my boss's room -- unfortunately it was a walk

25 of about 100 yards, because we happened to be at

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1 devolution, with the creation of the

2 Scottish Parliament, a much larger number of ministers

3 in the Scottish Government than there were in the

4 Scottish Office, were talking about a number of five

5 times as great, it's possible to put more matters to

6 ministers than one did in these olden days of the

7 mid-'80s.

8 **Q.** Just so that we have an idea of those numbers, in your

9 time, 1986 to 1989, you would have the Secretary of

10 State and how many junior ministers?

11 **A.** I can't recall. You can look it up. But it was of the

12 order of five.

13 **Q.** Including --

14 **A.** Michael Forsyth, tomorrow, will remember the answer to

15 that.

16 **Q.** You say now, the situation is -- did you say four or

17 fivefold?

18 **A.** Again, something like that. Again, you can look it up.

19 **Q.** Somewhere in the early 20s, probably, around?

20 **A.** You can look it up.

21 **Q.** We'll look it up. But the point is there are many more

22 now?

23 **A.** Yes, exactly.

24 **Q.** You say that it was a difficult decision for senior

25 members. Who would be making the decision about what

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1 different ends of the building -- and chat things

2 through to him and I passed his boss's room on my way

3 and I could always call in there.

4 So, metaphorically speaking, doors were open. We

5 had very high, a very high level of communication, oral

6 and to a lesser extent in writing -- no, oral and in

7 writing, within the Department.

8 **Q.** The physical proximity you had to other civil servants

9 wasn't always matched, was it, by the physical proximity

10 you had to ministers because they would have to spend

11 four days a week in London during Parliamentary term?

12 **A.** You're absolutely right. And that was an inhibition in

13 meeting ministers. Obviously, the telephone had been

14 invented, and we were able to speak on the telephone and

15 I well remember long conversations with Michael Forsyth

16 in particular. But, yeah, you couldn't -- the minister

17 couldn't easily summon you, and you couldn't easily ask

18 to speak face-to-face with the minister in the way that

19 I was able to do after devolution.

20 **Q.** How do you think that affected the way in which civil

21 servants and ministers communicated?

22 **A.** Yes, there was a -- it reinforced the kind of formal

23 distinction between the civil servant and the minister,

24 which, in my experience, has been -- that distinction

25 has been reduced in a favourable way by devolution.

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1 It meant that communication with the minister  
2 intended to be formal, in writing, and a formal exchange  
3 of correspondence with the minister. And that had  
4 advantages. You had to think out what you were going to  
5 say to a high degree, and you expressed yourself briefly  
6 because ministers were busy people. It inevitably had  
7 a penalty in that it was difficult to have an informal  
8 discussion with the minister. Less difficult, I have to  
9 say, when Michael Forsyth became the minister, because  
10 of his particular energy and desire to engage with the  
11 Civil Service.

12 Q. Did it make it harder to get an informal steer from  
13 a minister, perhaps at the edge of a meeting, about  
14 a particular topic?

15 A. Yes, precisely so, and I can recall cases with  
16 Michael Forsyth where it took couple of exchanges -- we  
17 maybe had a misconception about each other's position  
18 and it took a couple of rounds of correspondence before  
19 we got on the same page.

20 Q. You've mentioned Michael Forsyth. Lord Glenarthur, who  
21 preceded him, as you say only in post for a relatively  
22 short period of time, September '86 to June 1987, he had  
23 been, as we've heard, a minister in the Department of  
24 Health in London.

25 A. (The witness nodded)

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1 policy set by the Department of Health have on the  
2 policy that the Scottish Home and Health Department  
3 could follow?

4 A. I don't recall being in orbit around the DHSS at all.

5 Q. Did you feel you could -- if the Scottish Home and  
6 Health Department wanted to set its policy in  
7 a particular way, it had both the *de jure* and *de facto*  
8 ability to do that?

9 A. Yes. Now, as a matter good collective government,  
10 remember that we each reported to a member of the same  
11 Cabinet, we needed to take care that we didn't embarrass  
12 each other, but that -- and there are cases that you've  
13 asked me to give written evidence on, there are cases  
14 covered by my written evidence where we had quite close  
15 liaison in order to avoid embarrassing our ministers.

16 But it -- that wasn't a big feature, and you're  
17 right: we felt that we had the -- I certainly didn't  
18 have to knock on the door of DHSS and ask permission to  
19 do the kind of things, "policy", that we were thinking  
20 about in that series of meetings with the Common  
21 Services Agency and the Scottish National Blood  
22 Transfusion Service that that I alluded to earlier.

23 Q. I've been asked to ask you about whether or not steps  
24 were taken to ensure that ministers in the  
25 Scottish Office were getting the same advice on topics

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1 Q. How did that affect the way in which he approached his  
2 work, from your perspective, and the way in which the  
3 civil servants approached him?

4 A. Um, I didn't have an awful lot of conversation --  
5 contact with Lord Glenarthur, because he was only there  
6 very briefly, but I vividly remember when he was -- when  
7 he first became our minister, he came round to my room  
8 for a sort of briefing meeting, which was extremely  
9 helpful, and where I remember it being advantageous that  
10 he knew a lot about the *modus operandi* of the  
11 Health Service from his period in the Department of  
12 Health and Social Security.

13 Q. Do you recall it having any particular influence on  
14 blood policy and blood products policy?

15 A. Do you mean do I have -- are you asking about my  
16 recollection about my role or Simon Glenarthur's role.

17 Q. Simon Glenarthur's role --

18 A. No, I don't remember him having any -- having any impact  
19 on blood transfusion policy, but that may be a fault of  
20 my memory. It's 35 years ago.

21 Q. Let's turn to the relationship with the DHSS. Obviously  
22 a much larger Department with more staff, more experts  
23 on hand, and consultant advisers, for example, and its  
24 own CMO and its own hierarchy there. How much of a --  
25 if I may put it this way -- gravitational pull, did the

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1 that ministers in the Department of Health were getting.  
2 Were any such steps taken, particularly in relation to  
3 blood and blood policy?

4 A. Yes, they were. In these cases where we, or Department  
5 of Health, had identified the possibility of  
6 a collective embarrassment for the Government. There  
7 was one in particular that you asked me to give written  
8 evidence on which was the disposal of some out of date  
9 plasma where the same -- a very difficult question,  
10 because the plasma was potentially infected, where we  
11 and the Department of Health kept very closely in touch,  
12 and may even have shared drafts of submissions to  
13 ministers.

14 But that was very much the exception rather than  
15 the rule. I had perfectly good relationships with my  
16 opposite number in the Department of Health on Blood  
17 Transfusion Service and different opposite numbers on  
18 the other topics for which I was responsible, but they  
19 weren't -- they were perfectly good, informal  
20 relationships, but they weren't close. They weren't  
21 close relationships.

22 Q. The issue that you were discussing there, I think is the  
23 issue about untested plasma that still remained after  
24 tests for HIV had been introduced.

25 A. That's correct, but it wasn't the -- as I recollect it,

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1 it wasn't so much the plasma that had been tested; it  
2 was the donors from which the plasma had come.  
3 **Q.** Yes. Yes, and a question of what could and couldn't be  
4 done with that.

5 **A.** Yes.

6 **Q.** There was a scientific view as to what was safe --

7 **A.** **(The witness nodded)**

8 **Q.** -- and a political and public confidence view about  
9 whether or not the pure scientific view should be  
10 followed?

11 **A.** Yes, and a very difficult subject.

12 **Q.** I think in the end the view in Scotland was taken that  
13 that plasma shouldn't be used in blood products,  
14 notwithstanding the fact that scientists considered that  
15 such use would have been appropriate and, instead, would  
16 only be used in research, and the rest would be --

17 **A.** Yes, I can't actually remember just now what the  
18 eventual outcome was, but we being Scots were enormously  
19 careful to make sure that we didn't waste the stuff, but  
20 that it wasn't used in a way that could possibly infect  
21 patients.

22 **Q.** In that example, did you feel that you were being told,  
23 or being advised or being pressured by the Department of  
24 Health not to put an option to your own minister?

25 **A.** No, that would have been almost improper. What, the

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1 I assumed responsibility for the topic in 1986, and John  
2 resigned as our consultant adviser because of the  
3 appointment of Jim Donald as the chief executive of the  
4 Common Services Agency.

5 The Common Services Agency had not previously had  
6 a chief executive, but, in common with the introduction  
7 of chief executives across the territorial health  
8 boards, the Common Services Agency recruited one as  
9 well, and he made a very positive contribution to the  
10 conduct of business. Jim Donald.

11 John Cash felt that his line of communication with  
12 Jim Donald as his boss, as his new boss, would have been  
13 complicated if he also had a formal, direct line in to  
14 the Department, into the SHHD, as consultant adviser.  
15 So he resigned.

16 The difference was undetectable. He continued to  
17 offer advice and they continued to request advice from  
18 him in, I think, exactly the same way as before. I say  
19 I think because my period in office didn't span the --  
20 his -- the moment of his resignation, but certainly  
21 I felt no inhibition whatsoever in seeking John's  
22 advice, and John, not somebody to hide his light under  
23 a bushel, was certainly under no inhibition about  
24 offering advice when he felt it necessary to.

25 So we had, in effect, a consultant adviser and

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1 Department of Health controlling what I put to my  
2 ministers? No, absolutely not. We reached agreement,  
3 as far as I recollect, on what to put to our several  
4 ministers.

5 **Q.** It was working with colleagues from a different  
6 department on a joint way of thinking, as it were. It  
7 wasn't the Department of Health giving directions as to  
8 what you should be saying to your ministers?

9 **A.** That's absolutely correct.

10 **Q.** And just so that we are clear, was there any occasion  
11 where you felt that the Department of Health overstepped  
12 the mark in advising or suggesting or pressuring you in  
13 terms of what you could put to your ministers?

14 **A.** No, it was -- they wouldn't have tried to do that. It  
15 was just not the way that business was conducted. If  
16 they had tried, I would certainly remember it, but,  
17 across the range of my responsibilities, I recollect no  
18 such case.

19 **Q.** Then, finally, the Department of Health we know had  
20 a series of consultant advisers that assisted the  
21 minister. Did the Scottish Home and Health Department  
22 have either an equivalent set-up or access to the  
23 Department of Health's consultant advisers?

24 **A.** Yes, we had John Cash as our formal consultant adviser  
25 for a period which came to an end just before or just as

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1 John Cash was outstandingly useful in that role. A very  
2 distinguished experienced guy, who, unusually for  
3 a haematologist, became a -- what's it called? --  
4 the president of the Royal College of Physicians in  
5 Scotland. A distinguished, extremely competent man. So  
6 we had a great advantage in having him as effectively  
7 our consultant adviser, though he no longer had the  
8 title.

9 Now you asked also about our access to DHSS  
10 consultant advisers, and I don't think we had any such  
11 access, but there were collective bodies of advisers on  
12 different subjects, spanning the border between England  
13 and Scotland, to which we did have access, and  
14 Scottish people or Scottish members, be it from the  
15 Scottish National Blood Transfusion Service or from the  
16 Scottish Home and Health Department, were members or  
17 observers or assessors on such bodies.

18 **Q.** And they would feed back to you, would they?

19 **A.** Say again?

20 **Q.** Would they feed back to you on relevant topics?

21 **A.** Um ... "feed back" to us is not quite the term I would  
22 use. We could seek their advice and they would proffer  
23 advice sought, or perhaps also unsought, although  
24 I can't remember that.

25 **Q.** If, for example, a figure such as Dr McClelland had

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1 learnt something from a meeting that he had had with  
2 colleagues in England and Wales, and he felt that that  
3 was something that should be brought to the attention of  
4 the Scottish Home and Health Department, would he have  
5 a route to be able to do that?

6 **A.** Oh yes, absolutely. Dr McClelland would have -- his  
7 natural contact would be John Forrester and  
8 Archie McIntyre. He could also have contact through  
9 the SNBTS by feeding the results of such a meeting to  
10 John Cash, who would feed them to the Department.

11 So yes, Brian McClelland had ready access to that  
12 kind of line of advice.

13 **Q.** Briefly, just to finish this section, before we turn  
14 specifically to the relationship with the SNBTS, on  
15 funding, at paragraph 16.1 of your statement -- perhaps  
16 if we could bring this up, actually.

17 WITN7064001, page 10.

18 I will just read through that paragraph, what you  
19 say in it. You say that:

20 "In [your] recollection, the budget was set by  
21 means of a 3-year forward look (the Public Expenditure  
22 Survey) followed, with regard to the year immediately  
23 ahead, by the Supply Estimates which were approved by  
24 Parliament. The details varied from spending area to  
25 spending area. But in the case of the SNBTS, the

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1 the relationship -- (overspeaking) --

2 **A.** Surely.

3 **MR HILL:** -- example.

4 **SIR BRIAN LANGSTAFF:** Yes, well, we'll take a break now.

5 It'll be half an hour. So we'll come back at just  
6 on 11.45.

7 Now, this is the first break in your evidence.

8 You're under oath. When you give evidence on oath you  
9 may not talk to anyone, whoever that anyone is, about  
10 the evidence you have given, or for that matter any  
11 evidence which you anticipate you might be asked to  
12 give. But you can talk about anything else you like.

13 **THE WITNESS:** I understand. Thank you.

14 **SIR BRIAN LANGSTAFF:** 11.45.

15 (11.18 am)

(A short break)

17 (11.48 pm)

18 **SIR BRIAN LANGSTAFF:** Yes.

19 **MR HILL:** Mr Macniven, could we turn to your -- the  
20 Scottish Home and Health Department's relationship with  
21 the SNBTS.

22 **A.** Surely.

23 **Q.** If we could have on screen, please, WITN7064001,  
24 page 19. This is your witness statement. I won't read  
25 the whole of this paragraph out, paragraph 32.1, but you

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1 process involved a request from my Division to the CSA  
2 for bids covering all its functions, including the  
3 SNBTS. These bids were scrutinised by the team  
4 mentioned [earlier, that's the Finance group] ... and  
5 amalgamated into a bid covering the whole of [the  
6 Scottish Home and Health Department], which was in turn  
7 incorporated into a Scottish Office-wide bid approved by  
8 ministers which was the subject of discussions with the  
9 Treasury, with the final decision being taken  
10 collectively by the Cabinet."

11 You say you do not recall the DHSS being part of  
12 that process although you may have had some informal  
13 contact with them.

14 So is this right: the bids, as it were, came from  
15 the bottom up, the SNBTS would put together their bid  
16 for what they considered they needed, that would get  
17 through -- fed through the CSA, and then up to your  
18 division, who would consider it, and then scrutinised by  
19 the Finance Division, and then a bid put forward for the  
20 whole of the Home and Health Department, and then  
21 a wider Scottish Office bid; is that correct?

22 **A.** That's correct, yes.

23 **MR HILL:** Sir, I note the time. I'm about to move on to  
24 the topic of the relationship with the SNBTS and, after  
25 that, into the question of surrogate testing, and how

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1 say in it that there was a longstanding tension between  
2 the SNBTS and the SHHD that predated your involvement  
3 with the Inquiry. So was that something that you were  
4 aware of -- sorry, predated your involvement with the  
5 Department. Was that something you were aware of when  
6 you took up your post with the SHHD?

7 **A.** Yes, I remember Sandy Murray who worked for me on this,  
8 briefing me to the same effect as what I've said here.

9 **Q.** How would you describe, we can all read this paragraph,  
10 and it's available online as well, but in your own words  
11 now, how would you describe that tension between the  
12 SHHD and the SNBTS?

13 **A.** It was annoying but not critical to liaison between the  
14 two bodies.

15 **Q.** Why was it annoying, what --

16 **A.** Because you had to spend time smoothing it over. When  
17 there was other things more fruitful to do.

18 **Q.** You describe in the paragraph that there's a distinction  
19 between the macro level there, there was a common shared  
20 set of aims between the SHHD and the SNBTS about  
21 self-sufficiency, the use of Scottish blood products.

22 **A.** (The witness nodded)

23 **Q.** But then at micro level as you describe it, there were  
24 contentious issues which arose.

25 **A.** (The witness nodded)

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1 Q. How frequently did those issues arise?  
 2 A. I would say there would always be one or two bubbling  
 3 away at any given time.  
 4 Q. Was that common in other agencies with whom you dealt?  
 5 A. No.  
 6 Q. Why was it, do you think, that the SNBTS did create this  
 7 tension?  
 8 A. I would say it was largely the personality of John Cash,  
 9 for whom, as I've said already, I had the highest regard  
 10 and respect. But I think he would have himself  
 11 described his approach as being sometimes difficult to  
 12 work with.  
 13 Q. In what way was it difficult to work with him?  
 14 A. He had a determination to achieve the most for the BTS,  
 15 which was in most ways laudable, and which was a huge  
 16 advantage for Scotland. Having an energetic, capable,  
 17 indefatigable John Cash was an important weapon in our  
 18 armoury. But he tended to get the wrong end of the  
 19 stick. He was very impatient of bureaucracy and other  
 20 forms of obstruction to his endeavours, and he was  
 21 sometimes hard to persuade that life wasn't just quite  
 22 how he saw things and that was energy sapping.  
 23 Now I should emphasise that this should not be  
 24 brought up as some form of impediment in liaison between  
 25 the SNBTS and SHHD. It was not of that order. It was  
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1 for me, and my boss. And I particularly remember  
 2 Hugh Morison because he was my boss for most of the  
 3 period under review.  
 4 Q. To be clear, the issues with Dr Cash were not about you  
 5 questioning his expertise or his knowledge or his  
 6 pre-eminence in his field; it was the fact that when it  
 7 came to dealing with bureaucracy, as he saw it, that's  
 8 where the tension rose.  
 9 A. Yes, and he was commendably energetic to get the best  
 10 deal for the SNBTS. If one was to be cruel, which I am  
 11 not, one would describe it as empire building. I didn't  
 12 see it like that. I saw it as being effectively a chief  
 13 executive because, effectively, a chief executive he  
 14 was, energetic for his client group, viz the recipients  
 15 of blood and blood products.  
 16 Q. The SHHD, of course, had a wider perspective than just  
 17 that group and just that organisation and is that where  
 18 some of the tension arose from?  
 19 A. You're right, and there was a tension there because  
 20 John, in his role as *demandeur*, as bidder for resources,  
 21 was effectively bidding against the rest of the  
 22 Health Service and, within a pot of money, necessarily  
 23 finite, SHHD and eventually ministers had to weigh up  
 24 whether one was better to spend money on the Blood  
 25 Transfusion Service, or whether the needs of patients  
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1 a matter of, as I say, slightly energy sapping work to  
 2 calm John down, persuade him that things were not quite  
 3 how he saw it. It was possible to do, but it took  
 4 a little energy, and at times it was quite hard work,  
 5 separating the issues where John had the wrong end of  
 6 the stick, and issues where he did not, which it was  
 7 vital that we acted on.  
 8 And the way that I -- the approach that I took  
 9 right from the beginning of my time in SHHD, having been  
 10 briefed, as I say, by Sandy Murray of the existence of  
 11 this problem, was to communicate as clearly as I could  
 12 to John Cash where the Department was coming from, and  
 13 to understand as clearly as I could where John was  
 14 coming from, and distinguish between these -- thereby  
 15 distinguish between these two kinds of issues. At one  
 16 level it was intellectually stimulating. At another  
 17 level there were other ways in which my intellect could  
 18 have been stimulated.  
 19 Q. You were one of the people who liaised with Dr Cash.  
 20 A. Yes.  
 21 Q. Who else from the SHHD would have been involved in that  
 22 relationship?  
 23 A. Principally John Forrester, Archie McIntyre,  
 24 Graham Scott, the medical hierarchy, and, on the  
 25 administrative size of things, Sandy Murray, who worked  
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1 collectively, the nation of patients, would be better  
 2 served by putting money into another aspect of the  
 3 Health Service.  
 4 To return to an example I've used before, were we  
 5 better investing in the Blood Transfusion Service in  
 6 whatever -- satisfying whatever bid was in front of us  
 7 at the moment, or to reduce the number of single-manned  
 8 ambulances, which had a clear scope for improving the  
 9 services to patients and, thereby, the number of  
 10 patients who died, or were seriously affected by the  
 11 attendance of an ambulance with only one person, viz the  
 12 driver, in it?  
 13 Q. Are you able to give a view about how effective Dr Cash  
 14 was in that approach that he took for trying to maximise  
 15 the amount of resources that SNBTS had and did it work?  
 16 A. Did it work?  
 17 Q. Yes.  
 18 A. Were you asking "did it work"? Yes, I think worked  
 19 well. Under his tutelage, the Blood Transfusion Service  
 20 grew to meet increasing demand for blood and blood  
 21 products, and although also there were, at times,  
 22 difficulties with the quality of its services, it  
 23 achieved a great deal, for example, effective  
 24 self-sufficiency in blood and blood products, and  
 25 retained a quality of service which, to its -- to its  
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1 patients that I think Lord Penrose's Inquiry found  
 2 commendable.  
 3 But if John had been a different person he could  
 4 have achieved that excellent, commendable, important  
 5 outcome with less -- with less energy, with less  
 6 diversion of effort.  
 7 **Q.** You mentioned the phrase "empire building" and said that  
 8 you didn't consider that to be empire building?  
 9 **A.** (The witness nodded)  
 10 **Q.** Did any of your colleagues, to the best of your  
 11 knowledge, consider that Dr Cash was empire building?  
 12 **A.** I can't recollect.  
 13 **Q.** Just one further general point before we look at some  
 14 documents. There is -- I'm sure everybody will  
 15 recognise -- a potential difficulty where there is  
 16 a fractious relationship, that, even with best of  
 17 intentions on both sides, there can be a tendency to  
 18 dismiss the other side as falling back into the same  
 19 habits of seeking more or arguing with the bureaucrats  
 20 for the sake of argument with the bureaucrats, attempts,  
 21 as it were, to put up a wall with the antagonist. Is  
 22 that something that you think happened between some  
 23 within the SHHD and Dr Cash and the SNBTS generally?  
 24 **A.** I can't talk about the colleagues in the rest of -- my  
 25 colleagues in SHHD, but there was absolutely no question

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1 with the Scottish Transfusion Service.  
 2 "I cannot begin to understand the problems but the  
 3 quality of Dr Forrester's remarks at the last BTS  
 4 Sub-Committee meeting, in the context of the Sandos  
 5 Collaborative Research Agreement, were regarded by my  
 6 colleagues, particularly Dr McClelland and myself, as  
 7 bordering on insulting. They also revealed a depth of  
 8 scientific/medical understanding that was remarkably and  
 9 disturbingly shallow. Dr Forrester made identical  
 10 comments at the Commercial Interface Steering Group on  
 11 the 6th August and when challenged made it quite plain  
 12 that his view, that the clinical importance of endotoxigenic  
 13 shock/overwhelming coliform septicaemia was of historic  
 14 interest only and was nowadays, quantitatively,  
 15 a trivial matter, had been formed after appropriate  
 16 consultation and was 'the official SHHD view' on the  
 17 matter. I made it quite clear to Dr Forrester on the  
 18 6th August that I, and a very large body of scientific  
 19 and medical workers, worldwide, did not share his view  
 20 or that of the SHHD advisers and that if this view was  
 21 indeed the Department's official position then this must  
 22 be a matter of concern to those of us within the SNBTS  
 23 who are committing SHS resources into this area.  
 24 Dr Forrester did not take the trouble to make contact  
 25 with me in the period between 6th August and the BTS

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1 of a wall inhibiting receipt of John Cash's advice in my  
 2 case, and indeed, I think I would say also, my boss,  
 3 Hugh Morison's case. To whom I was very close and I can  
 4 recollect his attitude.  
 5 Because we were conscious that this was a very  
 6 important service, where John's stature and ability were  
 7 hugely helpful, it was just slightly irritating that one  
 8 had to spend time avoiding a wall being built up. But  
 9 I stress, there was no wall.  
 10 **Q.** Let's turn to a document from the time which is  
 11 indicative of some of the tension about which you've  
 12 spoken.  
 13 Can we have on screen, please, PRSE0004596, which  
 14 is a letter written from Dr Cash to your boss,  
 15 Hugh Morison, dated 21 August 1986.  
 16 It was copied to Mr Donald, who was the chief  
 17 executive of the CSA. It was not copied, at least  
 18 formally, to you, but I will read it out and then I'll  
 19 ask you a few questions about it, including what you  
 20 knew of it at the time.  
 21 What Dr Cash wrote is this:  
 22 "Dear Hugh  
 23 "I must once again request that consideration be  
 24 given by appropriate colleagues in SHHD to give  
 25 Dr JM Forrester duties which do not include interface

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1 Sub-Committee to further discuss the matter and indeed  
 2 had clearly briefed you (in my opinion wrongly) for our  
 3 meeting on the 18th August.  
 4 "This most recent episode has all the hallmarks of  
 5 the events which took place in late 1985 which led to  
 6 a 6 month delay in the AIDS validation studies of our  
 7 plasma derived blood products, a delay which could have  
 8 been much longer without the intervention of yourself  
 9 and the CMO. Taken together, along with other episodes  
 10 of only minor importance, I must, with regret, conclude  
 11 that the SNBTS Directors have little or no confidence in  
 12 the person who currently provides the vital medical link  
 13 to the operational part of the Blood Transfusion Service  
 14 and SHHD."  
 15 Go over to the next page, please.  
 16 "I would not wish to claim that all the fault lies  
 17 with Dr Forrester. I'm sure he may experience much  
 18 difficulty in dealing with certain SNBTS medical  
 19 colleagues and, in particular, myself. This I very much  
 20 regret but in our defence would wish to emphasise that  
 21 we have never that this type of difficulty with  
 22 Dr Forrester's predecessors. Faced with this apparently  
 23 intractable problem I must therefore conclude that the  
 24 only practical option open for resolution is an  
 25 accommodation by colleagues in SHHD.

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1 "I am copying this letter to Jim Donald, as  
 2 a matter of courtesy, because of the resource  
 3 implications of this scientific development."  
 4 That is signed by Dr Cash.  
 5 First of all, were you aware of this letter at the  
 6 time it was sent?  
 7 Can we take it down now, please, Lawrence.  
 8 **A.** No. And you can imagine why I wasn't: because it was  
 9 somebody complaining to my boss about a close colleague.  
 10 **Q.** The concerns expressed by Dr Cash in the letter include  
 11 a comment that Dr Forrester's scientific and medical  
 12 understanding was shallow. In your experience of  
 13 Dr Forrester, do you think that's a fair comment on his  
 14 abilities?  
 15 **A.** I'm not really in a position, as a non-medical, to  
 16 second-guess the question.  
 17 **Q.** Did you ever get a sense, when working with Dr Forrester  
 18 that, if I can put it this way, he was not up to the  
 19 job?  
 20 **A.** No, I didn't. John, as I've said earlier, was not  
 21 a very initially accessible person. He kept his  
 22 thoughts to himself. He expressed himself very briefly,  
 23 perhaps he showed his workings too little, orally, but  
 24 he was, to a remarkable degree, driven by the evidence.  
 25 He would energetically seek out evidence on the question

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1 which has been a trigger for a vituperative reaction of  
 2 John Cash, built on a difficulty of relationship between  
 3 the two men, which was partly that they were chalk and  
 4 cheese, personally -- in their personal characteristics,  
 5 I mean -- a difficulty of relationship between the two  
 6 Johns, and this apparently small event triggered  
 7 John Cash to write the letter, a letter where he was  
 8 commendably frank about the difficulty of dealing with  
 9 himself. He recognised that he wasn't an easy person to  
 10 deal with.  
 11 But I think, in looking at this document, you must  
 12 also look at the reply which the Inquiry kindly provided  
 13 me with -- which equally I hadn't seen at the same time  
 14 for the same reason -- that Iain Macdonald, the Chief  
 15 Medical Officer, sent to this letter which wasn't  
 16 addressed to him, but really was more his responsibility  
 17 than Hugh Morison's. And I think it would be important  
 18 to look at Iain's response to John Cash to get a more  
 19 statesman-like, a more authoritative view of John Cash's  
 20 concerns.  
 21 But before you call up that document, which  
 22 I would advise you to do, it might be worth saying this:  
 23 that I knew from the beginning when I took up the post,  
 24 I knew from Sandy Murray, my subordinate, that there was  
 25 a difficulty of relationship between John Forrester and

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1 in front of him, and come -- a very clever man -- come  
 2 to his own view on its significance, a view which did  
 3 not necessarily take into account the less  
 4 evidence-based views of John Cash.  
 5 **Q.** In the example that we've looked at there -- and I'm not  
 6 going to get into the detail of the rights and wrongs of  
 7 the medical argument that underlay it -- but it seemed  
 8 that Dr Cash was complaining that Dr Forrester,  
 9 a generalist, and somebody who worked in the SHHD, was  
 10 presuming to tell the specialists in the SNBTS about  
 11 what the official HHD line was on a topic that was more  
 12 within their realm than his. Was that, firstly,  
 13 something that he should have been doing?  
 14 **A.** That he, John Forrester, should have been doing?  
 15 **Q.** Yes.  
 16 **A.** It was certainly John's role to communicate to the SNBTS  
 17 the views of SHHD. I don't remember this issue at all.  
 18 And it sounds to me like, as you say, an issue where the  
 19 SNBTS folk would know what way was up better than  
 20 John Forrester. But I come back to the point that  
 21 John Forrester was, to an amazing degree, driven by  
 22 research and evidence, and there would have been  
 23 a reason for his statement.

24 It looks, to me, though like this is a relatively  
 25 trivial issue -- because I don't remember it at all --

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1 John Cash, two men that I got on with very well indeed,  
 2 and I took it upon myself to act as a conduit with  
 3 John Cash to a degree that I might not have otherwise  
 4 done had relationships been better between John Cash and  
 5 John Forrester.

6 In other words, there was no interruption of the  
 7 line of communication between the SNBTS and the person  
 8 of John Cash, and SHHD corporately, as a result of  
 9 an unfortunate, and I have to say unusual, lack of --  
 10 lack of good regard between the two Johns.

11 **Q.** We will, I can assure you, come to Dr Macdonald's reply,  
 12 out of fairness to Dr Forrester. I think it is quite  
 13 important to put that up on screen, I will do. There  
 14 are a couple of things I'd just like to pick up from  
 15 what you've just said, though, before we lose that  
 16 thread.

17 The first was your reference to Dr Forrester and  
 18 his evidence-based approach and the way that he would  
 19 seek out research. Does that mean that he independently  
 20 would throw himself into a topic and do reading around  
 21 it and come to his own views?

22 **A.** Yes, indeed. He saw it, and I saw it, as important that  
 23 he should do so. A questioning approach to the advice  
 24 being given by the SNBTS, in the same way as one took  
 25 a questioning approach to the advice given by anybody on

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1 any of the subjects with which I -- for which I had  
 2 responsibility. It was a commendable characteristic.  
 3 **Q.** A problem which is often associated with an autodidact  
 4 is that while there is, as you say, a commendable desire  
 5 to throw yourself into research, that might also lead to  
 6 a less commendable willingness to listen to others'  
 7 views, particularly those who may be more steeped in the  
 8 subject than you are. Do you think that was a problem  
 9 Dr Forrester had?  
 10 **A.** He certainly listened to the SNBTS views, articulated by  
 11 John Cash or by others, and he would have listened to  
 12 them, because of his characteristic, with great  
 13 attention.  
 14 But he would have wanted to make his own mind up  
 15 about the matter, taking into account not only the  
 16 assertions of the SNBTS, but also the evidence which he  
 17 was able to bring to bear.  
 18 **Q.** Just the other point I wanted to pick up from what  
 19 you've just said is your role in acting as  
 20 an alternative channel between the SNBTS and the SHHD.  
 21 Allowing for that and allowing both your best efforts  
 22 and Dr Cash's best efforts, you weren't medically  
 23 trained, so there was something that was lost. Dr Cash  
 24 refers to the vital medical link between the SNBTS and  
 25 the SHHD.

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1 Committee, the "board" of the Common Services Agency.  
 2 So he -- there came across the Management Committee  
 3 table a great many Blood Transfusion Service issues in  
 4 which Graham Scott had needed to be -- on which  
 5 Graham Scott needed to be informed.  
 6 So John Forrester was not the only medical brain  
 7 in the Department; he was the most junior of a hierarchy  
 8 of which I have mentioned the two others. But there was  
 9 also Iain Macdonald, who, although the Chief Medical  
 10 Officer and, therefore, a bit detached from the kind of  
 11 day-to-day problems that I was chewing over with  
 12 John Cash, had a long background as Deputy Chief Medical  
 13 Officer, as your document earlier showed, and who had  
 14 a very long time series of involvement with the Blood  
 15 Transfusion Service, as the document that you're about  
 16 to bring up on the screen refers to.  
 17 **Q.** Let's turn to that document now.  
 18 It's PRSE0002521.  
 19 As I say, out of fairness to Dr Forrester, I'm  
 20 going to read all of this as I read all of the letter of  
 21 complaint, as it were. This is sent from Dr Macdonald,  
 22 the Chief Medical Officer, to Dr Cash. Dr Macdonald  
 23 wrote this:  
 24 "Dear Dr Cash  
 25 "As I am sure you will understand Mr Morison has

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1 **A. (The witness nodded)**  
 2 **Q.** Was there something lost as a consequence of you having  
 3 to do that, rather than somebody who was medically  
 4 trained?  
 5 **A.** The fact that I'm a mere historian doesn't detract from  
 6 my ability to understand and weigh the information  
 7 imparted to me by doctors. So I'm not saying  
 8 that I knew as much on the subject as John Forrester,  
 9 never mind John Cash, but I was able to bring  
 10 intellectual rigour to the question of where the right  
 11 answer lay.  
 12 Secondly, John Forrester was not, as our previous  
 13 conversation has made perfectly clear, the only medical  
 14 voice in my ear. He worked for the inestimable  
 15 Archie McIntyre, who was a particularly easy person to  
 16 get on with, and was particularly well practised in  
 17 explaining medical -- medical information in an  
 18 accessible way for a layperson like me.  
 19 Archie worked for the Deputy Chief Medical  
 20 Officer, Graham Scott, a man of stature, who became  
 21 a Queen's Honorary Physician later in his career, in  
 22 other words he was very well regarded by his medical  
 23 colleagues, and Graham was, to an unusual degree,  
 24 involved in the matters of the BTS because he was one of  
 25 the Secretary of State's appointees to the Management

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1 discussed with me your letter of 21 August regarding the  
 2 replacement of Dr Forrester for his duties relating to  
 3 the Blood Transfusion Service. The allocation of  
 4 doctors' duties in the Department is my responsibility  
 5 and that is the reason for my replying to you.  
 6 "I have considered your request carefully and  
 7 I have consult colleagues but I have come to the  
 8 conclusion that I should not arrange to replace  
 9 Dr Forrester at this stage. I do not think that there  
 10 is sufficient reason for such a change.  
 11 "Dr Forrester was not involved in any way in the  
 12 policy considerations which led to the delay in the AIDS  
 13 validation studies. These matters were decided at DCMO,  
 14 CMO and ultimately Ministerial level. Dr Forrester is  
 15 a knowledgeable and experienced doctor who applies  
 16 himself with great diligence to his duties and this is  
 17 the first complaint about him that has come to my  
 18 notice.  
 19 "Unfortunately because of the highly unfavourable  
 20 conditions of service in the Medical Civil Service we  
 21 have lost some very experienced colleagues including  
 22 Dr Bell and at present we are operating four Senior  
 23 Medical Officers under strength. Nevertheless,  
 24 Dr McIntyre, although under extreme pressure at the  
 25 moment will monitor the position on BTS liaison and

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1 you should speak to him in the first instance if major  
 2 or even minor difficulties arise. As you recognise the  
 3 BTS has never been the simplest organisation to deal  
 4 with -- for many, many years -- and several of us have  
 5 the scars to prove it."  
 6 That's signed by Dr Macdonald.  
 7 The reference to operating at "four Senior Medical  
 8 Officers under strength", were you aware of that  
 9 under-manning at the time?  
 10 **A.** No, I wasn't, until I saw this letter many years after  
 11 the event. I had never any difficulty, that I can  
 12 recall, getting medical advice on any of the subjects  
 13 for which I had responsibility, which spanned the  
 14 responsibilities of quite a number of senior medical  
 15 officers in the Department.  
 16 As I think I said earlier, in the gap between  
 17 John Forrester's retirement and Ros -- what was Ros's  
 18 last name -- his successor who was called Ros's,  
 19 arrival -- I would have turned to Archie McIntyre for  
 20 any advice that I needed. I certainly would not have  
 21 been inhibited from seeking that advice.  
 22 So the answer is no. Poor Iain Macdonald  
 23 obviously felt the absence of his four senior medical  
 24 officers more keenly than I did.  
 25 **Q.** Dr Ros Skinner is the --  
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1 I suspect that this -- the letter of 21 August was  
 2 John Cash breaking into print on a matter where other  
 3 folk might have said "Ach, that's a pity, could have  
 4 been better done, but we need to get on with the job".  
 5 In other words, John Cash overreacting to  
 6 a difficulty -- a real difficulty, but not a major  
 7 difficulty -- that he had in the relationship with  
 8 John Forrester. We've all got people in our lives that  
 9 are difficult to deal with. You get on and blooming  
 10 well deal with them, not moan about it.  
 11 **Q.** I would like to turn to a specific issue now, which is  
 12 surrogate testing, and it touches upon this relationship  
 13 between the SNBTS and the SHHD. Just so that everybody  
 14 is aware of the terminology that's being implied --  
 15 that's being applied, surrogate testing was, in this  
 16 context, testing for hepatitis B core antibody or for  
 17 raised ALT levels in blood donations, as a proxy for  
 18 non-A, non-B hepatitis because in the period that we're  
 19 dealing with, 1986 to 1988, there was no specific test  
 20 for hepatitis C, as it later became known.  
 21 **A.** (The witness nodded)  
 22 **Q.** So that is the issue.  
 23 **SIR BRIAN LANGSTAFF:** The way you put that, is that those  
 24 two tests as alternatives or in combination?  
 25 **MR HILL:** At different points in the papers, there is  
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1 **A.** Of course, Ros Skinner, yes.  
 2 **Q.** Successor --  
 3 **A.** Thank you.  
 4 **Q.** Do you have any other comments on the letter that we  
 5 have just seen?  
 6 **A.** Yes, two. Two or three. In the first paragraph, you  
 7 emphasised "my" with an implication that John Cash  
 8 should have written to Iain rather than Hugh Morison.  
 9 Iain was a gentle soul and there would have been no --  
 10 in his mind, there would have been no rancour in the  
 11 fact -- or I don't imagine that Iain bore John Cash any  
 12 grudge from having misdirected the letter, as  
 13 misdirected -- he had done it, he had done. He  
 14 shouldn't have written to Hugh Morison, he should have  
 15 written to Iain Macdonald.  
 16 Secondly, the -- in paragraph 3, there's  
 17 a reference by Iain Macdonald to the same sort of  
 18 compliments about John Forrester as I gave.  
 19 Thirdly, it's interesting that Iain Macdonald set  
 20 up a liaison between John Cash and Archie McIntyre as  
 21 a way of bypassing the personal difficulties that the  
 22 two Johns suffered from.  
 23 I wasn't actually aware of Archie -- I, who was  
 24 ignorant of this letter at the time, wasn't aware of  
 25 John Cash suddenly dealing with Archie McIntyre.  
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1 discussion of applying one or the other or both --  
 2 **SIR BRIAN LANGSTAFF:** So we have to be mindful of the  
 3 context?  
 4 **MR HILL:** It depends on the context, yes.  
 5 **SIR BRIAN LANGSTAFF:** Thank you.  
 6 **A.** The important point is that neither of the two tests  
 7 certainly identified whether the donor had  
 8 non-A, non-B hepatitis, and that was because at the time  
 9 non-A, non-B hepatitis had not been identified as  
 10 a separate disease, if you like, so it wasn't possible  
 11 to devise a direct test, and these were -- for its  
 12 presence -- and these were two-second best ways of  
 13 doing, which were, as Matthew Hill says, alternatives,  
 14 as I understand it, as a non-doctor.  
 15 **Q.** Ultimately, the question of whether or not to introduce  
 16 surrogate testing in Scotland was a matter that fell  
 17 within the remit of the Scottish Home and Health  
 18 Department and the responsible minister; is that right?  
 19 **A.** Absolutely.  
 20 **Q.** It wasn't for the Department of Health to tell you what  
 21 to do, the SHHD could form its own policy, but would do  
 22 so, no doubt, in consultation with the Department of  
 23 Health?  
 24 **A.** Correct.  
 25 **Q.** Within the different hierarchies, both the SHHD and  
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1 externally, I just want to look at the different roles  
 2 that the different organisations and the different  
 3 people within those organisations would play. So,  
 4 firstly, what would be the role of the SNBTS and Dr Cash  
 5 on the question of surrogate testing?  
 6 **A.** They, principally John Cash, but also colleagues like  
 7 Brian McClelland, would be very, very, very concerned to  
 8 identify possible causes of infection from blood and  
 9 blood products and any way of protecting the patient  
 10 group against these problems.  
 11 Now, that's their general responsibility, so I saw  
 12 them at work trying to bottom out this difficult  
 13 question of what non-A, non-B hepatitis was, which  
 14 turned out to be a kind of basket of different viral  
 15 infections, as I understand it, and how one could  
 16 protect the quality of blood and blood products against  
 17 that infection. So they would have been very, very  
 18 energetically involved in keeping in touch with the  
 19 international research evidence on the matter.  
 20 **Q.** Is it fair to say that they would have more expertise on  
 21 the question of infections through blood products than  
 22 even the medical staff in the HHD?  
 23 **A.** Oh yes, hugely, but a different order of magnitude.  
 24 **Q.** What then was the role of the medical civil servants in  
 25 the SHHD in this policy?

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1 surrogate testing, for all its inadequacies and  
 2 side effects, was worth spending that sum of money on.  
 3 But I stress that that's a theoretical point  
 4 because, so far as I'm aware, the matter was never put  
 5 to ministers.  
 6 **Q.** I'm not aware of any evidence that it was put to  
 7 ministers either. We will come on to that in due  
 8 course.  
 9 Finally, externally, I alluded to it earlier, the  
 10 Department of Health. Would they have had any say or  
 11 what would have been their influence or their role, at  
 12 least as a consultee, in this matter?  
 13 **A.** Yes. Their resources were greater, the resources of the  
 14 Department were greater, and they had access, obviously,  
 15 to the advice from the people in the Blood Transfusion  
 16 Service in England. We would certainly have discussed  
 17 with them whether to introduce surrogate testing. As  
 18 I explained in the first half of the morning, they had  
 19 no power of direction over us. We could theoretically  
 20 have taken a different decision on either side of the  
 21 border, but we would certainly have had repeated  
 22 discussions both at administrative level and more  
 23 frequently, more importantly, at medical -- the  
 24 professional medical context between the two departments  
 25 would have been very important.

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1 **A.** In the same way as was true in generality, that they  
 2 were responsible for medical advice to ministers on the  
 3 matter.  
 4 **Q.** Did they play, in some way, a role in translating the  
 5 scientific advice that they may have been getting from  
 6 SNBTS into advice that was understandable to the  
 7 layperson, be it the civil servant or the minister?  
 8 **A.** Yes, although remember we also had -- I also had direct  
 9 contact with the BTS on the matter.  
 10 **Q.** What was your role, the role of the administrative civil  
 11 servants?  
 12 **A.** To consider whether one should spend a very large amount  
 13 of money -- £800,000 comes to mind, which in those days  
 14 was more valuable than it is today -- whether that was  
 15 best spent on this matter than on the other ways in  
 16 which patients could benefit from Health Service  
 17 spending and that involved taking a critical view of the  
 18 evidence for the effectiveness of these two forms of  
 19 surrogate testing that you've alluded to a moment ago.  
 20 **Q.** What about the DCMO, the CMO, what were their roles --  
 21 **A.** No different from the medical hierarchy that I mentioned  
 22 a moment ago. They were part of that medical hierarchy.  
 23 **Q.** Finally, the ministers, what was their role?  
 24 **A.** The ministers' role would have been to take a decision  
 25 on whether the game was worth the candle, whether

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1 There was something I wanted to add on that. They  
 2 didn't have power of direction. Although theoretically  
 3 we could have taken a different decision on either side  
 4 of the border, in practice this is an area where, as  
 5 I alluded to this morning, we would have had to be very  
 6 careful not to embarrass Cabinet colleagues. We were  
 7 part of the same Government, and we would have made sure  
 8 that we took the same attitude on this important matter,  
 9 or we would have agreed that the evidence about, for  
 10 example, the incidence of non-A, non-B hepatitis in the  
 11 two countries was such that a different decision on  
 12 surrogate testing was justified.  
 13 **Q.** If you had, in theory, taken a different decision in  
 14 Scotland, would you have required specific Treasury  
 15 approval for the spending of however many hundreds of  
 16 thousands of pounds it turned out to be, to introduce  
 17 the testing?  
 18 **A.** Your question is a theoretical one.  
 19 **Q.** Yes.  
 20 **A.** But no, Treasury approval would not, I think, have been  
 21 necessary. The way that the funding arrangements worked  
 22 was that the Scottish Office had a budget which it could  
 23 spend -- it was allocated a budget by Treasury which it  
 24 could spend more or less as it thought fit, in the  
 25 interests of, in this case, the patients of the NHS in

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1 Scotland. So although there were some cases where one  
2 had to seek specific Treasury approval for expenditure,  
3 I can't see that this would be one of them.

4 **Q.** There would have been, for example, no need to flag it  
5 in any PES bids saying, "Please be aware of" --

6 **A.** Yeah, yeah. We -- I can't see that there would have  
7 been any such reason. The sums that we were talking  
8 about for the Scottish budget as a whole would have been  
9 enormously much greater. So I think that's right. We  
10 wouldn't have had to refer to it in explaining a PES bid  
11 to Treasury.

12 I should explain that I say that with a certain  
13 amount of tentativeness because I wasn't in the finance  
14 function in the Scottish Government and so I am saying  
15 "would probably have been", rather than "would  
16 definitely have been".

17 **Q.** That is understood.

18 As you stressed earlier, this is a theoretical  
19 discussion, because, as you say at paragraph 54.1 of  
20 your statement -- and I won't ask to bring it up -- you  
21 said that your recollection is that the consistent and  
22 unanimous conclusion of the SHHD, throughout the period  
23 to which the documents we're going to look at relate,  
24 was that there was insufficient scientific or medical  
25 grounds for its introduction.

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1 than it being checked by --

2 **A.** That is my recollection, yes.

3 I say that slightly tentatively because I don't  
4 really remember 35 years later.

5 **Q.** Let's then look at some of the documents. What I'm  
6 going to do is introduce some elements of the chronology  
7 by reference to chapter 27 of the Penrose final report,  
8 which is something that you mention in your witness  
9 statement. We won't go through the detail of those  
10 documents, it's just to give us a structure. It begins  
11 at -- or at least the point at which I'm going to pick  
12 up the story, begins in February 1986. It's at  
13 paragraph 27.66 of chapter 27 of Penrose, with the Blood  
14 Bank Weekly, the official publication of the American  
15 Association of Blood Banks, reporting that the Blood  
16 Products Advisory Committee, the FDA, would recommend  
17 both ALT and anti-HBc testing later that year.

18 Indeed, we can see from the Penrose Report that  
19 such testing was introduced in the United States in 1986  
20 and 1987, and that had been in place in West Germany and  
21 in Italy for several years before but in many other  
22 European countries there was no surrogate testing.

23 In May 1986, so at around the time that you were  
24 joining the SHHD, the SNBTS included the figure that you  
25 gave earlier, £810,000, in their bid for funding,

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1 **A. (The witness nodded)**

2 **Q.** Firstly, is that an accurate summary of your evidence?

3 **A.** Well, that's why I put it in the written statement.

4 **Q.** Yes. Quite.

5 Secondly, is that a view that was reached within  
6 the SHHD by members of the SHHD without being leant on,  
7 as it were, or pressured by the DHSS --

8 **A.** Absolutely. There was no question of pressure. Indeed,  
9 you've let me see one document where one of my medical  
10 colleagues was saying, "Hey look, my -- the medics in  
11 the Department of Health are very worried that we'll go  
12 ahead with surrogate testing, and they'll be  
13 embarrassed". So no, they weren't in a position to  
14 direct us what to do. It was a question of discussion  
15 between the two departments.

16 But I should stress this: we had come to the view,  
17 the unanimous view, the repeated unanimous view on  
18 surrogate testing, which you mentioned a moment ago was  
19 in my written statement. We would have got a certain  
20 amount of comfort from the fact that the Department of  
21 Health, with its greater resources, and the Blood  
22 Transfusion Service in England, was of the same mind:  
23 that surrogate testing should not be introduced, despite  
24 the possible advantages that that would give.

25 **Q.** Was it then a case of having your view reinforced rather

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1 specifically to commence surrogate testing in 1987 to  
2 1988. So this was the SNBTS saying, "We would like this  
3 money to introduce surrogate testing".

4 Now, were you aware of that bid at the time it was  
5 made, and do you recall how significant an issue it was  
6 within the SHHD on your arrival at the Department?

7 **A.** I certainly would have been aware of that bid as soon as  
8 it was submitted, because of its size and difficulty.  
9 That was some months after I joined the SHHD. I don't  
10 recall, at the moment of my joining the SHHD, that it  
11 was a live question. I think it would have been brought  
12 to our notice first by that public expenditure survey  
13 bid, or by conversations with the SNBTS around the time  
14 that they were bidding.

15 **Q.** But it was clearly the view of the SNBTS at that time  
16 that they would like that money for that particular --

17 **A.** Correct.

18 **Q.** -- allocation?

19 **A.** Correct.

20 **Q.** If we could have, please, on screen now PRSE0000857.  
21 I just pause before we bring this up to note that  
22 there's a distinction that we must keep in mind  
23 throughout this between the official position of the  
24 SNBTS and the directors of the SNBTS, and individual  
25 scientists and doctors who worked for organisations

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1 either directly for SNBTS or connected with SNBTS, who  
2 at points, we can see, take a different view to the  
3 official SNBTS line.

4 Now, this document that we have on screen is  
5 a minute from Dr Forrester dated 12 June 1986. I'm  
6 going to read through not all of it but parts of it. It  
7 is entitled "Transmission of Non-A, Non-B Hepatitis by  
8 Blood and Blood Products: Is It Practicable to Reduce or  
9 Prevent It by Introducing ALT Testing of Donations?"

10 Paragraph 1, it says this:

11 "1. The information in this note is mostly  
12 derived from the PhD thesis entitled: 'Non-A,  
13 Non-B Hepatitis in West Scotland' completed in 1985 by  
14 Dr BC Dow under supervision of Dr Follet and others.

15 "2. Hepatitis can be transmitted by blood and  
16 blood products, and is in Scotland an occasional but  
17 serious consequence of blood transfusion."

18 It then goes on to discuss various other matters.  
19 This is about hepatitis A and hepatitis B as well.

20 "3. Non-A, non-B hepatitis is not a specific  
21 disease, but a heterogenous collection of diseases. The  
22 hepatitis conditions due to the Epstein-Barr virus and  
23 cytomegalovirus are a substantial part of it, but there  
24 is general belief that some as yet unidentified virus  
25 infection is also part of it. Thus there can be no

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1 chronic, and the long-term outlook is inevitably not yet  
2 known the case fatality rate is estimated in a textbook  
3 consult by Dr Dan Reid at less than 0.1%, except in  
4 pregnant women, who are at much greater risk (10% if  
5 they contract it during the last 3 months of  
6 pregnancy)."

7 It then goes on to talker about the use of ALT  
8 tests, and it emphasises that the drawbacks are that  
9 some infected donations might still be missed, false  
10 negatives, and some harmless donations might be  
11 excluded, false positives.

12 "The American evidence is that both drawbacks are  
13 serious: only perhaps 38% of genuinely infective  
14 donations are detected and some 70% of the apparently  
15 infective donations are harmless. Rejection of  
16 donations might reach 3% -- a grave loss."

17 Going over the page, it refers to the situation in  
18 New York:

19 "... the cost was put at 2 dollars per  
20 destination ... Dr Dow concludes that in Scotland 'cost  
21 would be extremely high and benefit minimal, especially  
22 when only a few cases of non-A, non-B post-transfusion  
23 hepatitis are reported each year'."

24 Then at point 8:

25 "Dr Dan Reid and Dr Follett do not recommend the

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1 accepted test capable of detecting the virus in blood,  
2 detection is by exclusion of other conditions such as  
3 those mentioned.

4 "4. Non-A, non-B hepatitis, thus defined, is not  
5 uncommon in the population; Dr Dan Reid reckons an  
6 incidence for Scotland of 154 cases per year, but has  
7 little confidence in this estimate because it can only  
8 be derived by starting from the total of all hepatitis  
9 cases reported (probably under-reported) by clinicians,  
10 and deducting the cases of hepatitis B detected in  
11 laboratories (probably fully reported). It is common  
12 among drug-abusers. But in association with blood  
13 transfusion it is very uncommon in the west of Scotland.  
14 Over the last 8 years, 1-5 cases are found each year  
15 there, and there is no upward trend. There are peculiar  
16 difficulties in identifying its presence in  
17 haemophiliacs, since their blood exhibits diverse  
18 reactions because of repeated administration of blood  
19 products, but Dr Dow found no evidence of any  
20 substantial problem. Dr Dow reckons that the proportion  
21 of donations infected with non-A, non-B hepatitis may be  
22 18 per hundred thousand."

23 "5. The condition is not as a rule serious, and  
24 most of the cases detected have not even been jaundiced.  
25 There may however be a tendency for it to become

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1 introduction of ALT testing of Scottish blood donations,  
2 for the above reasons."

3 Firstly on this minute, do you recall if you saw  
4 it at the time? I'm afraid there is no distribution  
5 list attached to it.

6 A. I don't recall.

7 Q. Paragraph 1, it states that the information in it is  
8 mostly derived from Dr Dow's thesis. This was a thesis  
9 that was criticised by Lord Penrose for some of its  
10 methodology. I'll just bring up that criticism,  
11 PRSE0005070.

12 If we could have -- you'll see this is chapter 27  
13 of Lord Penrose's report, and if we could have page 32,  
14 please. We can see there at 27.115 there is summary of  
15 some of the findings of the report from Dr Follett and  
16 Dr Dow, and it says this, in the second sentence:

17 "Recipients of the donations were not followed up  
18 and no data were gathered on the use of 10,655 donations  
19 or their destination within the blood services. Data  
20 were available of clinically likely cases of  
21 post-transfusion NANB Hepatitis reported to the Glasgow  
22 and West of Scotland BTS: there had been reports of nine  
23 cases only. The notification requirements related to  
24 'infective jaundice'. They were not well adapted to  
25 generate reports of [non-A, non-B hepatitis] which was,

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1 in fact, seldom associated with clinical jaundice. In  
 2 addition, reports of notifications of an infectious  
 3 disease whose characteristics were poorly understood by  
 4 clinicians generally were most unlikely to provide sound  
 5 evidence of prevalence to the condition. Without  
 6 follow-up of the donations tested, the study did not  
 7 provide a basis on which the prevalence of  
 8 post-transfusion NANB Hepatitis could, or should, have  
 9 been drawn. Unfortunately, it was concluded on the  
 10 basis of the reported cases that post-transfusion NANB  
 11 Hepatitis was 'not a major problem' in the region. That  
 12 conclusion was not based on sound evidence. Nor did it  
 13 indicate the potential value of ALT surrogate testing,  
 14 or a basis for assessing that value.

15 "Even more unfortunately, as will be seen below,  
 16 the conclusions from the report were for several years  
 17 used to support the contention that post-transfusion  
 18 NANB Hepatitis was not a significant problem."

19 That is Lord Penrose's conclusion or critique of  
 20 Dr Dow's thesis. Do you have any comment on Lord  
 21 Penrose's critique?

22 **A.** No, the -- it's based on thorough post-facto  
 23 investigation of all the evidence on the subject,  
 24 including the post-facto observations of expert  
 25 witnesses. So I would take it as absolutely

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1 raised, and may be submitted to the chair in due course,  
 2 is that a reason why the SHHD, and Dr Forrester and  
 3 others, placed emphasis on this paper was because it  
 4 supported their position, in effect confirmation bias.  
 5 Do you think that that would be a fair critique of  
 6 Dr Forrester --

7 **A.** I think that's putting the cart before the horse. It is  
 8 part of the information on which our view was based.  
 9 But I cannot imagine that it carried much weight with  
 10 Department of Health colleagues south of the border, who  
 11 came to the same conclusion as we did.

12 **Q.** There was, was there not, a dearth of research in  
 13 Scotland on NANB?

14 **A.** Yes, and that we saw as unfortunate. It was clear that  
 15 there was some difference internationally and  
 16 conceivably within the UK in the incidence of  
 17 blood-borne non-A, non-B hepatitis, but we didn't have  
 18 enough information on the scale of the Scottish problem.  
 19 So, yes, we were supportive of research on the matter,  
 20 which I think the Department of Health were also  
 21 supportive of, and research was indeed launched south of  
 22 the border, to our regret, without Scottish  
 23 participation.

24 **Q.** Dr McClelland, we know from reading Penrose, had pushed  
 25 for research really from the early 1980s.

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1 authoritative.

2 **Q.** Were you aware at the time that there were these  
 3 potential flaws in Dr Dow's methodology and Dr Dow's  
 4 study?

5 **A.** No.

6 **Q.** Now, it's correct, isn't it, that you stress in your  
 7 witness statement that Dr Dow's thesis was not the only  
 8 source of information that the SHHD had about the  
 9 severity of non-A, non-B and the wider issue of  
 10 surrogate testing, but at this stage, would you agree,  
 11 this note is expressly said to be mostly derived from  
 12 Dr Dow's thesis?

13 **A.** The note that you threw up a moment ago by  
 14 John Forrester? Yes --

15 **Q.** Yes.

16 **A.** -- you're correct, it's explicitly a summary of that PhD  
 17 thesis.

18 **Q.** Through the months that followed, Dr Dow's PhD thesis  
 19 continued, did it not, to be a significant source of  
 20 information for the HHD.

21 **A.** That's what Lord Penrose's Inquiry concluded, yes. But,  
 22 as I've said, not the only bit of information, but part  
 23 of the information base that we will have relied upon.

24 **Q.** Now, I'm conscious that you are, as you put it, a "mere  
 25 historian", not a scientist. But a question that may be

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1 **A. (The witness nodded)**

2 **Q.** Perhaps an obvious point but it would have been helpful  
 3 to you had those proposals been taken forward?

4 **A.** Absolutely, yes. Wise after the event, but yes, it  
 5 would have been.

6 **Q.** Of course, you weren't involved in any way in that?  
 7 You --

8 **A.** I wasn't involved in any way?

9 **Q.** You weren't involved in any way in deciding whether or  
 10 not those research proposals went forward because that  
 11 predated your time at the SHHD?

12 **A.** Yes, yes indeed.

13 **Q.** Just for completeness, Dr Dan Reid who was mentioned  
 14 there, he was the director of the Communicable Disease  
 15 Surveillance Centre at Ruchill Hospital in Glasgow?

16 **A.** Yes, so not part of the Blood Transfusion Service, but  
 17 a very relevant expert.

18 **Q.** Turning now to a little later, 16 October 1986. I won't  
 19 ask that this document be brought up, but the reference  
 20 is PRSE0004812. Dr Scott, the DCMO, sent a minute to  
 21 Dr Forrester and Mr Murray asking about  
 22 non-A, non-B hepatitis screening and saying that he  
 23 would like to know where this stands and says:

24 "CMO DHSS is worried that if we go ahead, England  
 25 and Wales will have to follow suit. I think there must

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1 be consultation with DHSS before we agree to provide  
 2 funds for this screening."  
 3 **A.** That is the document that I was recollecting a moment  
 4 ago, where the English Department medics were expressing  
 5 their concern that we might go ahead, to their  
 6 embarrassment.  
 7 **Q.** Dr Scott is referring to consultation not seeking  
 8 instructions from the Department of Health?  
 9 **A.** Correct, that's absolutely the right verb to use.  
 10 **Q.** If we then look at the response to that, and I will ask  
 11 that this is brought up, PRSE0004313, this is from  
 12 Sandy Murray, the SEO, senior executive officer, to  
 13 Dr Scott, and he writes this:  
 14 "I refer to your minute of 16 October, and can  
 15 confirm that the bid we are making to our Finance  
 16 colleagues for money for the SNBTS in 1987/88 makes no  
 17 provision for Non-A and Non-B Hepatitis screening."  
 18 Then he gives some figures that I needn't trouble  
 19 you with.  
 20 The exchange there suggests that Dr Scott is being  
 21 informed about the decision on the bid, not that he is  
 22 deciding the decision. That decision has already been  
 23 taken; is that a fair summary?  
 24 **A.** Yes, it is.  
 25 **Q.** In his written evidence for Lord Penrose, Mr Murray, who

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1 the matter. However, the implication, as you say, was  
 2 that he had not been involved in the decision taking,  
 3 which I deduce must have meant that his subordinates,  
 4 Archie McIntyre and John Forrester, regarded it as  
 5 insufficiently uncertain to escalate to their boss. But  
 6 these two will certainly have been involved in the  
 7 decision taking, as was I, and almost certainly  
 8 Hugh Morison, my boss.  
 9 **Q.** When you say "insufficiently uncertain", does that mean  
 10 that the view amongst those within the SHHD was  
 11 sufficiently certain that this should be refused?  
 12 **A.** Correct.  
 13 **Q.** They didn't need to involve anybody higher up?  
 14 **A.** Correct. At that stage, the bid -- obviously  
 15 Sandy Murray transmitting that bid to the Finance  
 16 Division was not the end of the story; there was also an  
 17 iterative process with Finance Division. But it's  
 18 a little unlikely that that iterative process would have  
 19 included any consideration of the introduction of  
 20 surrogate testing, because it had been eliminated as  
 21 a bid at an earlier stage.  
 22 **Q.** You said earlier that the minister's role in all of this  
 23 would be to decide whether the game was worth the  
 24 candle.  
 25 **A.** (The witness nodded)

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1 you will remember was the fifth tier of the  
 2 Civil Service hierarchy -- sorry, we can take that down  
 3 now, thank you very much, Lawrence.  
 4 Mr Murray said in his written evidence to  
 5 Lord Penrose that he was the one who, in effect, took  
 6 that decision, although he would have consulted with  
 7 senior -- more senior colleagues as well.  
 8 So the SNBTS, with their expertise, have suggested  
 9 that they want money for surrogate testing, and that bid  
 10 has not proceeded beyond Mr Murray and his colleagues.  
 11 First of all, would you have been one of those  
 12 colleagues.  
 13 **A.** Absolutely.  
 14 **Q.** The Deputy Chief Medical Officer is being informed about  
 15 that decision. It having already been taken. My  
 16 question to you is, why is it that the civil servants  
 17 and the medical officers around tier 4, tier 5, were the  
 18 ones taking that decision, rather than either more  
 19 senior civil servants, or more ultimately, the minister?  
 20 **A.** Because we regarded it -- I must say I was slightly  
 21 surprised to see that Graham Scott had not been involved  
 22 in the decision taking, particularly because he was  
 23 a member of the Common Services Agency Management  
 24 Committee, which was a party to the PES bid and it may  
 25 be that he was asking for his mind to be refreshed on

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1 **Q.** Whether the cost of surrogate testing was worth the  
 2 benefits to the patients that were said to derive from  
 3 it.  
 4 **A.** (The witness nodded)  
 5 **Q.** The minister can't take a decision on that unless he is  
 6 informed of it?  
 7 **A.** That's correct, and that is true of a multitude of other  
 8 decisions taken across the Scottish Office. As we've  
 9 covered already, there was a limit to the number of  
 10 decisions which ministers could take in person, rather  
 11 than through the medium of the Civil Service. So that  
 12 was an entirety, as I said at the time, theoretical  
 13 question, because it was never, to my knowledge, put to  
 14 ministers.  
 15 **Q.** Looking -- indeed, there is no evidence that it was --  
 16 evidence at least that I have seen or that Lord Penrose  
 17 found.  
 18 **A.** (The witness nodded)  
 19 **Q.** Looking back now, do you think that, as of 1986, it  
 20 should have been put to the minister?  
 21 **A.** I have no appetite for making retrospective decisions of  
 22 that kind. It is absolutely clear that in 1986 we did  
 23 not think that it was worth putting to ministers, and  
 24 it's clear why we didn't think that it was worth putting  
 25 to ministers.

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1 **Q.** The reason why was because the view of the SHHD was that  
 2 it was not worth the candle?  
 3 **A.** Correct. And it was the view also of the Department of  
 4 Health, I observe.  
 5 **MR HILL:** Sir, I note the time. We're going to take the  
 6 story forward through 1987 and into 1988, but perhaps  
 7 after a sandwich.  
 8 **SIR BRIAN LANGSTAFF:** Yes, we will take a break now until  
 9 two o'clock. So two o'clock.  
 10 (1.03 pm)  
 11 (The Luncheon Adjournment)  
 12 (2.00 pm)  
 13 **SIR BRIAN LANGSTAFF:** Yes, Mr Hill?  
 14 **MR HILL:** Mr Macniven, the next period I would like to take  
 15 you to is 1987, March and April of that year. On  
 16 3 March 1987 the SNBTS directors met, it was a meeting  
 17 attended by Dr Forrester, and the directors agreed to  
 18 recommend the implementation of surrogate testing in  
 19 Scotland from 1 April 1988, and the reference for those  
 20 who need it is PRSE0004163.  
 21 The SNBTS directors also included a further bid in  
 22 the public -- in the PES process in 1987, at lower  
 23 levels this time: £300,000 for year one and £105,000 for  
 24 year two, and that's at Penrose 27.180.  
 25 So SNBTS still pushing for the introduction of

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1 transfusion-associated 'Non-A, Non-B Hepatitis' was not  
 2 great ..."  
 3 I just pause there to note that's a reference, is  
 4 it not, to Dr Dow's research, and CSO funding is funding  
 5 from the chief -- is it central scientific --  
 6 **A.** No, Chief Scientific Office, yes, that's correct. It's  
 7 a reference to Dr Dow's research, the significance of  
 8 that was that this, I think, is that this is a request  
 9 for further Chief Scientist Office funding, and  
 10 Archie McIntyre brings out the point that Dr Dow's work  
 11 was carried out with CSO funding.  
 12 Just to explain a reference at the top of the  
 13 page, if you could page up a little to the top of the  
 14 page, you see the appearance of Dr Moir among the  
 15 addressees, now Dr Moir hasn't appeared in our  
 16 dramatis personae so far, and he was the director of the  
 17 Department's Chief Scientist Office, and it was the  
 18 Chief Scientist office that held the budget for  
 19 research. So Dr Moir was essentially the manager of the  
 20 research budget and other functions, but that's his  
 21 relevance there.  
 22 **Q.** Perhaps relevant as well, that he's featuring  
 23 prominently on this list of people to whom  
 24 -- (overspeaking) --  
 25 **A.** Yes, probably.

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1 surrogate testing at a corporate level. If I could take  
 2 you to a document which is from 6 April 1987, it's  
 3 PRSE0000618. This is a minute from Mr McIntyre, to  
 4 remind everybody the principal medical officer one tier  
 5 up from Dr Forrester. He produced a minute which was  
 6 sent to Dr Scott, the Deputy Chief Medical Officer,  
 7 Dr Moir, Mr Morison, your boss, to you, to Sandy Murray  
 8 and to Dr Forrester.

9 It's entitled: "Scottish Participation in UK  
 10 Research Project on Transfusion-Associated  
 11 Non-A, Non-B Hepatitis". The first three paragraphs set  
 12 out some background about non-A, non-B hepatitis and  
 13 surrogate testing and the introduction of surrogate  
 14 testing in the USA, which Dr McIntyre says he largely  
 15 suspects is the result of a fear of litigation.

16 What he then goes on to say in the second  
 17 paragraph from the bottom, starting "SHHD was asked" is  
 18 this:

19 "SHHD was asked last year to meet the expenditure  
 20 of [£810,000] annually to establish screening of all  
 21 blood donations with the intention of reducing  
 22 transmission of 'Non-A, Non-B Hepatitis' by blood and  
 23 blood products. Approval was not given as research  
 24 already conducted in the West of Scotland with CSO  
 25 funding indicated that the impact there of

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1 **Q.** If we could just go back -- thank you for that -- if we  
 2 could go back to the penultimate paragraph. So  
 3 Dr McIntyre is referred to Dr Dow's research and then he  
 4 also says:  
 5 "... also that the indirect screening proposed  
 6 would be expensive, could not in any event abolish the  
 7 transmission of this 'Hepatitis' by blood and blood  
 8 products, and would lead to a loss of a perceptible  
 9 amount of 'innocent' blood which nevertheless failed to  
 10 pass the screen. We also wished to await DHSS thinking  
 11 on this subject.

12 "DHSS have now invited their Transfusion  
 13 Associated Hepatitis Working Party, which includes two  
 14 Scottish members and an SHHD observer, to consider this  
 15 issue. The Working Party noted the research already  
 16 conducted in the West of Scotland and advised that  
 17 instead of embarking at once on expenditure amounting  
 18 the UK to perhaps £6-8 [million] ..."

19 **SIR BRIAN LANGSTAFF:** Once off, I would imagine, rather  
 20 than once on -- oh, sorry. I beg your pardon. My  
 21 misreading. Apologise. Sorry about that. Sorry,  
 22 Mr Hill.

23 **MR HILL:** No problem. I think there is a word missing  
 24 there which is:

25 "... instead of embarking at once on expenditure

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1 amounting ['in', I think is the word missing] the UK to  
 2 perhaps £6-8 [million] ..."  
 3 So that's the figure for the whole of the UK and  
 4 not just Scotland:  
 5 "... research should be commissioned to expand the  
 6 previous Scottish research; it is agreed that the impact  
 7 of this 'Hepatitis' differs considerably in different  
 8 countries. The research is planned to take place in  
 9 three English centres and one Scottish centre  
 10 (Edinburgh), the English component has been presented to  
 11 the Research Management Division of DHSS; a formal  
 12 application has been encouraged and is now being  
 13 prepared with a view to a start in September 1987.  
 14 "The Directors of SNBTS are unanimous, and are now  
 15 pressing fairly strongly, that this screening should be  
 16 instituted; though perfectly aware that it would be  
 17 costly and could not abolish transmission completely,  
 18 they could then claim to have taken all steps open to  
 19 them to reduce transmission. Before embarking on such  
 20 an expensive programme it would seem logical to  
 21 participate in the proposed research and to delay any  
 22 further action until the results of this were known."  
 23 That's Dr McIntyre's minute, his view. If we  
 24 could just go back to the front page we can see some  
 25 marginalia, there which is from Mr Morison, your boss.

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1 Your response in a minute, dated 9 April 1987, is  
 2 at PRSE0000784. This says, addressed to Dr McIntyre:  
 3 "Thank you for your minute of 6 April. I am  
 4 replying on my own behalf and that of Mr Morison;  
 5 Mr Murray of my Division is not in a position to reply,  
 6 since he is on sick leave.  
 7 "Dr Morison and I entirely agree with Dr Scott's  
 8 comments in his minute of 7 April to you. It is  
 9 important that the decision on whether or not to screen  
 10 all blood for Non-A and Non-B Hepatitis, which will not  
 11 be cheap and may not be certain, should be taken on the  
 12 basis of the sort of UK research you suggest."  
 13 That is 9 April 1987. We can see from those  
 14 documents that there is a clear consensus, is there not,  
 15 between you, Dr McIntyre, Dr Scott, Mr Morison, that the  
 16 cost-benefit analysis is clearly against testing, and  
 17 also a consensus that you want to encourage further  
 18 research; is that a fair summary?  
 19 **A.** Fair insofar as it goes. It's not simply a question of  
 20 cost effectiveness, though.  
 21 **Q.** What else was --  
 22 **A.** Well -- if you could bring up the document -- I think  
 23 Dr Scott's comments -- again, please.  
 24 **Q.** PRSE0002916, please.  
 25 **A.** There was something about "and may not be effective".

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1 The marginalia says:  
 2 "Mr Macniven  
 3 "Advice please. My initial reaction is that it  
 4 would not make sense to screen all blood for non-A non-B  
 5 as benefits appear out of all proportion to the risks.  
 6 "(b) we should therefore participate in the  
 7 Research.  
 8 "(c) CSO should be encouraged to fund it."  
 9 Then if we look at two replies to this minute, the  
 10 first comes from Dr Scott, the Deputy Chief Medical  
 11 Officer, that's at PRSE0002916, sent to Mr McIntyre  
 12 copied to Dr Moir, as you said earlier, and other  
 13 addressees of the previous minute.  
 14 Dr Scott, on 7 April 1987, wrote this:  
 15 "I agree in principle with the procedure outlined  
 16 in your minute of 6 April.  
 17 "We must do whatever we can to prevent the BTS  
 18 going ahead with a full scale introduction of this  
 19 testing -- or at least trying to blackmail us into the  
 20 provision of funds.  
 21 "The research proposal from Edinburgh will of  
 22 course have to be subject to the scrutiny of the  
 23 appropriate CSO group and the availability of finance.  
 24 I would not like to see it fail on the grounds of  
 25 finance because the stakes are high."

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1 There's the question ...  
 2 Yes, he deals with funds. It was maybe in  
 3 Archie McIntyre's note --  
 4 **Q.** Yes, PRSE -- (overspeaking) --  
 5 **A.** -- something to the effect of it would be costly and may  
 6 not be effective. It's not just a question of cost, is  
 7 my point. It's also a doubt, which we alluded to before  
 8 lunch, about whether the surrogate testing would be  
 9 sufficiently good to be helpful.  
 10 **Q.** Could we have up on screen, please, Lawrence,  
 11 PRSE0000618. This is Dr McIntyre's original note.  
 12 **A.** Yes, I'm sorry to get you to go back to an old document.  
 13 **Q.** No problem at all.  
 14 The penultimate paragraph starting "SHHD was  
 15 asked", and as we've seen it refers --  
 16 **A.** Yes, yes.  
 17 "... also that the indirect screening proposed  
 18 would be expensive ..."  
 19 Yes, the question of cost.  
 20 "... could not in any event abolish the  
 21 transmission of this 'Hepatitis' by blood and blood  
 22 products, and would lead to a loss of a perceptible  
 23 amount of 'innocent' blood which nevertheless failed to  
 24 pass the screen."  
 25 It is not simply a question of cost.

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1 **Q.** The wording used there by Dr McIntyre is "could not in  
2 any event abolish". Now, what might be said about that  
3 is that that is setting the bar too high, and that  
4 surrogate testing would not abolish, and nobody would  
5 claim that it would, but it would do some good. Did  
6 you, to the best of your knowledge, accept that I would  
7 do something to reduce the incidents of non-A, non-B --  
8 **A.** I can't remember contemporaneously, but among the  
9 multitude of papers that you've provided me with on the  
10 subject, there's one that says it would be about 40%  
11 ineffective. The false negatives, ie, infected people  
12 who did not -- who were not triggered by the surrogate  
13 testing, was in the region of 40%. So it was  
14 seriously -- it would fail to abolish the transmission  
15 by quite a margin according to the written evidence, the  
16 documents that you've supplied.  
17 I don't remember contemporaneously, though, how  
18 much these different factors weighed in the judgment we  
19 took, but all these factors were interwoven, and another  
20 one which Archie doesn't mention in this email, this  
21 minute, is that it would create a difficulty in relation  
22 to donors who falsely tested positive, and who would  
23 therefore have to be counselled that they had or might  
24 have had a disease which was -- non-A, non-B hepatitis,  
25 which was a bit mysterious but could, in some

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1 report he talked about other research projects that were  
2 going on in Europe at that time.  
3 Dr Scott's contribution, with which you and  
4 Mr Morison expressed your agreement, is expressed in  
5 some fairly stark terms:  
6 "We must do whatever we can to prevent the BTS  
7 going ahead ..."  
8 And also a reference to them blackmailing the  
9 SHHD.  
10 It may be submitted to the chair in due course  
11 that that is perhaps indicative of an approach from the  
12 SHHD which has slipped from being merely determined to  
13 being dogmatic in its opposition to surrogate testing  
14 and the SNBTS's proposals. What would you say, if that  
15 were a proposition that were put to the chair?  
16 **A.** Yes, it is a fairly dogmatic statement. I think it was  
17 fed by an impatience by Dr Scott, on the part of  
18 Dr Scott, with the tactics of the SNBTS. It does not  
19 speak to his root and branch opposition to any form of  
20 surrogate testing, hence the research which he is  
21 supporting.  
22 **Q.** Were you and your colleagues still listening to the  
23 arguments at that stage, for --  
24 **A.** Oh, absolutely. We continued to listen to the arguments  
25 throughout. We kept revisiting this question, my memory

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1 circumstances, be serious.  
2 **Q.** That is certainly an argument which is raised in other  
3 papers but, as you say, not by Dr McIntyre in this  
4 relatively short minute.  
5 **A.** Yes, indeed. I don't think Archie McIntyre was  
6 intending to give a full treatise on the subject. The  
7 purpose of his note was to persuade Boyd Moir to unlock  
8 the money.  
9 **Q.** This question of seeking the research, was that  
10 a genuine concern for additional data to inform the  
11 decision or was it a way of kicking this issue into the  
12 long grass?  
13 **A.** No, I think it was a genuine concern, which was shared  
14 by, for example, at an earlier stage, Brian McClelland.  
15 Now it could -- of the Scottish National Blood  
16 Transfusion Service, one of the regional directors.  
17 Now, it could be said that this hour in the day  
18 was too late to launch such research, but at the time,  
19 one didn't know what hour of the day it was. It was  
20 only a couple of years before hepatitis C was identified  
21 but one couldn't, at this stage, be certain that it was  
22 as short a period as that. So the research evidence  
23 could still be useful.  
24 **Q.** I think it's relevant to note, so that others can follow  
25 it if they wish to, but in chapter 27 of Lord Penrose's

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1 is, over quite a long period. Our mind was not closed  
2 because the -- for instance, because the SNBTS was still  
3 advocating surrogate testing.  
4 **Q.** There followed a series of letters in The Lancet, not  
5 obviously in response to this minute and this proposal,  
6 but just in coincidence at the time. I'm not going to  
7 go through all of them, but for the record, on  
8 18 April 1987, there was a letter in The Lancet opposing  
9 surrogate testing without further research, which came  
10 from Dr Catherine Anderson and others at the  
11 North London Blood Transfusion Centre.  
12 On 2 June 1987 another letter from other doctors  
13 at the same Centre, again opposing the introduction of  
14 surrogate testing without further research and  
15 prospective trials in particular.  
16 Then on 13 June 1987 a letter sent by Dr Dow,  
17 Dr Mitchell and Dr Follett from Glasgow expressing  
18 scepticism about surrogate testing and reporting  
19 Dr Dow's thesis and separately in the same edition  
20 a letter from Dr Gillon and colleagues at Edinburgh  
21 concluding that surrogate testing could not at that time  
22 be justified.  
23 Then, on 4 July 1987 there is a letter in support  
24 of surrogate testing which is sent on behalf of the  
25 directors of the SNBTS and if we could have that on

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1 screen, please, PRSE0001444.  
 2 If we just go to the second page, we can see the  
 3 signatories in the top of the second column. You can  
 4 see it's signed by Dr McClelland, Dr Cash, Dr Urbaniak,  
 5 Dr Mitchell, Dr Brookes, Dr Perry and Dr Whitrow.  
 6 If we go back, please, to the first page, I'm  
 7 going to read through this and I'm going to ask you to  
 8 comment on the arguments that were raised in this letter  
 9 in support of surrogate testing, noting the context that  
 10 there had been other letters to The Lancet which opposed  
 11 the introduction of surrogate testing at least without  
 12 further research.  
 13 The letter is entitled "Testing blood donors for  
 14 non-A, non-B hepatitis: irrational, perhaps, but  
 15 inescapable".  
 16 "Sir, -- in three letters in *The Lancet*  
 17 Dr Anderson, Dr Gillon, and Dr Dow and their colleagues  
 18 ... point out weaknesses in the arguments which have  
 19 been used to support the introduction of blood donor  
 20 screening to reduce transfusion-transmitted  
 21 non-A, non-B hepatitis ... using alanine  
 22 aminotransferase (ALT) and hepatitis B core antibody ...  
 23 as surrogate markers. All three letters suggest that  
 24 the UK transfusion services should not start donor  
 25 screening until prospective controlled studies have been

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1 antiviral treatment, these processes remain to be  
 2 validated in large-scale trials. Meantime, even if  
 3 surrogate marker screening would only modestly reduce  
 4 the level of infectivity in these products, many would  
 5 argue that some improvement is better than none.  
 6 "(3) The UK transfusion services, although the  
 7 major suppliers in this country, cannot afford to ignore  
 8 the wishes of consumers to be supplied with  
 9 'non-A, non-B tested' products, even if it is believed  
 10 that the real benefit in safety which is offered to the  
 11 patient is marginal. Commercial suppliers will not be  
 12 slow to point out that their products are made from  
 13 tested plasma and must therefore be safer. Clinicians  
 14 and patients can hardly be blamed for taking note of  
 15 this message. And this argument may be applied equally  
 16 to whole blood, red blood cells, platelets and plasma.  
 17 What better marketing employ for a private blood bank  
 18 than to emphasise that its donors are tested to exclude  
 19 hepatitis using the standards applied in the  
 20 United States, Germany, and France? The local NHS blood  
 21 supplier will have trouble shrugging off accusations of  
 22 providing a second-class product.  
 23 "It is also worth taking a second look at the  
 24 assumption that surrogate marker testing is necessarily  
 25 a 'bad buy' in comparison with the tests that are

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1 done in the UK to find out how many cases of  
 2 post-transfusion hepatitis would be prevented. No large  
 3 study to answer this critical question has yet been  
 4 presented, and we agree that the size of the benefit to  
 5 be gained from surrogate testing cannot be accurately  
 6 established without such a study. However, the time for  
 7 this study has already passed. Starting now will give  
 8 us an answer in 3-4 years -- and that is probably 3 to  
 9 4 years too late. The introduction of surrogate marker  
 10 testing for NANBH is now virtually inescapable, for  
 11 three reasons:

12 "(1) In 1988 European legislation on strict  
 13 product liability comes into force in the UK."

14 Pause to note that's a reference to the Consumer  
 15 Protection Act.

16 "If harm should come to the recipient of  
 17 a therapeutic product, the producer will be held liable  
 18 unless he can demonstrate that he has used all known  
 19 methods and information to avoid the risk. Under these  
 20 rules a patient who contracted NANBH via transfusion of  
 21 blood or a blood product would have a claim against the  
 22 supplier if it was shown to come from a donor who had  
 23 not been tested for both raised ALT and anti-HBc.

24 "(2) Although we all hope that pooled plasma  
 25 fractions will soon be made safe by heating or other

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1 accepted as essential to prevent other  
 2 transfusion-transmitted infections. Table 1 shows  
 3 a calculation to illustrate the cost of surrogate  
 4 testing to prevent one case of cirrhosis due to  
 5 transfusion-transmitted [non-A, non-B hepatitis]. This  
 6 should be compared with the cost of HIV antibody testing  
 7 to prevent one case of transfusion-transmitted AIDS.  
 8 Alternatively, one could compare the costs of the  
 9 present practice of routinely hepatitis B testing all  
 10 repeated blood donors (in whom the prevalence of in  
 11 infection is predictably very low). Table ii shows how  
 12 these testing costs relate to the gains in recipient  
 13 safety. These calculations suggest that, even if the  
 14 underlying assumptions are varied quite widely, the cost  
 15 of prevent morbidity by surrogate marker testing for  
 16 NANBH may be no greater, and could be less, than those  
 17 which are accepted for established screening programmes.  
 18 "Looking at these three factors -- producer's  
 19 liability, competition and value for money -- we suggest  
 20 that the decision which has to be made is when rather  
 21 than whether the UK transfusion services follow the lead  
 22 of the United States and the European countries in donor  
 23 screening."

24 We have already referred to the signatories and  
 25 I am not intending to go through the tables showing the

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1 cost-benefit analysis that has been put forward in this  
 2 paper.  
 3 If we could take that off the screen, please,  
 4 Lawrence.  
 5 I'd like you to address, if you would, the  
 6 arguments that are put forward. My screen has frozen  
 7 the document on there. I don't know if everybody can  
 8 still hear me?  
 9 **A.** Yes, I can still hear you fine.  
 10 **Q.** Thank you. Mr Macniven, the arguments that are put  
 11 forward, the first one is about the Consumer Protection  
 12 Act and the risk of legislation. Now, in your view, was  
 13 that a valid argument for the SNBTS directors to be  
 14 raising?  
 15 **A.** I can't now remember all these years later what  
 16 I thought about reading a Lancet article. I would  
 17 observe that we today have the benefit of hindsight and,  
 18 with the benefit of the hindsight, the very  
 19 knowledgeable and well-intentioned signatories of that  
 20 letter were simply wrong.  
 21 **Q.** They were wrong about what?  
 22 **A.** They were wrong on at least two of the three counts that  
 23 they gave. First, they said that it was inevitable that  
 24 it would be introduced. It was not inevitable. It was  
 25 not introduced either in England or in Scotland. The

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1 great to deal with the level of detail in these -- in  
 2 the article.  
 3 **Q.** Very well. We've discussed, as you say, the argument  
 4 that some improvement is better than none. Product  
 5 liability, I won't go into discussion of what litigation  
 6 was or was not brought, but would you accept that it was  
 7 a legitimate concern for the directors of the SNBTS to  
 8 be sure that they were, or to seek to ensure that they  
 9 were acting in a way that was compliant with recently  
 10 passed legislation?  
 11 **A.** Um, the question of product liability was very  
 12 complicated, and my recollection is that the SNBTS  
 13 directors did not fully understand it. We had long  
 14 conversations with Graham Calder, the Department's Chief  
 15 Pharmacist, who was the expert, the Scottish expert on  
 16 the subject of product liability, which I think allayed  
 17 their fears about product liability, fears which were  
 18 not uncalled for, for the reason you give, but were not  
 19 well founded.  
 20 **Q.** The comparison that they present with HIV and HBV, now  
 21 I'm not going to look at those specific figures and the  
 22 Penrose Report does contain some discussion of them, the  
 23 assumptions that lie behind them. Was that an argument  
 24 that you were aware was being made at the time, "We're  
 25 for HIV, we're testing for HBV, we should be testing for

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1 first of their arguments was that it related to product  
 2 liability and the fear of claims against the Blood  
 3 Transfusion Service, which could have been avoided by  
 4 the introduction of testing. Now, it may be that my  
 5 information is incomplete but I recollect in my time no  
 6 cases of that kind.  
 7 The third -- we've already dealt with the --  
 8 discussed their second argument. Their third argument  
 9 was that the market would shift away from the Protein  
 10 Fractionation Centre product towards commercially  
 11 produced product, which although not necessarily safer  
 12 and arguably more dangerous, had the gold seal of  
 13 surrogate testing. That did not happen.  
 14 Indeed, we may come on later this afternoon to the  
 15 fact that the clinicians in Scotland were deploring the  
 16 fact that we were no longer self-sufficient in blood  
 17 products. They were complaining about their inability  
 18 to prescribe freely the very product which this letter  
 19 to The Lancet suggests that they would regard as  
 20 anathema.  
 21 **Q.** Let's just go through the arguments one by one there,  
 22 and come on to how -- or look at them through the lens  
 23 at the time rather than retrospectively.  
 24 **A.** I fear that I can -- that I can't do that. My  
 25 recollection of reaction at the time is insufficiently

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1 NANB as well?"  
 2 **A.** I can't recollect. I can't recollect.  
 3 **Q.** The final argument that was made is that this testing  
 4 had been introduced in West Germany, in France and in  
 5 the United States. Now leaving aside quite why it was  
 6 introduced in each of those countries, was that  
 7 an argument that was at least worthy of consideration,  
 8 that these advanced western democracies were putting in  
 9 place such testing, and so we should at least be  
 10 thinking about it?  
 11 **A.** Yes, and we were indeed thinking about it, bear in mind  
 12 that the nature of the health service in the States  
 13 is -- and its propensity to litigate, or patients'  
 14 propensity to litigate, was completely different from  
 15 the UK scene, and bearing in mind too that these are  
 16 three countries, all as you say, western democracies,  
 17 the letter understandably did not list the western  
 18 democracies, including the rest of the UK, which had not  
 19 introduced surrogate testing service.  
 20 **Q.** One final document reporting final questions on  
 21 surrogate testing, PRSE0003515, please. This is  
 22 a minute that you wrote on 2 October 1987. It is sent  
 23 to Dr Forrester and copied to Dr McIntyre and to  
 24 Dr Forbes of the Chief Scientist Office, "SNBTS:  
 25 Screening Donations for Non-A, Non-B Hepatitis" and it

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1 refers to a minute that was sent to you on 1 October.  
 2 It says:  
 3 "Your final paragraph concerns timing. The PES  
 4 timetable really requires us to reach a decision very  
 5 soon on whether to earmark funds to the SNBTS for this  
 6 purpose. I have however taken steps to get round this  
 7 problem, by registering with Finance Division that  
 8 a need for [non-A, non-B] testing may emerge but (and  
 9 this is the key point) it would be premature to allocate  
 10 money to the SNBTS for the purpose at the moment.  
 11 "But I am a little anxious about the timescale  
 12 implied by your minute. I am very anxious indeed for  
 13 our decision (on whether or not to put resources into  
 14 NANB testing) should be properly informed by research  
 15 evidence. If that evidence justifies testing, then it  
 16 is very important that we should be able to find the  
 17 money to start it quickly. If it does not justify  
 18 testing, it is equally important that we should not have  
 19 allocated money to the SNBTS for the purpose, thereby  
 20 sterilising it for other uses. But I think the worst of  
 21 all possible worlds is that research cannot get off the  
 22 ground: I fear that, in those circumstances, we would be  
 23 subjected to increasingly irresistible pressure to spend  
 24 the money in any case, for the sake of improving (at any  
 25 price) the safety of blood and blood products."

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1 **Q.** Beginning of October 1987.  
 2 **A.** Paragraph 1 and the paragraph you've just quoted from  
 3 both demonstrate, I think, that our minds were open. My  
 4 mind was open, but I was expressing here the collective  
 5 thoughts, the unanimous thoughts that I've already  
 6 spoken about, of me and my colleagues that let me quote  
 7 it, that "if that evidence justifies testing". Our mind  
 8 was open and I was guarding against the possibility that  
 9 the answer was you've got to introduce it, and our  
 10 pockets were empty. And it would have been quite  
 11 unreasonable to expect the SNBTS to start testing  
 12 without some form of subvention for the purpose.  
 13 So this is an example, it's helpful that you've  
 14 thrown it up, that gives the -- that demonstrates that  
 15 it would be wrong to allege, as you seemed to be coming  
 16 close to alleging before lunch, that the departmental  
 17 mind, having been made up, was never going to change.  
 18 That was not the way that we operated.  
 19 **Q.** I'm making no allegations. I'm putting propositions to  
 20 you so that you have an opportunity to --  
 21 **A.** Very well. You were proposing that that was the case.  
 22 **Q.** I was putting the proposition so that you had  
 23 an opportunity to respond to it.  
 24 **A.** Well, it's useful to have evidence in support of the  
 25 answer I then gave.

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1 Now, a couple of things to pick up from there.  
 2 Firstly is the question of the acute need to sort out  
 3 the funding bids for the PES round and it appears from  
 4 this minute that you had resolved that problem by  
 5 talking to the Finance Division and --  
 6 **A.** Up to a point. I had -- I had kept the possibility open  
 7 but that possibility could not be kept open indefinitely  
 8 because, in the end, Finance Division would have to set  
 9 budgets.  
 10 **Q.** Would you have consulted with others within the SHHD  
 11 before taking those steps?  
 12 **A.** I would have done. I don't recall having done so but  
 13 it's inconceivable that I wouldn't have done.  
 14 **Q.** The second point about the research, the wording that  
 15 you use there seems to hold open the possibility that  
 16 the research might show that surrogate testing --  
 17 **A.** Oh, yes.  
 18 **Q.** -- would --  
 19 **A.** Yes.  
 20 **Q.** That was something that was on your mind at that time?  
 21 **A.** Say that again, sorry?  
 22 **Q.** That was something that was still in your mind?  
 23 **A.** Oh, yes, I mean, an interesting thing about this  
 24 minute -- could you page down a little so I can see its  
 25 date? Yes, October '87.

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1 **Q.** By this stage, there is no evidence that I've seen, and  
 2 I don't think you've seen any evidence either, that the  
 3 issue had gone to a minister?  
 4 **A.** Correct. I don't think -- as we've said before, I don't  
 5 think it ever did.  
 6 **Q.** By October 1987 you had two PES rounds in which SNBTS  
 7 had made a bid for this?  
 8 **A.** (The witness nodded) --  
 9 **Q.** You have a seemingly stark disagreement between the  
 10 directors, and I stress the directors of the SNBTS?  
 11 **A.** (The witness nodded)  
 12 **Q.** -- and the SHHD about the issue, and that has ventilated  
 13 in The Lancet, it was the SNBTS directors view has been  
 14 ventilated in The Lancet, and again, I note that other  
 15 clinicians disagreed with them?  
 16 **A.** (The witness nodded)  
 17 Other clinicians within the organisation disagreed  
 18 with them, yes. I wonder whether it's right to call  
 19 them "clinicians" -- other people within the  
 20 organisation. "Clinicians" has a specificity of  
 21 definition that I'm not sure whether they meet or not,  
 22 but anyway, experts within the organisation were of  
 23 different views.  
 24 **Q.** I completely accept that correction.  
 25 The question that arises, therefore, is where

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1 there is this difference in view about, in essence, the  
 2 benefits that may be brought against the costs that may  
 3 be incurred, why was it that a minister was not asked to  
 4 judge whether or not that was worth it.

5 **A.** I don't know that I've got anything further to add to  
 6 what I've said this morning. (a) in general, it was  
 7 a very difficult call as to whether a matter was put up  
 8 to a minister for decision or not. (b) specifically on  
 9 this issue, we regarded the -- despite what you say  
 10 about the difference of opinion within the BTS, we  
 11 didn't regard the issue as being sufficiently open to  
 12 put to ministers, I deduce. I don't recollect this, but  
 13 I deduce from the papers that you've provided to me.

14 **Q.** Do you remember there ever being a discussion amongst  
 15 yourselves about whether or not this did need to go to  
 16 a minister?

17 **A.** There must have been, but I don't recall it, and the  
 18 papers that you have had kindly provided don't  
 19 illuminate the matter, but there must have been because,  
 20 as I say, it was always a difficult question about when  
 21 to involve ministers, whether to involve ministers.  
 22 We've clearly, over quite a period, repeatedly decided  
 23 that the time was not right to involve ministers.

24 **Q.** Just so that we complete the chronology, it appears that  
 25 after the autumn of 1987, some of the heat went out of

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1 And I think a part of what was in the Department's  
 2 mind would have been that we were in as good a position  
 3 as they were to evaluate the strength of that pressure.  
 4 I think there was no -- I think it would be wrong to  
 5 crack up a difference, as you and I may have been  
 6 slightly guilty of doing a moment ago, a difference of  
 7 scientific opinion between the chiefs in the SNBTS and  
 8 the expert Indians, if one is allowed to use chiefs and  
 9 Indians these days -- well, I'll find a synonym, the  
 10 senior folk in the SNBTS and their more junior but  
 11 expert colleagues.

12 I don't think there was such a scientific  
 13 difference of opinion. It was a difference of opinion  
 14 of that -- on that issue which I've mentioned a moment  
 15 ago which I've come up back to, which is that how great  
 16 is the pressure on us to introduce it, despite the lack  
 17 of scientific evidence and, for that reason, you could  
 18 imagine that the senior folk could take a different view  
 19 in a way that it wasn't really open. Their more junior  
 20 colleagues, however expert, didn't have the world view  
 21 that that kind of judgment required.

22 My point is that I do not think there was  
 23 a difference of scientific opinion within the SNBTS in  
 24 the way that you and I were, a moment ago, sort of  
 25 feeling our way towards.

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1 the issue. The SNBTS directors set up a Scottish  
 2 research project. There's a convoluted story about  
 3 which research projects got off the ground that I don't  
 4 think we need to trouble you with, and there was also,  
 5 April 1988, agreement from the SNBTS directors not to  
 6 introduce surrogate testing in Scotland until -- unless  
 7 and until it became a UK policy.

8 Then the following month, May 1988, we had the  
 9 announcement from Chiron, the American firm, that they  
 10 had identified what became known as the hepatitis C  
 11 virus.

12 **A.** Might I come back to a point that these remarks remind  
 13 me of? Going back to the question of how much weight  
 14 did we put on the SNBTS directors letter to The Lancet  
 15 *vis à vis* the letters from their staff. The directors  
 16 were never saying, as far as I can recollect and they  
 17 were certainly not saying in The Lancet letter --  
 18 remember what its headline was -- they were not saying  
 19 surrogate testing is scientifically/medically necessary.

20 They were saying, despite the paucity of  
 21 scientific/medical evidence, which is what their  
 22 subordinates were concerned with, despite the lack or  
 23 the paucity of that evidence, it is inevitable we will  
 24 be pressurised into it, not because we think it's good,  
 25 but because we have come under irresistible pressure.

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1 **Q.** Does it follow, then, that there would have been less  
 2 deference from the non-specialists in the SHHD on  
 3 a question which was one, as you say, of policy and  
 4 discussion of costs and benefits, than there would have  
 5 been if it had been a matter of pure science?

6 **A.** My recollection doesn't illuminate it, but that's my  
 7 deduction from the information -- from the written  
 8 information that you've provided.

9 **Q.** Do you have any memory now about why it is that the  
 10 issue does seem to fade away from the autumn of --

11 **A.** Yes, I don't have a contemporary recollection but,  
 12 linked to what I've just said, I think the chiefs in the  
 13 SNBTS were -- had perhaps become more confident that  
 14 pressure would not reach an irresistible level --  
 15 international pressure, commercial pressure, would not  
 16 reach an irresistible level.

17 **Q.** That is something that you are inferring now from the  
 18 documents you have seen, rather than --

19 **A.** Correct. It would be very interesting to ask  
 20 Brian McClelland whether that hypothesis is correct.  
 21 But it -- but I reach it on the basis of the  
 22 contemporaneous documents that you've provided.

23 **Q.** We also see, in April 1989, the creation of the Advisory  
 24 Committee on the Virological Safety of Blood as  
 25 a UK-wide body --

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1 A. Yes.  
 2 Q. -- and we're getting closer to the end of your time in  
 3 that role in the SHHD.  
 4 A. Yes.  
 5 Q. Why was it that a UK-wide body was instituted, in that  
 6 sense, for considering further testing, in particular  
 7 HCV testing?  
 8 A. I can't remember, I'm sorry, and although some of the  
 9 documents that you've provided deal with the creation of  
 10 that body, they don't -- as far as I remember, say why.  
 11 But in passing, I would say that this is an example of  
 12 an advisory body which I alluded to earlier, when I was  
 13 discussing the relationship between England and  
 14 Scotland, an advisory body which spans the border and  
 15 Archie McIntyre's email about the research proposal  
 16 which we were looking at a moment ago refers to another  
 17 such body, the name of which I can't remember, but  
 18 that's just two examples of what I was alluding to  
 19 earlier.  
 20 Q. Do you have any insight as to why it was that it wasn't  
 21 until April 1989 that the Advisory Committee on the  
 22 Virological Safety of Medicines --  
 23 A. I'm sorry, I don't.  
 24 Q. I'm going to move on, then, from the testing, the  
 25 question of testing --

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1 balanced that it required to be referred to ministers  
 2 for decision."  
 3 It seems to me that that is quite an authoritative  
 4 conclusion, briefly expressed on the basis of a great  
 5 deal of research on this matter that Lord Penrose's  
 6 Inquiry carried out.  
 7 Q. In your view, do you think that it was -- if we separate  
 8 those two issues out -- the substantive decision and the  
 9 process behind that decision, in your view, looking back  
 10 now, having the benefit of the papers and Lord Penrose's  
 11 report, do you have any regrets about the course that  
 12 you took?  
 13 A. That sort of question of hindsight I have no particular  
 14 views on. I think it's salutary to look at the  
 15 conclusion of Lord Penrose, who looked at it in  
 16 a dispassionate way at these matters, with the benefit  
 17 of hindsight.  
 18 Q. Lawrence, thank you. We can take that down now, please.  
 19 I am going to move on, unless there are any other  
 20 observations you'd like to make about surrogate testing?  
 21 There are a few topics now. All of them will be  
 22 relatively brief, partly because your involvement in  
 23 them was relatively brief or, in some instances, because  
 24 everything has been set out either in your witness  
 25 statement or in Lord Penrose's Report or both.

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1 A. Could I, before you do, take you to the conclusions of  
 2 Lord Penrose's Inquiry which looked, obviously from  
 3 an entirely Scottish angle, at the events surrounding  
 4 surrogate testing? Because it was an important topic.  
 5 Q. Have you got a particular paragraph --  
 6 A. Yeah, hold on a sec. I think the key one is on page 103  
 7 of chapter 27 of Lord Penrose's final report. I can  
 8 give you the paragraph reference, if you'd prefer that?  
 9 Q. Can we try, please, PRSE -- there may be some issue  
 10 about precise page numbers but I'm sure we can find  
 11 it -- PRSE0005070, page 103.  
 12 A. I propose to read out that paragraph, if that's okay.  
 13 Q. Which paragraph is it please?  
 14 A. Paragraph 27.415. So it's not a long paragraph. I'll  
 15 manage to read it quite quickly. May I?  
 16 Q. Please, go ahead.  
 17 A. "The Inquiry [that is Lord Penrose's Inquiry] does not  
 18 attribute blame for the fact that surrogate testing was  
 19 not introduced, given the diversity of respected medical  
 20 and scientific views over the period 1986-91. There was  
 21 no consistent support for the procedure on tenable  
 22 scientific or medical grounds that would have made it  
 23 possible to conclude that officials [that's me and my  
 24 colleagues] should have recommended the introduction of  
 25 ALT testing, or that the question was so narrowly

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1 The first concerns financial support in the  
 2 instigation of the Macfarlane Trust, and then the  
 3 second, the HIV Litigation.  
 4 Now, in your witness statement at page 50,  
 5 paragraph 77.1, you say, in effect, that you don't  
 6 recall anything about the topic, the papers haven't  
 7 helped you, and that the Home and Health Department  
 8 division concerned with HIV and AIDS took the lead on  
 9 that question. So is it right to understand that your  
 10 personal involvement in these matters was really very  
 11 limited?  
 12 A. I don't recall my personal involvement, and I deduce  
 13 that it was limited, yes.  
 14 Q. You able to assist us in understanding what role the  
 15 SHHD as a whole played in overseeing or funding the  
 16 Macfarlane Trust?  
 17 A. I'm sorry, I don't recall the topic at all.  
 18 Q. On the HIV Litigation, we do have one minute from you,  
 19 which is at SCGV0000229\_052, and it is a minute that was  
 20 sent to Mr Forsyth at that time. It is dated  
 21 15 February 1989, so Mr Forsyth, I think, would still  
 22 have been the Parliamentary Under-Secretary of State of  
 23 the Scottish Office and it refers to a Daily Record  
 24 article date 6 January 1989, entitled "You Gave Us  
 25 AIDS". The reason for the minute is explained in

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1 paragraph 1, the minister requested advice on the  
2 Daily Record article.

3 A little background is give in paragraphs 2 and 3  
4 about a series of articles on the campaign for  
5 compensation and financial support, and reference is  
6 made to the establishment of the Macfarlane Trust in  
7 November 1987. Then at point 4, it says this:

8 "In an attempt to gain further compensation, some  
9 of the 75 haemophiliacs in Scotland who are HIV positive  
10 have raised actions in the Court of Session -- alleging  
11 negligence by the NHS."

12 Just on that paragraph, do you know where the  
13 figure of 75 would have come from?

14 A. I'm afraid not.

15 Q. It's fair to surmise though that, as you are providing  
16 this to the Minister, you would have done your best at  
17 the time to ascertain how many there were and give  
18 an accurate --

19 A. I will have done, although I see that in paragraph 6  
20 I got the number of summonses wrong by two, and  
21 Rab Panton, who worked for me, has corrected it to  
22 13 from 11. So I will have done my best. I may not  
23 have been successful.

24 Q. But obviously other colleagues will have looked at this  
25 submission going up as well and, it's fair to say, that

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1 "... 5 pending the granting of legal aid and the  
2 others while ... information is gathered by the  
3 pursuers' solicitors."

4 Then 7:

5 "We are working with the Solicitor's Office to  
6 prepare defences on behalf of the Secretary of  
7 State ..."

8 Do you know what work was undertaken by way of  
9 factual enquiry by the SHHD into the underlying facts of  
10 the case, and the question of whether or not the  
11 treatment that had been provided, the steps taken, had  
12 been appropriate or reasonable or adequate?

13 A. I'm afraid I don't.

14 Q. Are you able to say whether or not you played any role  
15 in such an inquiry?

16 A. The fact that I used the first person plural in opening  
17 paragraph 7 suggests that I was involved but I don't  
18 recollect it. It wouldn't have been unreasonable for me  
19 to be involved. It's a serious matter, and it wouldn't  
20 have been improper for me to be involved, but I don't  
21 recall it.

22 Q. It probably goes -- or we can probably work out the  
23 answer from what you've said before -- but do you  
24 remember the role played by Dr Cash in preparing the --

25 A. No, we would have certainly asked the SNBTS for the

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1 75 was the best figure that you and your colleagues had  
2 at the time?

3 A. I imagine so.

4 Q. If we go to paragraph 5:

5 "The haemophiliacs allege that the Factor VIII  
6 (the blood clotting agent) used to treat them was  
7 contaminated with the AIDS virus. A batch of  
8 Factor VIII manufactured for four blood donations were  
9 screened for HIV infection has since proved to be  
10 contaminated. A case is made out against the Health  
11 Board, the Scottish National Blood Transfusion Service  
12 and the Secretary of State. The case against the  
13 Secretary of State alleges that he failed to fulfil his  
14 statutory duties, by not taking steps to prevent the  
15 infection of haemophiliacs. Their main argument is that  
16 Factor VIII should not have been used after 1984."

17 Now, on that paragraph, the reference to "a batch  
18 of Factor VIII manufactured", does that suggest that, at  
19 the time, you and your colleagues thought that only  
20 a single batch of PFC produced Factor VIII had caused  
21 the infections in Scotland?

22 A. Yes.

23 Q. In the following paragraph, you've mentioned, the  
24 13 summonses had been issued, all had been sisted --  
25 which means stayed or suspended -- at the time:

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1 factual information necessary to put together the  
2 defences on behalf of the Secretary of State. We would  
3 have certainly asked the SNBTS, probably we would have  
4 routed it through John Cash, but I don't recall doing  
5 so.

6 Q. I think we have probably taken that as far as we can do  
7 there.

8 Do you remember anybody ever raising with you  
9 the prospect of a public inquiry, either in Scotland or  
10 the United Kingdom?

11 A. No, not at that time. Obviously, Lord Penrose's Inquiry  
12 was launched about a decade ago, but not in 1987 or '88,  
13 or whatever it was.

14 Q. Do you have any insight or any view about why it was  
15 that the prospect of a public inquiry wasn't raised?

16 A. Was not raised?

17 Q. Yes.

18 A. It would have been --

19 Q. -- (overspeaking) --

20 SIR BRIAN LANGSTAFF: I think that may be a very difficult  
21 question to answer because it's asking about a negative,  
22 which depends on so many other people.

23 However --

24 MR HILL: We will --

25 SIR BRIAN LANGSTAFF: -- I think if we can ask a question

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1 about the facts rather than speculation about reasons,  
2 it may be more helpful to me.

3 **MR HILL:** Let's turn, then, to the question of the  
4 procurement of the English and Welsh product 8Y that was  
5 produced at BPL, the heat-treated product produced there  
6 as opposed to the heat-treated product that was produced  
7 at the PFC at the time.

8 Now, were you aware in 1986 or 1987 that there was  
9 a product that was being produced in England and Wales  
10 that was thought to have a better effect against  
11 non-A, non-B hepatitis?

12 **A.** I will have been aware because it was a very important  
13 matter, and my normal communication with the SNBTS would  
14 have brought it to my attention. But I don't recall --  
15 I don't recall that.

16 **Q.** Would your source of knowledge have been via the SNBTS  
17 then?

18 **A.** Oh yes. From whom else would I learn it? I had no  
19 direct contact with the English blood transfusion folk,  
20 and it's very unlikely that the Department of Health  
21 would have said it. No, the SNBTS would have  
22 undoubtedly been the source, either directly or mediated  
23 through John Forrester or Archie McIntyre.

24 **Q.** Would this, then, have been one of those incidents that  
25 we spoke about before lunch, that if somebody sitting on

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1 a pan-UK body had found out this and wished to raise it  
2 with the SHHD, then a door would have been found through  
3 which relevant information could pass?

4 **A.** I don't know. But your question implies that you have  
5 to be sitting on a body before you learn things.  
6 I would have thought that it was more natural for the  
7 blood -- whatever it is -- the BPL folk to say on the --  
8 to say to their colleagues in Scotland, "Hey, look,  
9 we're getting on better than we expected" or "We're  
10 getting on quite well with the development of  
11 a heat-treated product", the advent of which we were all  
12 keenly awaiting.

13 **Q.** Were you ever made aware that there had been people in  
14 Scotland who had become infected with hepatitis C,  
15 non-A, non-B, as it may have been known at the time,  
16 through the use of a Scottish blood product, when  
17 a safer English blood product was available?

18 **A.** The first part of your question, was I aware that folk  
19 had been infected with NANB, the answer to that is yes.  
20 I don't think the link with the second was quite so  
21 clear. I recall nothing of that kind and I don't think  
22 the papers that you have let me see illuminate that.  
23 There will certainly be, in Lord Penrose's researches,  
24 authoritative -- an authoritative answer to that  
25 question.

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1 **Q.** But it's not an issue that you recall being brought to  
2 your attention?

3 **A.** No.

4 **Q.** You say in your statement that it wasn't the role of the  
5 SHHD to obtain supplies of 8Y or any other blood  
6 product. That was the individual clinicians. I wonder  
7 if you could just expand on why that was so.

8 **A.** Okay. So far -- the individual patient had no interface  
9 with the Scottish Home and Health Department. The  
10 interface for the individual patient was with his or her  
11 clinician. For example, Chris Ludlam, who's given  
12 evidence to you.

13 What Chris Ludlam would have done -- well, it  
14 would be better to ask Chris Ludlam that question,  
15 because I'm retelling secondhand information, or -- or  
16 deducing what Chris Ludlam would have done. I don't  
17 know that I can add usefully to what I've already said  
18 in written evidence.

19 **SIR BRIAN LANGSTAFF:** I think the question was actually not  
20 directed at the clinician; it was directed to the  
21 Scottish Home and Health Department's activities, and  
22 you were asked could you expand on why it wasn't for the  
23 SHHD to obtain the supplies of a product which might,  
24 probably was, better capable of eliminating hepatitis  
25 non-A, non-B from recipients, and making it available

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1 for those in Scotland who might want to use it. That's  
2 the question. So it's not directed to the clinicians,  
3 it's directed to the supplier.

4 **A.** Yes, right. I follow. Thanks for the redirection.  
5 I was trying to go back too far.

6 So far as I'm aware, SHHD acquired no  
7 pharmaceutical products for prescription to patients.  
8 It wasn't the way that the system worked.

9 Now, I say that slightly tentatively because it  
10 wasn't my area of responsibility; it was a matter for  
11 Graham Calder, the Chief Pharmacist, but I can recall no  
12 pharmaceutical product of any kind which was procured by  
13 the Scottish Home and Health Department.

14 **Q.** Was there any role for the SHHD or the Chief Pharmacist  
15 or indeed the Chief Medical Officer in overseeing or  
16 giving advice to clinicians about the type of product  
17 that they should be using?

18 **A.** I can recall nothing contemporaneously. But something  
19 in the mound of documents that you've provided me with,  
20 there is a statement by I think Iain Macdonald, which  
21 said that -- it would probably be Iain's testimony to  
22 the Penrose Inquiry or the extract from the report of  
23 the Penrose Inquiry commenting on Iain Macdonald's  
24 evidence, which said that he would be -- he would have  
25 been very unwilling to override the clinical judgment of

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1 people like Chris Ludlam, and require them to prescribe  
 2 a particular product.  
 3 Now, the general policy of SHHD as regards blood  
 4 products was that we tried very hard to make sure that  
 5 the Scottish National Blood Transfusion Service was able  
 6 to meet any request for blood or a blood product from  
 7 a clinician. But we drew back and the reason for that  
 8 was that we felt that it was (a) safer and (b) cheaper  
 9 than buying product in. But we constantly drew back --  
 10 our medics constantly drew back -- from trying to  
 11 dictate that solution to their clinical colleagues in  
 12 the Health boards.  
 13 **Q.** That presumably goes for commercial products generally  
 14 as well as 8Y; is that right?  
 15 **A.** Indeed, yes. Yes.  
 16 I suspect that it was much more directed to  
 17 commercial products than the product called 8Y, which,  
 18 if my memory of the documents that you've provided me  
 19 with serves me right, was very hard to get hold of,  
 20 because the BPL production was not sufficient to meet  
 21 English needs, never mind administer to Scottish  
 22 patients.  
 23 So I remember seeing a reference to Chris Ludlam  
 24 having acquired, really on the old boys net, a small  
 25 quantity of a product which I think was 8Y for giving to

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1 seems, were able to resolve at least the initial part  
 2 of it fairly quickly, and then a wider scheme was  
 3 introduced later that autumn.  
 4 Now, from your knowledge at the time, and from the  
 5 papers you saw both at the time and since, are you able  
 6 to say why it was that such a scheme hadn't been  
 7 introduced before your intervention?  
 8 **A.** Yes. It was because it was a difficult nut to crack.  
 9 You asked earlier about whether Treasury approval was  
 10 necessary to fund surrogate testing, and my answer to  
 11 that was no, that was not one of the areas of our work  
 12 that required specific Treasury approval. But the issue  
 13 of compensation payments to anyone are -- an agreement  
 14 to make a payment in an insurance sort of way did  
 15 require specific Treasury approval. So it wasn't  
 16 something that one often did; it was rather -- it was  
 17 rather unusual and potentially difficult.  
 18 Secondly, the issue initially was complicated by  
 19 confusion about exactly what it was, exactly what  
 20 circumstance Chris Ludlam wanted compensation triggered.  
 21 And I should explain that it wasn't that compensation --  
 22 that patients were infected and eligible for  
 23 compensation; it was Chris's fear that they might be --  
 24 they might be hardened by the non-therapeutic use of the  
 25 product in clinical trials.

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1 one of his patients, but that was -- he was, I think --  
 2 he regarded himself very fortunate to have been able to  
 3 do that. It wasn't an easy matter of whistling up  
 4 a lorryload of 8Y.  
 5 **Q.** Do you think the SHHD would have been in a better place  
 6 to do that than Dr Ludlam and his colleagues in the old  
 7 boys club?  
 8 **A.** No, because it wasn't the way we operated at all. It  
 9 would have been a very unusual thing to do.  
 10 **Q.** Let me turn briefly to the compensation and indemnity  
 11 arrangements for the Z8 trials. This is dealt with in  
 12 your statement at section 50. And you also make  
 13 reference to the relevant chapter of Lord Penrose's  
 14 report, I think chapter 24, on this.  
 15 I'm not going to go through it in detail. It  
 16 appears that the issue is a concern expressed,  
 17 principally by Dr Ludlam, about the provisions for  
 18 compensation for patients who suffered adverse effects  
 19 in the trials of Z8. It was raised for several years,  
 20 not in respect of Z8 more generally, with the SHHD  
 21 before you joined. Raised with you personally in  
 22 December 1986 and January 1987, by which stage there was  
 23 an acute risk, as it were, that it could delay the  
 24 trials.  
 25 You then stepped in, made arrangements and, it

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1 As far as I know, nobody was harmed, and  
 2 the compensation scheme which we set up was never  
 3 needed. So it was a little difficult to pin down  
 4 exactly what Chris Ludlam wanted compensated for and  
 5 before my time in SHHD, my colleagues, or my future  
 6 colleagues asked the CSA to come up with a scheme. That  
 7 wasn't a ridiculous request because the CSA not only had  
 8 the Blood Transfusion Service, therefore conscious --  
 9 more conscious than the Department about the  
 10 circumstances in which compensation might be called for,  
 11 but also the Central Legal Office, which had an  
 12 understandable knowledge of the legal aspects of  
 13 compensation schemes.  
 14 However, it -- I think because it wasn't an urgent  
 15 matter, and it was a difficult matter, nothing seemed to  
 16 have been done, or a grasp was never taken of the issue  
 17 until Chris Ludlam gave his ultimatum: "I won't try the  
 18 product on patients until this compensation scheme is in  
 19 effect."  
 20 Once that ultimatum had been issued and the matter  
 21 narrowed down to a particular point in the trialling of  
 22 products, I got a grip of it, it was easy to resolve,  
 23 Treasury approved it very quickly, and the conclusion of  
 24 Lord Penrose's Inquiry was that the start to  
 25 the clinical trials was perhaps slightly postponed by

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1 a matter of weeks, but the trials were completed before  
2 the product was ready for application to patients, so no  
3 time was, in the end, lost.

4 But it wasn't the most sparkling example of  
5 departmental administration. And that is the reason for  
6 it. It was a complicated matter which required Treasury  
7 approval. It didn't appear urgent until Chris Ludlam's  
8 ultimatum.

9 **Q.** Just finally on this point, I've been asked to raise  
10 this with you: the reference in your statement is to the  
11 different stages of the trials, and there is a stage  
12 which is referred to in your statement as the  
13 non-therapeutic stage.

14 **A. (The witness nodded)**

15 **Q.** Now I've been asked to clarify what is meant by that.  
16 Is that providing the product to people who didn't need  
17 it or is that something to do with the stages of  
18 a trial?

19 **A.** It's both. At the start of testing the effectiveness of  
20 the new product, Chris Ludlam wanted to be sure that it  
21 had the effect on the haemophiliac patient that was  
22 desired: that it would have the necessary effect on  
23 stopping a bleed. The patients on whom he tried it were  
24 not in therapeutic need of that product so were  
25 particularly public spirited in agreeing to be part of

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1 ABPI, Association of the British Pharmaceutical  
2 Industry, guidelines, so it must have been precedented,  
3 but I think it was very unusual, which is why we had to  
4 break the ground with a blood product, which is  
5 a slightly out of the ordinary pharmaceutical product.

6 **Q.** You said that the individuals who took part in that  
7 trial were particularly public spirited because they  
8 agreed to do it.

9 **A. (The witness nodded)**

10 **Q.** So you would expect fully informed consent to have been  
11 taken from those individuals?

12 **A.** Yes, and that was the point, I think, that Chris Ludlam  
13 was most worried about. He found it hard -- and one can  
14 understand it, and I understood it at the time -- he  
15 found it hard to recommend to patients that they  
16 participate with no safety net of compensation if  
17 something went wrong. In the unlikely event that  
18 something went wrong and, as I've said, nothing did in  
19 fact go wrong.

20 **Q.** The SHHD was obviously involved in the indemnity side of  
21 it. Would the consent side of it have been left to  
22 Dr Ludlam --

23 **A.** Yes, indeed.

24 **Q.** Finally, just two final points. The first is a point  
25 that was raised by, among others, Lady Hooper, in her

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1 the trial, and so were, one could argue, particularly  
2 meritorious for contribution if something went wrong.

3 But as the second part of your question implies,  
4 that was only the first stage of a series of trials,  
5 which looked at the -- not only the efficacy but also  
6 the safety of the product and I think Chris Ludlam  
7 had -- well, it's hard to tell.

8 The bottom line was that we eventually covered all  
9 the stages of the trial, but it was useful to have  
10 started with the bit where the recipient patient didn't  
11 need the product because that was the case that was most  
12 worthy of sympathy in the eyes of Treasury, whose  
13 approval we needed.

14 **Q.** It was also, was it not, the first stage of the trial?

15 **A. (The witness nodded)**

16 **Q.** So it was going to be the bit that came earliest in  
17 the --

18 **A.** Yes.

19 **Q.** The bit that needed to be sorted out first?

20 **A.** Yes, that's right.

21 **Q.** Did you understand that to be standard practice for  
22 a clinical trial of a drug --

23 **A.** No, it was --

24 **Q.** -- to have that --

25 **A.** -- I think exceptional. We based the compensation on

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1 statement, so a former Department of Health Minister.  
2 She made the point that she felt that there wasn't  
3 a sufficient amount of consultation with individuals who  
4 were infected and affected directly -- between ministers  
5 and those individuals. From your perspective, do you  
6 remember meeting and discussing the situation with  
7 people who were infected and affected?

8 **A.** No, not at all. I had -- in part of my responsibility  
9 for services for physically disabled people I had a lot  
10 of contact with patients. Other than that, I had none,  
11 because the Department -- unlike services for physically  
12 disabled patients, the Department wasn't the provider.  
13 The provider in this case was, first, the haemophiliac  
14 directors like Chris Ludlam, and behind them, the SNBTS.  
15 The Department was one step further behind, and I had --  
16 there would have been no locus for the Department to  
17 have direct contact with patients.

18 Patients' representatives was a bit of a different  
19 kettle of fish. The Haemophilia Society, I remember,  
20 was energetic and knowledgeable in contacting the  
21 Department. The mountain of papers you've provided me  
22 with contained couple of bits of correspondence of that  
23 kind, but that wasn't the -- quite the direct contact  
24 with individual patients that Gloria Hooper was  
25 referring to.

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1 **Q.** Finally, this: in that period that you were at the SHHD  
2 in that role in 1986 to 1989, do you think that there  
3 was an awareness of the impact of what had happened on  
4 people who were infected and who had been affected by  
5 the tragedy?

6 **A.** Yes, absolutely. Particularly -- remember that the  
7 Department collectively had been through the  
8 HIV infection from blood products, where the testimony  
9 of patients -- the public profile of patients was very  
10 high, and I think the public sympathy for these  
11 patients, particularly the -- particularly haemophiliac  
12 patients, whose -- who had expected to be made better by  
13 the blood products that were administered to them,  
14 the sympathy for these patients was widespread in the  
15 Department.

16 **MR HILL:** Those are the questions that I have for you,  
17 Mr Macniven. There will now be an opportunity for Core  
18 Participants to put questions to you and I'll hand back  
19 to the chair to explain that.

20 **SIR BRIAN LANGSTAFF:** Yes.

21 Well, at this stage of proceedings, the  
22 Core Participants, represented by their recognised legal  
23 representatives, have a right, through those  
24 representatives, to put questions to counsel, for him to  
25 ask you in turn.

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1 **A.** Ah, there we are.

2 **SIR BRIAN LANGSTAFF:** Don't worry.  
3 Right, Mr Hill, we're ready.

4 **MR HILL:** Thank you, sir.  
5 Mr Macniven, I'd like to begin with questions  
6 about decision making within the Scottish Home and  
7 Health Department. Can we have on screen, please,  
8 PRSE0002521, which is Dr Macdonald's response to Dr Cash  
9 that we looked at earlier, in respect of the complaint  
10 over Dr Forrester. It's actually a different point that  
11 I'd like to pick out from that in the third paragraph,  
12 where Dr Macdonald is referring to Dr Cash's reference  
13 to the delay, as Dr Cash saw it in AIDS validation  
14 studies.

15 Dr Macdonald writes, and I quote:  
16 "These matters were decided at [Deputy Chief  
17 Medical Officer], [Chief Medical Officer] and ultimately  
18 Ministerial level."

19 The question I'm asked to put to you arising from  
20 that is that decisions about anti-HIV testing went to  
21 ministers, in 1985. Why were decisions about surrogate  
22 testing not put to ministers in 1986 and in 1987?

23 **A.** Okay, I wasn't involved at the stage that Iain Macdonald  
24 is referring to in this letter, so I can't make the  
25 comparison that's necessary to answer your question

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1 Plainly, they will have listened to what you've  
2 been saying. They have to be given a chance to think  
3 about what they might want to ask, and then invite  
4 counsel to ask them. So we have to give them some time.  
5 And what I propose -- how long do you think you might  
6 need, Mr Hill?

7 **MR HILL:** Could I ask for half an hour, sir?

8 **SIR BRIAN LANGSTAFF:** Yes, certainly.

9 It is -- for safety's sake, as it were, we will  
10 say no earlier than 3.55, so no earlier than 3.55. It  
11 may be later. So you'll be told. And how long you're  
12 detained after that, it really depends how many  
13 questions there are.

14 **A.** My train back is tomorrow morning at 8 o'clock.

15 **SIR BRIAN LANGSTAFF:** I think you may be done by then.

16 **A.** Thank you.

17 **SIR BRIAN LANGSTAFF:** So 3.55.

18 **(3.23 pm)**

**(A short break)**

20 **(3.57 pm)**

21 **SIR BRIAN LANGSTAFF:** May I just check, please, is the  
22 lawyer for Mr Macniven present?

23 **A.** She's just gone out, in fact.

24 **SIR BRIAN LANGSTAFF:** Well, let us wait until she's -- it's  
25 appropriate to wait.

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1 properly. I would merely refer back to the points that  
2 we were making -- that I was making earlier, both in  
3 relation to contact with ministers generally, and  
4 contact with ministers specifically on surrogate  
5 testing, that it is very difficult -- a difficult matter  
6 of judgement when to put matters to ministers, and  
7 I think I explained quite fully why we had not done so  
8 in the case of surrogate testing. But it's difficult  
9 for me. I can't make the comparison that you seek.

10 **Q.** Can I just perhaps pose it this way, as a structural  
11 matter rather than specific: the decision in 1985 was to  
12 introduce testing, so obviously a minister has to be  
13 involved when the expense is going to be laid out.

14 **A. (The witness nodded)**

15 **Q.** A minister doesn't have to be involved if the decision  
16 is to maintain the status quo. Does that mean that it  
17 is less likely that a decision to maintain the  
18 status quo will end up being put to a minister?

19 **A.** Yes, that's a fair point. It's necessary, I would  
20 suggest, not only for expenditure authorisation  
21 purposes, but more importantly, for a change in  
22 procedure for ministers to be consulted. So if, for  
23 example, we had decided that surrogate testing was  
24 a very good thing, we would have undoubtedly put it to  
25 ministers to check that out, as was, I deduced, the case

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1 in the example that Iain Macdonald's referring to.  
 2 In other words, it becomes more clear-cut -- that  
 3 difficult decision of when to involve, whether to  
 4 involve ministers, it becomes more clear-cut if there is  
 5 a specific, positive decision for change recommended.

6 But there was not a difficulty in putting things  
 7 to ministers. We were not at all deterred in our view  
 8 that surrogate testing should not be introduced on  
 9 present level of knowledge. That was a decision that we  
 10 revisited. We were not deterred from introducing it by  
 11 the feeling that it would be necessary to involve the  
 12 minister, and that was a difficult thing. It wasn't  
 13 a difficult thing at all; the procedures for involving  
 14 ministers were straightforward.

15 The difficulty was in deciding when a matter was  
 16 ripe for ministerial decision.

17 **Q.** I've been asked to pick up on something you said earlier  
 18 about difficult cases going to the Minister. Are you  
 19 able to give any examples of what those difficult cases  
 20 were or any criteria, not set criteria but general  
 21 criteria, that might lead to a difficult case going to  
 22 the Minister?

23 **A.** Yes, I understand the question, and as you hint, there  
 24 were no set criteria. The sort of thing that we would  
 25 have put to ministers, and I'm sure the same kind of

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1 hasn't seen it?

2 **A.** But might discover afterwards. It would be mostly the  
 3 minister discovering in retrospective that an important  
 4 decision had not been put to him or her.

5 **Q.** The handful of examples that you give, are they all  
 6 taken from this period 1986 to 1989 --

7 **A.** No.

8 **Q.** -- or are we talking across your career?

9 **A.** No.

10 **Q.** Sorry, across your career, then?

11 **A.** Yes.

12 **Q.** You said earlier in your evidence that almost without  
 13 exception you got the judgment call of when to put  
 14 something to a minister right.

15 **A.** **(The witness nodded)**

16 **Q.** Is that --

17 **A.** In the view of the minister we got it right. Whether it  
 18 was objectively right or not is a difficult question to  
 19 answer.

20 **Q.** You're basing that on the response which you got from  
 21 ministers across your career --

22 **A.** Correct.

23 **Q.** -- about what ...

24 Turning to the group of seven people that you  
 25 mentioned who were the equivalent of the policy unit,

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1 criteria, are around today -- there's nothing peculiar  
 2 about them -- is whether it was a matter of public note,  
 3 whether the minister was likely to be criticised, or the  
 4 Government likely to be criticised in the press or in  
 5 the public. That would make it -- or in Parliament,  
 6 rather. That would make it more likely that we would  
 7 put a decision to ministers. If there was some kind of  
 8 ethical question, we might be more likely to put it to  
 9 ministers.

10 It's that kind of thing which is in question in  
 11 that difficult area of when do you put things to  
 12 ministers. Might I observe that it would be interesting  
 13 to ask Michael Forsyth that kind of question tomorrow?  
 14 You may already expect to do so, because it would be  
 15 illuminating to get the minister's eye view on that  
 16 difficult question. Did the Civil Service generally get  
 17 it right in what it put to ministers?

18 But my experience was that generally we did get it  
 19 right. As I observe in my written evidence, I can  
 20 remember a handful of cases where I was criticised for  
 21 not putting an issue to ministers. It was -- there  
 22 wasn't a large seam of criticism about that difficult  
 23 judgment call.

24 **Q.** Where would the criticism come from? Because obviously  
 25 a minister who hasn't seen something won't know that he

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1 not in a formal sense, but the group that you raised  
 2 when I brought that issue up with you, I've been asked  
 3 to ask you about whether, in essence, the policy about  
 4 the Blood Transfusion Service in Scotland was run by  
 5 that group of seven?

6 **A.** Yes, as I made clear at the time, it wasn't a formal  
 7 group. If we wanted to take a view on something, that's  
 8 the sort of dramatis personae that we would assemble.

9 **Q.** Do you think that it is a fair characterisation that the  
 10 BTS in Scotland was run by that group itself?

11 **A.** No. The BTS in Scotland was run by John Cash and the  
 12 Regional Transfusion Directors and Bob Perry. The  
 13 question was more about the formulation of policy.

14 **Q.** The group of seven that you mentioned didn't include any  
 15 Haemophilia Centre Directors, for example?

16 **A.** Correct.

17 **Q.** Please go on. I think you were about to say something?

18 **A.** Correct. But the -- (a) the Haemophilia Directors were  
 19 very close to the Regional Transfusion Directors and,  
 20 thus, to John Cash; and (b) at the -- the Haemophilia  
 21 Directors met periodically, and John Forrester and, no  
 22 doubt, Bert Bell before him, was invariably present when  
 23 they met, so their views were, to some extent,  
 24 represented by the medical staff of the Department.

25 The Haemophilia Directors, though, were in

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1 a different organisational position. They were part of  
 2 the 15 regional local health boards. The policy group  
 3 that I was talking about was purely within SHHD and the  
 4 BTS because you were asking me what the equivalent of  
 5 an English body was. Now, the group that I've cracked  
 6 up was not a formal body; it was an ad hoc assembly.  
 7 But I deduced that that English -- I deduced perhaps  
 8 wrongly, from your question -- that that group was  
 9 essentially a Department of Health one.

10 **Q.** Were you concerned, either at the time or  
 11 retrospectively, that there was an imbalance in the  
 12 strength of voice of the manufacturers of blood and  
 13 blood products in Scotland, when compared to those who  
 14 were using them, the Haemophilia Centres?

15 **A.** I certainly wasn't aware of that at the time, and I have  
 16 no retrospective view of authority.

17 **Q.** Turning to the CSA, the CSA oversaw the Central Legal  
 18 Office, as well as other services; is that correct?

19 **A.** Yes, it is.

20 **Q.** Would that mean that those who were running the SNBTS  
 21 and the CSA would also have been aware of litigation  
 22 coming in against the SNBTS?

23 **A.** Oh, certainly so.

24 **Q.** I --

25 **A.** I don't know that they -- that they would necessarily

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1 **A.** Absolutely not. Well, I say absolutely not, but I don't  
 2 have a before and after comparison: John Cash, while he  
 3 was consultant adviser and afterwards. I just have the  
 4 "after" picture. But in the "after" picture, we were so  
 5 keen to get John's advice, not that he was backward in  
 6 coming forward with it, but that it would surprise me if  
 7 we were any more enthusiastic while he was formally  
 8 consultant adviser.

9 **Q.** Thinking about your own reaction to his advice, would  
 10 the formal mark of being consultant adviser have made  
 11 any difference to your view?

12 **A.** Absolutely not.

13 **Q.** The Scottish Government prepared a report that was  
 14 published in October 2000 on an investigation into the  
 15 development of heat-treated factor concentrates at the  
 16 PFC, in the years 1985 to 1987. Were you consulted  
 17 about that or did you give any advice or any evidence as  
 18 part of that report?

19 **A.** I worked at the time for the Forestry Commission and the  
 20 link was not self-evident.

21 **Q.** I suppose for -- the reason they would have consulted  
 22 you was about your previous role rather than your  
 23 current role, but you don't recall being asked by the --

24 **A.** Oh, I would have certainly recalled because it would  
 25 have been such an unusual event, and it certainly did

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1 have become aware of it because they were in the same  
 2 organisational structure of the -- as the Central Legal  
 3 Office. I'm sure that if litigation was raised against  
 4 a health board, the Central Legal Office would be in  
 5 rapid contact with the health board.

6 **Q.** Would that then be passed on to you?

7 **A.** To me?

8 **Q.** Yes.

9 **A.** Why?

10 **Q.** You wouldn't expect to have news of litigation board  
 11 against the SNBTS or the health boards brought to your  
 12 attention?

13 **A.** Certainly not health boards. The SNBTS, yes, probably,  
 14 in the sense that I was -- that I was in the Department  
 15 responsible for the topic. But not as a matter of  
 16 urgency. It would depend on the nature of the legal  
 17 case.

18 **Q.** Turning --

19 **A.** I'm not quite sure what -- yes, on you go.

20 **Q.** Let's turn to Professor Cash and his resignation as  
 21 consultant adviser. Would that -- was the result of  
 22 that not a lessening of his ability to give you advice,  
 23 because you've said he continued to do so, but  
 24 a lessening of the chance that that advice would be  
 25 accepted by the SHHD?

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1 not happen.

2 **Q.** Moving on to surrogate testing. This is to do with  
 3 the relationship between the SHHD and the Department of  
 4 Health, and the research that then took place on  
 5 a UK-wide level. Firstly, the opinion of the directors  
 6 in Scotland as expressed in the letter to the Lancet,  
 7 and indeed elsewhere, was, "There's no time for this  
 8 research now" --

9 **A.** **(The witness nodded)**

10 **Q.** -- "We need to get cracking on. It's too late."  
 11 Was that not in itself an evidence base for  
 12 pressing ahead with surrogate testing? You have a body  
 13 of considerable expertise, with people with  
 14 international reputations such as Dr Cash and  
 15 Dr McClelland giving you that advice; was that not in  
 16 itself an evidence base on which to take that decision  
 17 or at least to put it to ministers?

18 **A.** Of course it was part of the evidence that we took in  
 19 coming to the constant revisiting of the decision. But  
 20 there were other -- sorry, could you repeat the question  
 21 please, Mr Hill.

22 **Q.** When you have a body of expertise, such as that of SNBTS  
 23 directors, saying that "We should press ahead" --

24 **A.** Yes, I'm sorry, I recall now. I think the SNBTS  
 25 directors were probably right that it was too late to

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1 carry out research. The research would have been  
 2 worthwhile if it had been launched at the time that  
 3 Brian McClelland had wanted it to be. I don't know  
 4 that I knew that at the time. As the email that you  
 5 threw up on the screen earlier indicated, I was really  
 6 quite keen on that research to fill a hole in the --  
 7 a major hole in the evidence base.  
 8 I was wrong in my expectations about the speed  
 9 with which that research could be carried out, but I was  
 10 keen for it to be carried out. But I think that's  
 11 a slightly different question from the senior folk, the  
 12 chiefs, in the SNBTS, recommending, in the slightly  
 13 backhanded way that they did in The Lancet letter, or in  
 14 more direct communications at other times, that  
 15 surrogate testing should be introduced. On that,  
 16 I think we've very thoroughly explored why we came --  
 17 we, the Department -- came to the constant view that we  
 18 did.  
 19 **Q.** You mentioned a moment ago that you were wrong about the  
 20 timescale that you anticipated the research would take.  
 21 **A.** Yes.  
 22 **Q.** Doing the best you can now to think back to your views  
 23 at the time, how long were you anticipating it would  
 24 take for a worthwhile research to be produced?  
 25 **A.** Yeah, I have no recollection. But it seems from that

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1 be conducted?  
 2 **A.** I'm afraid I can't remember and nor can I recollect any  
 3 of the mountain of documentation that bears on that.  
 4 **Q.** The question of the Consumer Protection Act and consumer  
 5 protection legislation more generally, do you recall  
 6 taking legal advice with the Law Officers about the  
 7 possible ramifications of surrogate testing and not  
 8 introducing surrogate testing, and the Consumer  
 9 Protection Act?  
 10 **A.** No, I don't recollect. We would certainly not have gone  
 11 to the Law Officers, ie the Government ministers  
 12 responsible for advising ministers on their legal  
 13 obligations. It's inconceivable that the legal  
 14 questions would have been difficult enough that they  
 15 couldn't have been resolved at official level from the  
 16 Department's lawyers. I don't recall whether I went to  
 17 the Department's lawyers or not on the question of  
 18 surrogate testing.  
 19 On the question of the Consumer Liability Act,  
 20 I certainly would have gone to the Department's lawyers  
 21 on the implications. Indeed, one of the mountain of  
 22 documents that you've presented me with is a circular  
 23 that I issued not in my Blood Transfusion Service  
 24 responsibilities but in view of my responsibilities for  
 25 NHS procurement, a circular to health authorities to

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1 minute that my hopes for the -- for an expeditious  
 2 outcome were unrealistic.  
 3 **Q.** The question -- two questions following on from that,  
 4 the first is that: was there a risk that the SHHD were  
 5 setting too high a standard for the data that it  
 6 required in order to introduce testing in a similar way  
 7 to the Department of Health, referring to no conclusive  
 8 proof about HIV or about blood products causing AIDS?  
 9 Was a similar thing being deliberately or otherwise  
 10 undertaken here, but a high hurdle was being placed so  
 11 that it would not be cleared?  
 12 **A.** That was not the conclusion of Lord Penrose's Inquiry,  
 13 which I read out earlier. I have no more authoritative  
 14 view on the matter.  
 15 **Q.** From your perspective, you weren't raising hurdles; you  
 16 were interested in answers?  
 17 **A.** Could you say that again, please?  
 18 **Q.** From your perspective, were you raising hurdles or were  
 19 you interested in the answers that the research would  
 20 provide?  
 21 **A.** The latter.  
 22 **Q.** Finally, on this point, to what extent was this desire  
 23 for research, the SHHD falling in behind the Department  
 24 of Health and following the rest of the UK, and to what  
 25 extent was it an independent desire for this research to

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1 health boards, about the implications of the Consumer  
 2 Protection Act and I would certainly have consulted  
 3 lawyers about the wording of that advice.  
 4 **Q.** What other resources or information or research impacted  
 5 on your decision making in surrogate testing other than  
 6 the Dow study?  
 7 **A.** I think we've, before the break, considered extensively  
 8 the factors that influenced us on the surrogate testing,  
 9 and the point that I would emphasise in relation to that  
 10 narrow question is that Dr Dow's study was only one  
 11 factor in a number of factors that influenced us in our  
 12 view, and I -- as I said earlier, I cannot imagine that  
 13 it carried much weight with the Department of Health,  
 14 which independently arrived at the same view. Dr Dow  
 15 was part of the Scottish Blood Transfusion Service, it  
 16 had been funded by the Scottish Chief Scientist office.  
 17 It's a little unlikely that it carried weight in London.  
 18 **Q.** Can you recall now any other studies or pieces of  
 19 research that you relied on at that time?  
 20 **A.** No, I can't recall at this point. But I think that  
 21 would probably -- a light would have been cast on that  
 22 question I think by the Penrose Inquiry.  
 23 **Q.** We can look at the documents for -- and the underlying  
 24 documents --  
 25 **A.** Yes, you were throwing up on the screen earlier

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1 Lord Penrose's comments on the sort of academic basis of  
 2 Dr Dow's thesis, and I suspect that in that area of  
 3 Lord Penrose's report there must have been something  
 4 about the other information of a similar kind. So it  
 5 may be that turning to that would assist you. But  
 6 I cannot --

7 **Q.** There's certainly reference to textbooks that were  
 8 consulted by Dr Reid, and we have -- Lord Penrose was  
 9 able to identify which textbooks those were and which  
 10 editions.

11 **A.** Okay.

12 **Q.** That is there for people to be able to look at.  
 13 A counter-factual question. Had you been aware of  
 14 the limitations of Dr Dow's study identified by  
 15 Lord Penrose, do you think that that would have led you  
 16 to take a different approach on --

17 **A.** I'm sorry, that's too hypothetical a question for me to  
 18 answer with authority.

19 **Q.** Did you seek a view from Dr Gunson about the likely  
 20 prevalence rates of hepatitis C in Scotland?

21 **A.** Now, Dr Gunson, as far as I remember, was the director  
 22 of the Blood Products Laboratory at Elstree; is that  
 23 right? Dr Gunson --

24 **Q.** He was the consultant adviser to the Department of  
 25 Health on blood transfusion. Elstree was Dr Lane.

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1 **A.** Yes, it's possible. John Cash was very good at  
 2 providing advice orally.

3 **Q.** Of course, that leaves us with the problem of not being  
 4 able to identify it at this stage of things --

5 **A.** Yes, yes.

6 **Q.** -- (overspeaking) --

7 Finally, on the Macfarlane Trust, if there had  
 8 been involvement from the Scottish Home and Health  
 9 Department and the Scottish Office in setting up and  
 10 overseeing the Macfarlane Trust, would that matter have  
 11 come to your personal attention, do you think?

12 **A.** I'm afraid I don't remember anything at all about the  
 13 Macfarlane Trust, to the extent that I wonder whether  
 14 the question you've just asked relates to the period for  
 15 which I was responsible.

16 **Q.** The Macfarlane Trust was certainly set up in the period  
 17 during which you were responsible.

18 **A.** Doesn't ring any bells. It may be that it was the  
 19 responsibility of the division in SHHD group 5, which  
 20 dealt with the problem of HIV infection.

21 **Q.** I think that possibly answers the final question that  
 22 I've been asked to put to you, which is how far we can  
 23 go in deducing from the fact that you have no  
 24 recollection about the formation and oversight of the  
 25 Macfarlane Trust, how much we can deduce from that and

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1 **A.** Okay.

2 **Q.** Dr Gunson is -- well, formally the head of a Regional  
 3 Transfusion Centre and consultant adviser --

4 **A.** Okay, right. He's a name that I remember but I had no  
 5 contact with him whatsoever, and I certainly wouldn't  
 6 have contacted him on this subject.

7 It may be that my medical colleagues did so but  
 8 I have no evidence of that.

9 **Q.** Did you seek a formal or informal piece of advice from  
 10 Professor Cash on the likely prevalence rates of  
 11 non-A, non-B hepatitis in the donor pool?

12 **A.** We will certainly have done so, whether I did so  
 13 personally or not, and I imagine that there's  
 14 information about that in Lord Penrose's report.

15 **Q.** Do you think that's something that somebody within the  
 16 SHHD would have done?

17 **A.** Oh, yes, yes. Oh, absolutely. Yes, that would be  
 18 an important bit of information. Unfortunately,  
 19 I suspect that the answer would have been, "We don't  
 20 have enough evidence to bring to bear on the matter",  
 21 hence the research proposal that was talked about.

22 **Q.** Is it possible, then, that an answer of that nature  
 23 which is "I'm sorry, I can't help you, we don't have  
 24 enough information at present", may have been conveyed  
 25 orally rather than written down?

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1 the lack of papers with your name -- a conclusion that  
 2 the Scottish Office more widely was not involved in --

3 **A.** Yes, I think it would be dangerous to draw a conclusion  
 4 that the Scottish Office more widely was not involved.  
 5 It would have been the responsibility of a different  
 6 division.

7 **MR HILL:** Mr Macniven, those are the questions I have for  
 8 you. At this time, if I were present in court, I would  
 9 turn to your legal team and ask if they have any  
 10 questions. And as I'm unable to do that, I will --

11 **A.** I think they're indicating that they have no questions.  
 12 Is that correct?

13 **SIR BRIAN LANGSTAFF:** You're allowed to speak.

14 **LEGAL REPRESENTATIVE:** No questions.

15 **A.** Okay, right.

16 **SIR BRIAN LANGSTAFF:** I have no questions of my own.

17 **MR HILL:** Mr Macniven, as with all of our witnesses, there  
 18 is now an opportunity for you to make any final comments  
 19 that you wish to make.

20 **A.** I have none other than this: that the Inquiry should not  
 21 have the impression that the Scottish Home and Health  
 22 Department, both administrators like me and medics like  
 23 Archie McIntyre, was uncaring about the problem of  
 24 non-A, non-B hepatitis, or indeed the problem of HIV  
 25 infection, nor were we in the business of setting up

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1 bureaucratic hurdles to prevent the development of the  
 2 safest possible blood products. Quite the reverse. We  
 3 were very concerned indeed with the safety of blood and  
 4 blood products, and partly, it has to be said, under the  
 5 spur of the energetic and authoritative Dr Cash, we were  
 6 active in the matter. We were not setting up  
 7 bureaucratic hurdles.

8 **SIR BRIAN LANGSTAFF:** Well, for my part, can I thank you.  
 9 It's obvious you're going to make your train tomorrow  
 10 morning.

11 **A.** Assuming they run them.

12 **SIR BRIAN LANGSTAFF:** Well, I was going to say thank you  
 13 very much for coming down in what must have been  
 14 a tentative journey at times, I suspect, to give us --  
 15 give your evidence here in person. It's very much  
 16 appreciated that you've chosen, or been able to do it  
 17 that way. I'm sorry that the arrangements had to be  
 18 such that Mr Hill wasn't here in person, although  
 19 I think we have lost very little in the translation to  
 20 the screen.

21 But thank you again for the careful precision with  
 22 which you've given your answers, and I note and take  
 23 note of the slight hint of irritation at the suggestion  
 24 that you might have been not quite as careful as you  
 25 would have wanted to be at the end. But you will

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1 appreciate that we have to, and entirely properly,  
 2 explore all the facts in a way in which inevitably, for  
 3 many witnesses, will feel that we are taking -- or that  
 4 counsel, I should say -- not me -- I just listen to the  
 5 evidence -- is asking questions which you don't find, or  
 6 the witness doesn't find entirely comfortable. But  
 7 that's as it is.

8 **A.** I'm very grateful for what you say, sir, and I agree  
 9 that Mr Hill's absence in body but presence in spirit  
 10 worked perfectly well.

11 **SIR BRIAN LANGSTAFF:** Well, thank you very much for that.  
 12 Now, Mr Hill, are you ready to tell us what is  
 13 happening tomorrow?

14 **MR HILL:** Lord Forsyth tomorrow, sir.

15 **SIR BRIAN LANGSTAFF:** 10.00, Lord Forsyth.

16 **(4.33 pm)**  
 17 **(The hearing adjourned until 10.00 am the following day)**

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<p><b>LEGAL REPRESENTATIVE:</b> [1] 156/14 <b>MR HILL:</b> [17] 2/13 46/23 47/3 47/19 67/25 68/4 89/5 89/14 92/23 124/24 125/3 137/16 138/7 139/4 156/7 156/17 158/14 <b>SIR BRIAN LANGSTAFF:</b> [29] 1/3 1/5 1/22 2/12 47/4 47/14 47/18 67/23 68/2 68/5 89/8 89/13 92/19 124/20 124/25 127/19 137/20 138/8 138/15 138/17 138/21 138/24 139/2 156/13 156/16 157/8 157/12 158/11 158/15 <b>THE WITNESS:</b> [3] 1/4 1/21 47/13</p> <hr/> <p>'<b>80s</b> [1] 34/7 '<b>86</b> [1] 37/22 '<b>87</b> [2] 13/18 110/25 '<b>87 to</b> [1] 13/18 '<b>88</b> [2] 13/18 124/12 '<b>89</b> [1] 4/15 '<b>89 as</b> [1] 4/15 '<b>98</b> [1] 4/23 '<b>98 to</b> [1] 4/23 '<b>99</b> [1] 4/23 '<b>99 to</b> [1] 4/23 '<b>bad</b> [1] 103/25 '<b>cost</b> [1] 79/20 '<b>Hepatitis</b> [3] 92/7 93/7 96/21 '<b>in</b> [1] 93/1 '<b>infective</b> [1] 80/24 '<b>innocent</b> [2] 92/9 96/23 '<b>Non</b> [4] 77/12 90/22 91/1 103/9 '<b>Non-A</b> [1] 77/12 '<b>non-A, non-B</b> [1] 103/9 '<b>Non-A, Non-B Hepatitis</b> [2] 90/22 91/1</p>	<p>'<b>not</b> [1] 81/11 '<b>policy</b> [1] 32/2 '<b>the</b> [1] 55/16</p> <hr/> <p><b>0</b> <b>0.1</b> [1] 79/3 <b>052</b> [1] 120/19</p> <hr/> <p><b>1</b> <b>1 April 1988</b> [1] 89/19 <b>1 October</b> [1] 109/1 <b>1-5</b> [1] 78/14 <b>1.03</b> [1] 89/10 <b>10</b> [2] 45/17 79/4 <b>10 September 1986</b> [1] 11/16 <b>10,655</b> [1] 80/18 <b>10.00</b> [3] 1/2 158/15 158/17 <b>100 yards</b> [1] 35/25 <b>103</b> [2] 118/6 118/11 <b>105,000</b> [1] 89/23 <b>11</b> [1] 121/22 <b>11.1</b> [1] 32/18 <b>11.18</b> [1] 47/15 <b>11.45</b> [2] 47/6 47/14 <b>11.48</b> [1] 47/17 <b>12 June 1986</b> [1] 77/5 <b>13</b> [1] 100/16 <b>13 from</b> [1] 121/22 <b>13 June 1987</b> [1] 11/17 <b>13 summonses</b> [1] 122/24 <b>14</b> [2] 21/13 21/16 <b>14.1</b> [1] 19/7 <b>15</b> [4] 21/13 21/16 21/25 145/2 <b>15 February 1989</b> [1] 120/21 <b>154</b> [1] 78/6 <b>16 October</b> [1] 85/14 <b>16 October 1986</b> [1] 84/18 <b>16 years</b> [1] 15/19 <b>16.1</b> [1] 45/15 <b>18</b> [1] 78/22 <b>18 April 1987</b> [1] 100/8 <b>18th August</b> [1] 56/3 <b>19</b> [1] 47/24 <b>19 July 2022</b> [1] 1/1</p>	<p><b>1973</b> [2] 3/4 25/3 <b>1974</b> [1] 17/1 <b>1978</b> [3] 21/22 22/15 22/17 <b>1980s</b> [1] 83/25 <b>1983</b> [1] 13/16 <b>1984</b> [2] 13/2 122/16 <b>1985</b> [8] 14/1 16/8 17/1 56/5 77/13 139/21 140/11 147/16 <b>1986</b> [23] 3/11 4/1 4/15 8/8 11/16 17/6 25/16 34/9 43/1 54/15 67/19 75/12 75/19 75/23 77/5 84/18 88/19 88/22 125/8 130/22 137/2 139/22 143/6 <b>1986-91</b> [1] 118/20 <b>1987</b> [28] 11/17 13/16 37/22 75/20 76/1 89/6 89/15 89/16 89/22 90/2 93/13 94/14 95/1 95/13 100/8 100/12 100/16 100/23 108/22 111/1 112/6 113/25 121/7 124/12 125/8 130/22 139/22 147/16 <b>1987/88</b> [1] 85/16 <b>1988</b> [14] 13/2 13/3 13/19 14/1 16/8 16/11 17/22 67/19 76/2 89/6 89/19 102/12 114/5 114/8 <b>1989</b> [13] 4/4 4/8 14/1 14/22 16/12 25/16 34/9 116/23 117/21 120/21 120/24 137/2 143/6 <b>1990</b> [2] 4/4 13/3 <b>1991</b> [1] 14/2 <b>1992</b> [1] 13/19 <b>1995</b> [1] 11/8 <b>1999</b> [4] 6/6 6/16 6/18 8/8</p> <hr/> <p><b>2</b> <b>2 October 1987</b> [1] 108/22 <b>2.00</b> [1] 89/12 <b>20.1</b> [1] 14/4 <b>2000</b> [1] 147/14</p>	<p><b>2003</b> [2] 4/23 4/24 <b>2011</b> [3] 2/18 2/20 4/25 <b>2022</b> [2] 1/1 2/17 <b>20s</b> [1] 34/19 <b>21 August</b> [2] 64/1 67/1 <b>21 August 1986</b> [1] 54/15 <b>24</b> [1] 130/14 <b>27</b> [5] 75/7 75/13 80/12 98/25 118/7 <b>27.115</b> [1] 80/14 <b>27.180</b> [1] 89/24 <b>27.415</b> [1] 118/14 <b>27.66</b> [1] 75/13</p> <hr/> <p><b>3</b> <b>3 March 1987</b> [1] 89/16 <b>3-4 years</b> [1] 102/8 <b>3.23</b> [1] 138/18 <b>3.55</b> [3] 138/10 138/10 138/17 <b>3.57</b> [1] 138/20 <b>300,000</b> [1] 89/23 <b>32</b> [1] 80/13 <b>32.1</b> [1] 47/25 <b>35 years</b> [4] 16/2 30/4 38/20 75/4 <b>38</b> [1] 79/13</p> <hr/> <p><b>4</b> <b>4 July 1987</b> [1] 100/23 <b>4 years</b> [1] 102/9 <b>4.33</b> [1] 158/16 <b>40</b> [2] 97/10 97/13 <b>40 staff</b> [2] 25/25 28/9 <b>4D</b> [2] 9/7 9/11</p> <hr/> <p><b>5</b> <b>50</b> [2] 120/4 130/12 <b>54.1</b> [1] 73/19</p> <hr/> <p><b>6</b> <b>6 April</b> [2] 94/16 95/3 <b>6 April 1987</b> [1] 90/2 <b>6-8</b> [2] 92/18 93/2 <b>6th August</b> [3] 55/11 55/18 55/25</p>	<p><b>7</b> <b>7 April</b> [1] 95/8 <b>7 April 1987</b> [1] 94/14 <b>70</b> [1] 79/14 <b>75</b> [2] 121/9 121/13 <b>75 was</b> [1] 122/1 <b>77.1</b> [1] 120/5</p> <hr/> <p><b>8</b> <b>8 June</b> [1] 5/20 <b>8 June 2022</b> [1] 2/17 <b>8 o'clock</b> [1] 138/14 <b>8 years</b> [1] 78/14 <b>8.1</b> [1] 25/12 <b>800,000</b> [1] 70/13 <b>810,000</b> [2] 75/25 90/20 <b>88</b> [1] 85/16 <b>8Y</b> [6] 125/4 127/5 129/14 129/17 129/25 130/4</p> <hr/> <p><b>9</b> <b>9 April 1987</b> [2] 95/1 95/13 <b>9.2</b> [1] 5/22 <b>9.3</b> [1] 26/22 <b>91</b> [1] 118/20</p> <hr/> <p><b>A</b> <b>A, [28]</b> 68/8 68/9 69/13 72/10 77/7 78/4 78/21 79/22 80/25 82/9 83/17 84/22 90/11 90/12 90/22 91/1 97/7 97/24 101/14 101/21 103/9 104/5 109/8 125/11 126/15 127/25 154/11 156/24 <b>abiding</b> [1] 30/4 <b>abilities</b> [1] 57/14 <b>ability</b> [5] 31/8 39/8 54/6 62/6 146/22 <b>able</b> [18] 36/14 36/19 45/5 52/13 61/17 62/9 109/16 120/14 123/14 129/5 130/2 131/1 131/5 141/19 153/9 153/12 155/4 157/16 <b>abolish</b> [6] 92/6 93/17 96/20 97/2 97/4 97/14</p>
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<p><b>A</b></p> <p><b>about [129]</b> 6/5 10/15 12/15 22/8 22/24 23/3 24/14 24/14 24/15 26/19 30/16 30/18 31/1 33/18 34/4 34/25 35/6 35/25 37/13 37/17 38/10 38/15 38/16 39/20 39/23 40/23 41/8 43/23 44/9 46/23 47/9 47/12 48/20 51/4 52/13 53/24 54/11 54/19 57/9 58/10 59/8 61/15 63/15 64/17 66/18 67/10 70/20 72/9 73/8 77/19 79/7 82/8 84/21 85/21 86/14 90/12 92/21 95/25 96/8 97/2 97/10 99/1 100/18 105/11 105/16 105/21 106/17 107/17 108/10 108/11 109/11 110/14 110/23 111/6 112/12 113/1 113/10 113/15 113/20 114/2 116/9 117/15 118/10 119/11 119/20 120/6 121/4 124/12 124/14 124/21 125/1 125/1 125/25 128/16 130/17 131/9 131/19 132/9 135/13 138/3 139/6 139/20 139/21 141/18 142/2 142/22 143/23 144/3 144/3 144/13 144/17 145/3 147/9 147/17 147/22 149/8 149/19 150/8 150/8 151/6 152/1 152/3 153/4 153/19 154/14 154/21 155/12 155/24 156/23</p> <p><b>above [1]</b> 80/2</p> <p><b>ABPI [1]</b> 135/1</p> <p><b>absence [2]</b> 65/23 158/9</p> <p><b>absolutely [24]</b> 2/15 15/22 16/10 29/20 33/25 35/14 36/12 42/2 42/9 45/6 53/25 68/19 74/8 81/25 84/4</p>	<p>85/9 86/13 88/22 99/24 137/6 147/1 147/1 147/12 154/17</p> <p><b>abusers [1]</b> 78/12</p> <p><b>academic [1]</b> 153/1</p> <p><b>accept [3]</b> 97/6 107/6 112/24</p> <p><b>accepted [4]</b> 78/1 104/1 104/17 146/25</p> <p><b>access [6]</b> 42/22 44/9 44/11 44/13 45/11 71/14</p> <p><b>accessible [2]</b> 57/21 62/18</p> <p><b>accommodation [1]</b> 56/25</p> <p><b>according [1]</b> 97/15</p> <p><b>account [2]</b> 58/3 61/15</p> <p><b>accounting [1]</b> 1/12</p> <p><b>accurate [3]</b> 2/22 74/2 121/18</p> <p><b>accurately [1]</b> 102/5</p> <p><b>accusations [1]</b> 103/21</p> <p><b>Ach [1]</b> 67/3</p> <p><b>achieve [1]</b> 49/14</p> <p><b>achieved [3]</b> 29/20 52/23 53/4</p> <p><b>acquired [2]</b> 128/6 129/24</p> <p><b>across [10]</b> 10/21 19/1 28/8 42/17 43/7 63/2 88/8 143/8 143/10 143/21</p> <p><b>act [15]</b> 4/6 4/11 17/21 21/22 22/15 22/17 22/17 22/17 60/2 102/15 105/12 151/4 151/9 151/19 152/2</p> <p><b>acted [1]</b> 50/7</p> <p><b>acting [2]</b> 61/19 107/9</p> <p><b>action [1]</b> 93/22</p> <p><b>actions [1]</b> 121/10</p> <p><b>active [1]</b> 157/6</p> <p><b>activities [2]</b> 10/22 127/21</p> <p><b>actuality [1]</b> 13/6</p> <p><b>actually [6]</b> 9/10 41/17 45/16 66/23 127/19 139/10</p>	<p><b>acute [2]</b> 110/2 130/23</p> <p><b>ad [1]</b> 145/6</p> <p><b>adapted [1]</b> 80/24</p> <p><b>add [3]</b> 72/1 113/5 127/17</p> <p><b>addition [2]</b> 25/19 81/2</p> <p><b>additional [1]</b> 98/10</p> <p><b>address [1]</b> 105/5</p> <p><b>addressed [2]</b> 59/16 95/2</p> <p><b>addressees [2]</b> 91/15 94/13</p> <p><b>adequate [1]</b> 123/12</p> <p><b>adjourned [1]</b> 158/17</p> <p><b>Adjournment [1]</b> 89/11</p> <p><b>administer [1]</b> 129/21</p> <p><b>administered [1]</b> 137/13</p> <p><b>administration [2]</b> 78/18 133/5</p> <p><b>administrative [4]</b> 13/21 50/25 70/10 71/22</p> <p><b>administrators [1]</b> 156/22</p> <p><b>adopt [1]</b> 31/9</p> <p><b>advanced [1]</b> 108/8</p> <p><b>advantage [3]</b> 28/2 44/6 49/16</p> <p><b>advantageous [1]</b> 38/9</p> <p><b>advantages [2]</b> 37/4 74/24</p> <p><b>advent [2]</b> 33/10 126/11</p> <p><b>adverse [1]</b> 130/18</p> <p><b>advice [36]</b> 16/17 16/18 17/9 26/4 29/3 39/25 43/17 43/17 43/22 43/24 44/22 44/23 45/12 54/1 60/23 60/25 65/12 65/20 65/21 70/2 70/5 70/6 71/15 94/3 121/1 128/16 146/22 146/24 147/5 147/9 147/17 148/15 151/6 152/3 154/9 155/2</p> <p><b>advise [1]</b> 59/22</p>	<p><b>advised [2]</b> 41/23 92/16</p> <p><b>adviser [11]</b> 42/24 43/2 43/14 43/25 44/7 146/21 147/3 147/8 147/10 153/24 154/3</p> <p><b>advisers [6]</b> 38/23 42/20 42/23 44/10 44/11 55/20</p> <p><b>advising [2]</b> 42/12 151/12</p> <p><b>advisory [5]</b> 75/16 116/23 117/12 117/14 117/21</p> <p><b>advocating [1]</b> 100/3</p> <p><b>affairs [2]</b> 6/18 10/3</p> <p><b>affect [1]</b> 38/1</p> <p><b>affected [5]</b> 36/20 52/10 136/4 136/7 137/4</p> <p><b>afford [1]</b> 103/7</p> <p><b>afraid [6]</b> 6/14 80/4 121/14 123/13 151/2 155/12</p> <p><b>after [15]</b> 11/18 36/19 40/23 46/24 55/15 65/10 76/9 84/4 89/7 113/25 122/16 138/12 147/2 147/4 147/4</p> <p><b>afternoon [1]</b> 106/14</p> <p><b>afterwards [2]</b> 143/2 147/3</p> <p><b>again [19]</b> 8/23 12/11 13/2 16/1 16/9 20/24 20/24 25/12 32/1 34/18 34/18 44/19 54/23 95/23 100/13 110/21 112/14 150/17 157/21</p> <p><b>against [14]</b> 51/21 69/10 69/16 95/16 102/21 106/2 111/8 113/2 122/10 122/12 125/10 145/22 146/3 146/11</p> <p><b>agencies [1]</b> 49/4</p> <p><b>Agency [17]</b> 10/9 20/21 20/22 21/3 21/10 21/21 22/3 22/18 22/23 25/23 27/10 39/21 43/4 43/5 43/8 63/1 86/23</p>	<p><b>Agency's [1]</b> 25/7</p> <p><b>agent [1]</b> 122/6</p> <p><b>ago [14]</b> 16/2 30/4 38/20 70/19 70/22 74/18 82/13 85/4 115/6 115/15 115/24 117/16 124/12 149/19</p> <p><b>agree [6]</b> 82/10 85/1 94/15 95/7 102/4 158/8</p> <p><b>agreed [4]</b> 72/9 89/17 93/6 135/8</p> <p><b>agreeing [1]</b> 133/25</p> <p><b>agreement [5]</b> 42/2 55/5 99/4 114/5 131/13</p> <p><b>Ah [1]</b> 139/1</p> <p><b>ahead [9]</b> 45/23 74/12 84/24 85/5 94/18 99/7 118/16 148/12 148/23</p> <p><b>aid [1]</b> 123/1</p> <p><b>AIDS [8]</b> 56/6 64/12 104/7 120/8 120/25 122/7 139/13 150/8</p> <p><b>aims [1]</b> 48/20</p> <p><b>air [1]</b> 27/24</p> <p><b>alanine [1]</b> 101/21</p> <p><b>Albert [1]</b> 16/25</p> <p><b>Albert Bell [1]</b> 16/25</p> <p><b>Alexander [1]</b> 13/16</p> <p><b>algorithm [1]</b> 33/6</p> <p><b>all [56]</b> 1/15 3/7 3/18 5/15 9/13 11/13 16/22 23/16 28/12 30/10 35/23 39/4 46/2 48/9 56/4 56/16 57/5 58/17 58/25 63/20 63/20 67/8 71/1 77/6 78/8 81/23 86/11 87/22 90/20 93/18 94/4 94/5 95/10 96/13 97/19 100/7 101/23 102/18 102/24 104/9 105/15 108/16 109/21 119/21 120/17 122/24 126/11 130/8 134/8 136/8 141/7 141/13 143/5 155/12 156/17 158/2</p> <p><b>allayed [1]</b> 107/16</p> <p><b>allegations [1]</b> 111/19</p> <p><b>allege [2]</b> 111/15 122/5</p>
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<b>A</b>	44/23 46/12 52/21 63/9 64/24 70/8 72/2 73/1 86/6 102/24 103/6 106/11 117/8 121/19 157/18 <b>always</b> [11] 1/7 13/17 13/18 16/3 17/17 24/21 35/11 36/3 36/9 49/2 113/20 <b>am</b> [13] 1/2 18/20 47/15 51/10 57/1 63/25 73/14 95/3 104/25 109/11 109/12 119/19 158/17 <b>amalgamated</b> [1] 46/5 <b>amazing</b> [1] 58/21 <b>ambulance</b> [10] 24/5 24/7 25/23 27/10 27/12 27/14 27/17 28/23 31/7 52/11 <b>ambulances</b> [3] 27/12 31/10 52/8 <b>American</b> [3] 75/14 79/12 114/9 <b>aminotransferase</b> [1] 101/22 <b>among</b> [4] 78/12 91/14 97/8 135/25 <b>amongst</b> [2] 87/10 113/14 <b>amount</b> [9] 18/23 33/17 52/15 70/12 73/13 74/20 92/9 96/23 136/3 <b>amounting</b> [2] 92/17 93/1 <b>an abiding</b> [1] 30/4 <b>an accurate</b> [1] 121/18 <b>an ad hoc</b> [1] 145/6 <b>an advisory</b> [2] 117/12 117/14 <b>an algorithm</b> [1] 33/6 <b>an alternative</b> [1] 61/20 <b>an amazing</b> [1] 58/21 <b>an ambulance</b> [2] 27/14 52/11 <b>an answer</b> [1] 154/22 <b>an argument</b> [2] 107/23 108/7	<b>an Assistant</b> [3] 8/6 8/10 8/12 <b>an attempt</b> [1] 121/8 <b>an authoritative</b> [1] 119/3 <b>an autodidact</b> [1] 61/3 <b>an awful</b> [1] 38/4 <b>an easy</b> [1] 59/9 <b>an element</b> [1] 31/12 <b>an English</b> [1] 145/5 <b>an entirely</b> [1] 118/3 <b>an example</b> [2] 111/13 117/11 <b>an expeditious</b> [1] 150/1 <b>an expensive</b> [1] 93/20 <b>an experience</b> [1] 29/7 <b>an extremely</b> [1] 26/8 <b>an idea</b> [2] 9/16 34/8 <b>an imbalance</b> [1] 145/11 <b>an immense</b> [1] 29/24 <b>an implication</b> [1] 66/7 <b>an important</b> [2] 118/4 154/18 <b>an independent</b> [1] 150/25 <b>an informal</b> [2] 37/7 37/12 <b>an inhibition</b> [1] 36/12 <b>an inquiry</b> [1] 123/15 <b>an institutional</b> [1] 30/19 <b>an interesting</b> [1] 110/23 <b>an irresistible</b> [1] 116/16 <b>an issue</b> [2] 58/18 76/5 <b>an obvious</b> [1] 84/2 <b>an opportunity</b> [5] 28/16 29/17 30/6 111/20 111/23 <b>an option</b> [1] 41/24 <b>an SEO</b> [1] 8/22 <b>an SHHD</b> [1] 92/14 <b>an Under-Secretary</b> [1] 8/2	<b>an unfortunate</b> [1] 60/9 <b>analysis</b> [2] 95/16 105/1 <b>anathema</b> [1] 106/20 <b>Anderson</b> [2] 100/10 101/17 <b>angle</b> [1] 118/3 <b>announcement</b> [1] 114/9 <b>annoying</b> [2] 48/13 48/15 <b>annually</b> [1] 90/20 <b>another</b> [5] 50/16 52/2 97/19 100/12 117/16 <b>answer</b> [18] 33/7 34/14 62/11 65/22 102/3 102/8 111/9 111/25 123/23 124/21 126/19 126/24 131/10 139/25 143/19 153/18 154/19 154/22 <b>answers</b> [6] 12/8 16/3 150/16 150/19 155/21 157/22 <b>antagonist</b> [1] 53/21 <b>anti</b> [3] 75/17 102/23 139/20 <b>anti-HBc</b> [2] 75/17 102/23 <b>anti-HIV</b> [1] 139/20 <b>antibody</b> [3] 67/16 101/22 104/6 <b>anticipate</b> [1] 47/11 <b>anticipated</b> [1] 149/20 <b>anticipating</b> [1] 149/23 <b>antiviral</b> [1] 103/1 <b>anxious</b> [3] 28/2 109/11 109/12 <b>any</b> [69] 2/25 4/9 4/12 10/13 14/11 14/13 14/13 16/20 16/23 18/4 31/14 38/13 38/18 38/18 40/2 42/10 44/10 47/10 49/3 53/10 61/1 64/11 65/11 65/12 65/20 66/4 66/11 69/9 71/6 71/10 73/5 73/7 78/19	81/20 84/6 84/8 84/9 87/19 92/6 93/21 96/20 97/2 99/19 109/24 109/24 112/2 116/9 117/20 119/11 119/19 123/14 124/14 124/14 127/5 128/12 128/14 129/6 141/19 141/20 144/14 147/7 147/11 147/17 147/17 151/2 152/18 155/18 156/9 156/18 <b>anybody</b> [3] 60/25 87/13 124/8 <b>anyone</b> [4] 18/21 47/9 47/9 131/13 <b>anything</b> [4] 47/12 113/5 120/6 155/12 <b>anyway</b> [2] 1/23 112/22 <b>Apologise</b> [1] 92/21 <b>apparently</b> [3] 56/22 59/6 79/14 <b>appear</b> [2] 94/5 133/7 <b>appearance</b> [1] 91/14 <b>appeared</b> [2] 2/19 91/15 <b>appears</b> [4] 9/9 110/3 113/24 130/16 <b>appetite</b> [1] 88/21 <b>application</b> [2] 93/12 133/2 <b>applied</b> [3] 67/15 103/15 103/19 <b>applies</b> [1] 64/15 <b>applying</b> [1] 68/1 <b>appointees</b> [1] 62/25 <b>appointment</b> [1] 43/3 <b>appointments</b> [1] 22/22 <b>appreciate</b> [3] 17/9 27/7 158/1 <b>appreciated</b> [1] 157/16 <b>approach</b> [8] 49/11 50/8 52/14 60/18 60/23 60/25 99/11 153/16 <b>approached</b> [2] 38/1 38/3 <b>appropriate</b> [6] 41/15 54/24 55/15 94/23
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(43) alleges - appropriate



<p><b>A</b></p> <p><b>appropriate... [2]</b> 123/12 138/25</p> <p><b>approval [9]</b> 72/15 72/20 73/2 90/23 131/9 131/12 131/15 133/7 134/13</p> <p><b>approved [3]</b> 45/23 46/7 132/23</p> <p><b>April [13]</b> 89/15 89/19 90/2 94/14 94/16 95/1 95/3 95/8 95/13 100/8 114/5 116/23 117/21</p> <p><b>April 1988 [1]</b> 114/5</p> <p><b>April 1989 [2]</b> 116/23 117/21</p> <p><b>Archie [27]</b> 15/18 15/22 16/16 17/10 17/20 28/22 29/5 31/21 31/22 35/16 35/16 45/8 50/23 62/15 62/19 65/19 66/20 66/23 66/25 87/4 91/10 96/3 97/20 98/5 117/15 125/23 156/23</p> <p><b>Archie McIntyre [14]</b> 17/10 17/20 31/22 35/16 45/8 50/23 62/15 65/19 66/20 66/25 87/4 91/10 125/23 156/23</p> <p><b>Archie McIntyre's [2]</b> 96/3 117/15</p> <p><b>Archie's [1]</b> 29/2</p> <p><b>are [70]</b> 1/9 1/15 1/17 1/24 1/25 2/1 4/14 5/9 5/25 7/10 8/13 13/11 13/16 14/25 21/16 23/9 28/5 34/21 38/15 39/12 39/13 42/10 52/13 55/23 60/14 61/8 64/22 67/9 74/11 77/23 78/14 78/15 79/4 79/8 79/12 79/14 79/15 79/23 82/24 85/15 93/14 93/14 94/25 103/12 103/18 103/25 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(44) appropriate... - because



<b>B</b>	135/21 136/16 137/4 137/7 138/2 141/17 143/4 144/2 145/21 147/25 149/1 149/2 151/14 151/15 152/16 152/21 153/3 153/13 154/19 154/24 155/8 155/22 156/5 157/13 157/16 157/24 <b>because... [18]</b> 124/21 125/12 127/15 128/9 129/20 130/8 131/8 132/7 132/14 134/11 135/7 136/11 142/14 142/24 145/4 146/1 146/23 147/24 <b>become [4]</b> 78/25 116/13 126/14 146/1 <b>becomes [2]</b> 141/2 141/4 <b>becoming [1]</b> 15/2 <b>been [146]</b> 2/6 8/21 11/9 12/24 13/3 15/14 16/18 17/12 17/15 24/14 29/6 30/21 30/22 33/8 33/13 36/13 36/24 36/25 37/23 39/23 40/24 41/1 41/15 41/25 43/12 50/9 50/18 50/21 53/3 55/15 56/8 58/13 58/14 58/22 59/1 60/4 65/3 65/21 66/9 66/10 67/4 68/9 69/17 70/5 70/24 71/11 71/25 72/20 73/4 73/7 73/8 73/15 73/16 75/20 76/7 76/11 78/24 80/22 81/9 84/2 84/3 84/5 85/22 86/11 86/15 86/21 87/2 87/6 87/20 88/20 93/10 93/12 101/10 101/19 101/25 102/3 102/23 105/1 106/3 108/4 111/10 111/17 112/13 113/17 113/19 115/2 115/5 116/1 116/5 116/5 119/24 120/22 121/23 122/16 122/24 122/24 123/11 123/12 123/18 123/20 124/18 125/12 125/16 125/22 125/24 126/2 126/13 126/15 126/19 128/25 130/2 130/5 130/9 131/6 132/16 132/20 133/9 133/15 135/2 135/10	135/21 136/16 137/4 137/7 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(59) justice - long



<p><b>L</b></p> <p><b>long-term [1]</b> 79/1</p> <p><b>longer [5]</b> 15/15 30/23 44/7 56/8 106/16</p> <p><b>longstanding [1]</b> 48/1</p> <p><b>look [24]</b> 3/20 6/22 16/3 34/11 34/18 34/20 34/21 45/21 53/13 59/12 59/18 69/1 73/23 74/10 75/5 85/10 94/9 103/23 106/22 107/21 119/14 126/8 152/23 153/12</p> <p><b>looked [6]</b> 58/5 118/2 119/15 121/24 134/5 139/9</p> <p><b>looked at [4]</b> 58/5 119/15 121/24 134/5</p> <p><b>looking [8]</b> 4/14 9/4 59/11 88/15 88/19 104/18 117/16 119/9</p> <p><b>looks [1]</b> 58/24</p> <p><b>Lord [39]</b> 2/18 3/25 6/25 11/4 11/13 11/15 11/21 12/12 37/20 38/5 53/1 80/9 80/13 81/19 81/20 82/21 85/25 86/5 88/16 98/25 118/2 118/7 118/17 119/5 119/10 119/15 119/25 124/11 126/23 130/13 132/24 150/12 153/1 153/3 153/8 153/15 154/14 158/14 158/15</p> <p><b>Lord Forsyth [5]</b> 6/25 11/21 12/12 158/14 158/15</p> <p><b>Lord Glenarthur [4]</b> 11/13 11/15 37/20 38/5</p> <p><b>Lord Penrose [4]</b> 86/5 119/15 153/8 153/15</p> <p><b>Lord Penrose's [16]</b> 11/4 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(60) long-term - measure

<b>M</b>	<b>mention [3]</b> 19/15 75/8 97/20	11/15 11/25 33/1 33/10 33/10 33/12 33/12 33/17 33/21 35/1 36/16 36/18 36/23 37/1 37/3 37/8 37/9 37/13 37/23 38/7 41/24 42/21 68/18 70/7 86/19 88/5 88/20 112/3 113/3 113/8 113/16 121/1 121/16 136/1 140/12 140/15 140/18 141/12 141/18 141/22 142/3 142/25 143/3 143/14 143/17 <b>minister's [2]</b> 87/22 142/15	<b>missed [1]</b> 79/9 <b>missing [2]</b> 92/23 93/1 <b>Mitchell [2]</b> 100/17 101/5 <b>mixture [1]</b> 2/4 <b>moan [1]</b> 67/10 <b>modern [1]</b> 5/4 <b>modestly [1]</b> 103/3 <b>modus [1]</b> 38/10 <b>modus operandi [1]</b> 38/10 <b>Moir [6]</b> 90/7 91/14 91/15 91/19 94/12 98/7 <b>moment [18]</b> 2/7 5/18 16/14 43/20 52/7 64/25 70/19 70/22 74/18 76/10 82/13 85/3 109/10 115/6 115/14 115/24 117/16 149/19 <b>momentum [1]</b> 30/19 <b>money [16]</b> 28/3 51/22 51/24 52/2 70/13 71/2 76/3 76/16 85/16 86/9 98/8 104/19 109/10 109/17 109/19 109/24 <b>monitor [1]</b> 64/25 <b>month [2]</b> 56/6 114/8 <b>months [3]</b> 76/9 79/5 82/18 <b>morbidity [1]</b> 104/15 <b>more [57]</b> 2/5 10/11 10/12 11/25 20/22 24/1 24/15 26/17 28/4 28/16 29/16 30/8 31/18 32/20 33/12 34/5 34/21 38/22 38/22 48/17 53/19 58/11 59/16 59/18 59/19 61/7 65/24 69/20 70/14 71/22 71/23 72/24 81/15 86/7 86/18 86/19 106/12 115/10 115/19 116/13 125/2 126/6 129/16 130/20 132/9 140/21 141/2 141/4 142/6 142/8 144/13 147/7 149/14 150/13	151/5 156/2 156/4 <b>more likely [1]</b> 142/8 <b>Morison [13]</b> 13/2 51/2 54/15 63/25 66/8 66/14 87/8 90/7 93/25 95/4 95/7 95/15 99/4 <b>Morison's [2]</b> 54/3 59/17 <b>morning [5]</b> 71/18 72/5 113/6 138/14 157/10 <b>most [13]</b> 9/1 11/9 32/19 49/14 49/15 51/2 56/4 63/7 78/24 81/4 133/4 134/11 135/13 <b>mostly [4]</b> 77/11 80/8 82/11 143/2 <b>mound [1]</b> 128/19 <b>mountain [3]</b> 136/21 151/3 151/21 <b>move [4]</b> 13/7 46/23 117/24 119/19 <b>moved [1]</b> 26/15 <b>Moving [1]</b> 148/2 <b>Mr [41]</b> 1/3 1/14 2/8 2/11 2/12 2/13 26/7 47/19 54/16 63/25 84/21 85/25 86/4 86/10 89/13 89/14 90/3 90/7 92/22 93/25 94/2 94/11 95/4 95/5 95/15 99/4 105/10 120/20 120/21 137/17 138/6 138/22 139/3 139/5 148/21 156/7 156/17 157/18 158/9 158/12 159/3 <b>Mr Donald [1]</b> 54/16 <b>Mr Forsyth [1]</b> 120/21 <b>Mr Hill [10]</b> 1/14 2/8 2/12 89/13 92/22 138/6 139/3 148/21 157/18 158/12 <b>Mr Hill's [1]</b> 158/9 <b>Mr Macniven [12]</b> 1/3 2/13 26/7 47/19 89/14 94/2 105/10 137/17 138/22 139/5 156/7 156/17 <b>Mr McIntyre [2]</b> 90/3 94/11
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(61) mediated - Mr McIntyre



<b>M</b>	125/13 125/14 128/10 129/18 131/10 132/5 132/5 132/5 136/8 138/14 142/18 142/19 149/8 150/1 151/23 151/24 154/7 156/16 157/8 <b>myself</b> [4] 31/23 55/6 56/19 60/2 <b>mysterious</b> [1] 97/25	<b>N</b> <b>name</b> [8] 12/19 16/7 17/7 28/24 65/18 117/17 154/4 156/1 <b>names</b> [3] 11/5 13/15 13/24 <b>NANB</b> [8] 80/21 81/8 81/10 81/18 83/13 108/1 109/14 126/19 <b>NANBH</b> [3] 102/10 102/20 104/16 <b>narrow</b> [1] 152/10 <b>narrowed</b> [1] 132/21 <b>narrowly</b> [1] 118/25 <b>nasty</b> [1] 30/11 <b>nation</b> [1] 52/1 <b>national</b> [14] 20/11 22/1 22/5 22/13 22/25 23/4 23/13 27/4 29/12 39/21 44/15 98/15 122/11 129/5 <b>natural</b> [2] 45/7 126/6 <b>nature</b> [3] 108/12 146/16 154/22 <b>necessarily</b> [5] 51/22 58/3 103/24 106/11 145/25 <b>necessary</b> [10] 32/11 43/24 72/21 114/19 124/1 131/10 133/22 139/25 140/19 141/11 <b>need</b> [14] 30/1 67/4 73/4 87/13 89/20 109/8 110/2 113/15 114/4 133/16 133/24 134/11 138/6 148/10 <b>needed</b> [9] 33/5 39/11 46/16 63/4 63/5 65/20 132/3 134/13 134/19 <b>needn't</b> [2] 19/7 85/18 <b>needs</b> [2] 51/25	129/21 <b>negative</b> [1] 124/21 <b>negatives</b> [2] 79/10 97/11 <b>negligence</b> [1] 121/11 <b>neither</b> [1] 68/6 <b>net</b> [2] 129/24 135/16 <b>never</b> [12] 17/7 56/21 62/9 65/3 65/11 71/4 88/13 111/17 114/16 129/21 132/2 132/16 <b>nevertheless</b> [3] 64/23 92/9 96/23 <b>new</b> [3] 43/12 79/18 133/20 <b>New York</b> [1] 79/18 <b>news</b> [1] 146/10 <b>next</b> [6] 12/18 13/7 13/20 27/9 56/15 89/14 <b>NHS</b> [8] 4/6 14/24 21/17 21/22 72/25 103/20 121/11 151/25 <b>nine</b> [1] 80/22 <b>no</b> [100] 1/12 3/7 3/8 15/15 16/1 16/13 16/22 18/6 24/14 31/3 31/4 33/5 35/7 36/6 38/18 41/25 42/2 42/14 42/17 43/21 43/23 44/7 49/5 53/25 54/9 56/11 57/8 57/20 60/6 65/10 65/22 66/9 66/10 67/19 68/22 70/21 71/19 72/20 73/4 74/8 74/13 75/22 77/25 78/15 78/19 80/4 80/18 81/22 82/5 85/16 88/15 88/21 91/6 92/23 96/13 98/13 102/2 104/16 106/5 106/16 111/19 112/1 115/4 118/21 119/13 123/25 124/11 125/18 125/21 127/3 127/8 128/6 128/11 130/8 131/11 133/2 134/23 135/16 136/8 136/16 138/10 138/10 141/24 143/7 143/9 144/11 144/21 145/16 148/7 149/25 150/7	150/13 151/10 152/20 154/4 154/8 155/23 156/11 156/14 156/16 <b>nobody</b> [3] 27/15 97/4 132/1 <b>nod</b> [2] 12/9 81/12 <b>nodded</b> [41] 7/15 7/20 7/23 8/1 8/3 8/5 8/16 8/20 9/6 9/8 9/18 9/21 12/6 14/9 15/1 15/4 18/11 23/6 23/8 23/10 37/25 41/7 48/22 48/25 53/9 62/1 67/21 74/1 84/1 87/25 88/4 88/18 112/8 112/11 112/16 133/14 134/15 135/9 140/14 143/15 148/9 <b>nodding</b> [1] 12/7 <b>noise</b> [1] 35/21 <b>non</b> [72] 24/18 57/15 67/18 67/18 68/8 68/8 68/9 68/9 68/14 69/13 69/13 72/10 72/10 77/7 77/7 77/13 77/20 77/20 78/4 78/4 78/21 78/21 79/22 79/22 80/25 80/25 82/9 82/9 83/17 83/17 84/22 84/22 85/17 85/17 90/11 90/11 90/12 90/12 90/22 91/1 94/4 94/4 95/10 95/10 97/7 97/7 97/24 97/24 101/14 101/14 101/21 101/21 103/9 104/5 104/5 108/25 108/25 109/8 109/8 116/2 125/11 125/11 126/15 126/15 127/25 127/25 131/24 133/13 154/11 154/11 156/24 156/24 <b>non-A</b> [6] 67/18 77/20 85/17 94/4 95/10 108/25 <b>non-A, non-B</b> [6] 79/22 82/9 97/7 109/8 126/15 127/25 <b>non-A, non-B</b> <b>hepatitis</b> [19] 68/8 68/9 69/13 72/10 77/7 78/4 78/21 80/25	83/17 84/22 90/11 90/12 97/24 101/14 101/21 104/5 125/11 154/11 156/24 <b>non-B</b> [3] 67/18 94/4 108/25 <b>non-B hepatitis</b> [4] 77/13 77/20 85/17 95/10 <b>non-executive</b> [1] 24/18 <b>non-specialists</b> [1] 116/2 <b>non-therapeutic</b> [2] 131/24 133/13 <b>none</b> [6] 3/2 10/15 103/5 107/4 136/10 156/20 <b>nor</b> [3] 81/12 151/2 156/25 <b>normal</b> [1] 125/13 <b>normally</b> [3] 8/24 8/24 35/3 <b>Norman</b> [1] 19/16 <b>Norman Kernohan</b> [1] 19/16 <b>North</b> [1] 100/11 <b>North London</b> [1] 100/11 <b>not</b> [221] <b>note</b> [20] 9/19 12/3 26/7 46/23 76/21 77/11 82/11 82/13 89/5 91/3 96/3 96/11 98/7 98/24 102/14 103/14 112/14 142/2 157/22 157/23 <b>noted</b> [1] 92/15 <b>nothing</b> [6] 31/16 126/21 128/18 132/15 135/18 142/1 <b>notice</b> [2] 64/18 76/12 <b>notification</b> [1] 80/23 <b>notifications</b> [1] 81/2 <b>noting</b> [1] 101/9 <b>notwithstanding</b> [1] 41/14 <b>November</b> [2] 2/20 121/7 <b>November 1987</b> [1] 121/7 <b>now</b> [67] 3/22 9/4
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(62) Mr Morison - now



<b>N</b>	<b>obvious [3]</b> 7/17 84/2 157/9	86/14 90/4 90/6 94/11 128/15 139/17 139/17	145/9 151/21 152/10	31/22 31/22 31/24
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20/21 21/16 25/11	38/21 65/23 71/14	13/25 14/6 14/25	<b>online [5]</b> 1/9 1/11	39/23 40/4 41/9 41/23
28/5 32/9 32/17 34/16	87/14 100/5 118/2	64/23 65/8 65/15	1/17 2/2 48/10	41/23 42/12 42/12
34/22 39/9 41/17 44/9	121/24 124/11 135/20	65/24 86/17 151/6	<b>only [27]</b> 11/19 27/13	42/22 42/25 44/14
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69/11 76/4 76/20 77/4	42/10	<b>official [8]</b> 10/24	56/10 56/24 61/15	51/5 51/25 52/7 52/10
82/6 82/24 84/18 86/3	<b>occasional [1]</b> 77/16	55/16 55/21 58/11	62/13 63/6 78/7 79/13	53/19 55/20 56/11
88/19 89/8 91/15	<b>October [9]</b> 2/18	75/14 76/23 77/3	79/22 80/23 82/7	61/11 65/2 66/6 66/11
92/12 93/12 93/14	84/18 85/14 108/22	151/15	82/22 98/20 103/3	67/16 67/24 68/1 68/1
97/2 98/15 98/17	109/1 110/25 111/1	<b>officials [2]</b> 33/4	122/19 132/7 134/4	68/15 70/7 71/10
102/7 102/10 105/12	112/6 147/14	118/23	134/5 140/20 152/10	71/11 72/9 72/24
105/15 106/4 107/20	<b>October '87 [1]</b>	<b>often [6]</b> 7/16 8/18 9/9	<b>onwards [1]</b> 4/8	73/24 74/7 75/11
108/5 110/1 116/9	110/25	30/14 61/3 131/16	<b>open [16]</b> 35/11 35/13	76/13 77/1 77/8 80/19
116/17 119/10 119/18	<b>October 1987 [2]</b>	<b>oh [17]</b> 1/22 3/18	35/14 35/18 35/23	81/8 81/14 81/19 84/9
119/21 120/4 122/17	111/1 112/6	15/22 16/10 33/25	36/4 56/24 93/18	86/19 88/16 94/19
125/8 128/9 129/3	<b>October 2000 [1]</b>	35/13 45/6 69/23	110/6 110/7 110/15	95/9 97/23 98/11
131/4 133/15 137/17	147/14	92/20 99/24 110/17	111/3 111/4 111/8	102/21 102/25 105/25
145/5 148/8 148/24	<b>October 2011 [1]</b> 2/18	110/23 125/18 145/23	113/11 115/19	106/22 107/6 107/8
149/22 152/18 153/21	<b>odd [1]</b> 20/10	147/24 154/17 154/17	<b>opening [2]</b> 23/2	108/13 109/13 112/21
156/18 158/12	<b>off [6]</b> 32/16 92/19	<b>okay [9]</b> 12/9 21/11	123/16	113/4 113/8 113/15
<b>nowadays [2]</b> 33/25	103/21 105/3 109/21	118/12 127/8 139/23	<b>operandi [1]</b> 38/10	114/22 118/22 118/25
55/14	114/3	153/11 154/1 154/4	<b>operated [5]</b> 21/18	119/23 119/25 119/25
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(72) successful - that I

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(73) that I... - tier



<b>T</b>	<b>Tom [1]</b> 13/18 <b>Tom Macdonald [1]</b> 13/18 <b>tomorrow [10]</b> 6/25 12/12 33/19 34/14 35/6 138/14 142/13 157/9 158/13 158/14 <b>too [11]</b> 6/14 57/23 97/3 98/18 102/9 108/15 128/5 148/10 148/25 150/5 153/17 <b>took [21]</b> 11/18 16/11 16/14 37/16 37/18 48/6 50/3 50/8 52/14 56/5 59/23 60/2 60/24 72/8 86/5 97/19 119/12 120/8 135/6 148/4 148/18 <b>top [4]</b> 11/7 91/12 91/13 101/3 <b>topic [12]</b> 23/12 23/12 29/17 37/14 43/1 46/24 58/11 60/20 118/4 120/6 120/17 146/15 <b>topics [16]</b> 6/23 9/17 10/19 14/19 14/22 27/6 28/5 28/7 28/18 28/20 29/23 30/2 39/25 40/18 44/20 119/21 <b>total [1]</b> 78/8 <b>touch [2]</b> 40/11 69/18 <b>touches [1]</b> 67/12 <b>towards [3]</b> 18/10 106/10 115/25 <b>tragedy [1]</b> 137/5 <b>train [2]</b> 138/14 157/9 <b>trained [2]</b> 61/23 62/4 <b>trainee [1]</b> 3/4 <b>transcript [1]</b> 12/7 <b>transfusion [79]</b> 3/13 3/17 3/19 14/11 17/11 20/3 20/9 22/1 22/6 22/8 22/12 22/13 23/1 23/4 23/13 24/9 24/15 25/4 25/19 27/5 27/5 28/22 29/4 29/7 29/11 29/13 31/1 31/19 32/4 32/9 32/12 38/19 39/22 40/17 44/15 51/25 52/5 52/19 55/1	56/13 63/3 63/15 64/3 71/15 74/22 77/17 78/13 79/22 80/21 81/8 81/10 81/17 84/16 90/10 91/1 92/12 98/16 100/11 101/20 101/24 102/2 102/20 103/6 104/2 104/5 104/7 104/21 106/3 122/11 125/19 129/5 132/8 144/4 144/12 144/19 151/23 152/15 153/25 154/3 <b>transfusion-associate d [2]</b> 90/10 91/1 <b>transfusion-transmitt ed [4]</b> 101/20 104/2 104/5 104/7 <b>translating [1]</b> 70/4 <b>translation [1]</b> 157/19 <b>transmission [8]</b> 27/23 77/7 90/22 92/7 93/17 93/19 96/21 97/14 <b>transmitted [5]</b> 77/15 101/20 104/2 104/5 104/7 <b>transmitting [1]</b> 87/15 <b>Treasury [12]</b> 46/9 72/14 72/20 72/23 73/2 73/11 131/9 131/12 131/15 132/23 133/6 134/12 <b>treat [1]</b> 122/6 <b>treated [4]</b> 125/5 125/6 126/11 147/15 <b>treatise [1]</b> 98/6 <b>treatment [2]</b> 103/1 123/11 <b>trend [1]</b> 78/15 <b>trial [6]</b> 133/18 134/1 134/9 134/14 134/22 135/7 <b>trialling [1]</b> 132/21 <b>trials [10]</b> 100/15 103/2 130/11 130/19 130/24 131/25 132/25 133/1 133/11 134/4 <b>tried [4]</b> 42/14 42/16 129/4 133/23 <b>trigger [1]</b> 59/1 <b>triggered [3]</b> 59/6	97/12 131/20 <b>tripartite [1]</b> 32/5 <b>trivial [3]</b> 9/3 55/15 58/25 <b>trouble [4]</b> 55/24 85/18 103/21 114/4 <b>true [3]</b> 12/16 70/1 88/7 <b>Trust [8]</b> 120/2 120/16 121/6 155/7 155/10 155/13 155/16 155/25 <b>try [3]</b> 16/3 118/9 132/17 <b>trying [5]</b> 52/14 69/12 94/19 128/5 129/10 <b>Tucker [1]</b> 13/12 <b>Tuesday [1]</b> 1/1 <b>turn [17]</b> 5/8 20/18 25/11 27/14 32/14 38/21 45/13 46/6 47/19 54/10 63/17 67/11 125/3 130/10 137/25 146/20 156/9 <b>turned [3]</b> 65/19 69/14 72/16 <b>turning [5]</b> 84/18 143/24 145/17 146/18 153/5 <b>tutelage [1]</b> 52/19 <b>two [35]</b> 6/4 10/5 12/19 27/4 48/14 49/2 50/15 59/3 59/5 60/1 60/10 63/8 66/6 66/6 66/22 67/24 68/6 68/12 70/18 71/24 72/11 74/15 87/6 89/9 89/9 89/24 92/13 94/9 105/22 112/6 117/18 119/8 121/20 135/24 150/3 <b>two o'clock [2]</b> 89/9 89/9 <b>two years [1]</b> 27/4 <b>two-second [1]</b> 68/12 <b>type [2]</b> 56/21 128/16 <b>typical [1]</b> 26/17	103/6 104/21 108/15 108/18 114/7 116/25 117/5 126/1 148/5 150/24 <b>ultimately [4]</b> 64/14 68/15 86/19 139/17 <b>ultimatum [3]</b> 132/17 132/20 133/8 <b>Um [3]</b> 38/4 44/21 107/11 <b>unable [1]</b> 156/10 <b>unaffected [1]</b> 12/1 <b>unanimous [5]</b> 73/22 74/17 74/17 93/14 111/5 <b>uncalled [1]</b> 107/18 <b>uncaring [1]</b> 156/23 <b>uncertain [2]</b> 87/5 87/9 <b>Unclear [1]</b> 21/15 <b>uncommon [2]</b> 78/5 78/13 <b>under [21]</b> 8/2 11/21 11/24 12/25 13/4 21/19 43/22 43/23 47/8 51/3 52/19 64/23 64/24 65/8 65/9 77/14 78/9 102/19 114/25 120/22 157/4 <b>under-manning [1]</b> 65/9 <b>under-reported [1]</b> 78/9 <b>Under-Secretary [2]</b> 13/4 120/22 <b>underlay [1]</b> 58/7 <b>underlying [4]</b> 14/24 104/14 123/9 152/23 <b>undersecretary [1]</b> 5/5 <b>understand [12]</b> 47/13 50/13 55/2 62/6 63/25 68/14 69/15 107/13 120/9 134/21 135/14 141/23 <b>understand it [2]</b> 107/13 135/14 <b>understandable [2]</b> 70/6 132/12 <b>understandably [1]</b> 108/17 <b>understanding [3]</b>
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(74) tier... - understanding



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43/9 47/4 48/10 52/19	105/21 107/5 113/6	151/16 154/12 155/13	26/21 33/22 46/7	100/14 101/11 102/6
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67/10 74/3 77/19	114/21 115/1 116/12	<b>whichever [1]</b> 30/9	<b>widely [3]</b> 104/14	<b>WITN7064001 [4]</b>
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134/7 137/21 138/24	141/19 142/17 143/23	<b>who [70]</b> 1/9 10/22	137/14	8/20 9/6 9/8 9/18 9/21
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157/8 157/12 158/10	150/24 152/4 157/13	16/25 18/24 19/9	<b>will [51]</b> 1/14 1/16 2/2	23/6 23/8 23/10 25/12
158/11	158/8 158/12	19/20 20/14 22/20	2/7 2/8 12/11 15/15	37/25 41/7 47/24
<b>well-intentioned [1]</b>	<b>what's [1]</b> 44/3	23/7 29/5 29/13 34/25	16/1 19/4 19/21 24/14	48/22 48/25 53/9 62/1
105/19	<b>whatever [6]</b> 52/6	37/20 44/2 45/10	34/14 35/8 45/18	67/21 74/1 75/8 82/7
	52/6 94/17 99/6	46/18 48/7 50/19	53/14 54/18 60/11	84/1 87/25 88/4 88/18

(76) way... - witness

<p><b>W</b></p> <p><b>witness...</b> [12] 112/8 112/11 112/16 119/24 120/4 133/14 134/15 135/9 140/14 143/15 148/9 158/6</p> <p><b>witnesses</b> [3] 81/25 156/17 158/3</p> <p><b>women</b> [1] 79/4</p> <p><b>won't</b> [11] 5/24 20/24 26/22 32/18 47/24 73/20 75/9 84/18 107/5 132/17 142/25</p> <p><b>wonder</b> [3] 112/18 127/6 155/13</p> <p><b>word</b> [2] 92/23 93/1</p> <p><b>wording</b> [3] 97/1 110/14 152/3</p> <p><b>words</b> [7] 16/17 23/17 48/10 60/6 62/22 67/5 141/2</p> <p><b>work</b> [17] 1/7 19/24 27/18 29/2 38/2 49/12 49/13 50/1 50/4 52/15 52/16 52/18 69/12 91/10 123/8 123/22 131/11</p> <p><b>worked</b> [16] 14/5 15/20 16/9 23/5 48/7 50/25 52/18 58/9 62/14 62/19 72/21 76/25 121/21 128/8 147/19 158/10</p> <p><b>workers</b> [1] 55/19</p> <p><b>working</b> [8] 4/5 28/9 32/21 42/5 57/17 92/13 92/15 123/5</p> <p><b>workings</b> [1] 57/23</p> <p><b>works</b> [1] 1/13</p> <p><b>world</b> [1] 115/20</p> <p><b>worlds</b> [1] 109/21</p> <p><b>worldwide</b> [1] 55/19</p> <p><b>worried</b> [3] 74/11 84/24 135/13</p> <p><b>worry</b> [1] 139/2</p> <p><b>worst</b> [1] 109/20</p> <p><b>worth</b> [10] 59/22 70/25 71/2 87/23 88/1 88/23 88/24 89/2 103/23 113/4</p> <p><b>worthwhile</b> [2] 149/2</p>	<p>149/24</p> <p><b>worthy</b> [2] 108/7 134/12</p> <p><b>would</b> [235]</p> <p><b>wouldn't</b> [8] 29/18 42/14 73/10 110/13 123/18 123/19 146/10 154/5</p> <p><b>write</b> [1] 59/7</p> <p><b>writes</b> [2] 85/13 139/15</p> <p><b>writing</b> [3] 36/6 36/7 37/2</p> <p><b>written</b> [18] 3/25 5/20 39/13 39/14 40/7 54/14 66/8 66/14 66/15 74/3 74/19 85/25 86/4 97/15 116/7 127/18 142/19 154/25</p> <p><b>wrong</b> [14] 49/18 50/5 105/20 105/21 105/22 111/15 115/4 121/20 134/2 135/17 135/18 135/19 149/8 149/19</p> <p><b>wrongly</b> [2] 56/2 145/8</p> <p><b>wrongs</b> [1] 58/6</p> <p><b>wrote</b> [5] 26/23 54/21 63/23 94/14 108/22</p> <hr/> <p><b>Y</b></p> <p><b>yards</b> [1] 35/25</p> <p><b>yeah</b> [6] 15/11 36/16 73/6 73/6 118/6 149/25</p> <p><b>year</b> [9] 45/21 45/22 75/17 78/6 78/14 89/15 89/23 89/24 90/19</p> <p><b>year'</b> [1] 79/23</p> <p><b>years</b> [20] 15/19 16/2 27/4 27/8 28/11 30/4 30/22 38/20 65/4 65/10 75/4 75/21 78/14 81/16 98/20 102/8 102/9 105/15 130/19 147/16</p> <p><b>yes</b> [137] 2/15 2/21 2/24 3/6 3/14 3/18 3/24 4/2 4/12 4/17 5/2 5/19 6/4 6/21 9/12</p>	<p>9/14 12/9 12/15 13/6 14/8 14/20 15/22 16/10 17/7 17/15 19/19 19/25 22/3 22/11 25/10 26/14 27/3 31/16 32/24 33/25 34/23 35/13 35/13 35/14 36/22 37/15 39/9 40/4 41/3 41/3 41/5 41/11 41/17 42/24 45/6 45/11 46/22 47/4 47/18 48/7 50/20 51/9 52/17 52/18 58/15 60/22 66/1 66/6 68/4 69/23 70/8 71/13 72/19 74/4 75/2 82/14 82/15 82/21 83/14 83/19 84/4 84/4 84/12 84/12 84/16 85/24 89/8 89/13 91/6 91/25 96/2 96/4 96/12 96/16 96/16 96/19 98/5 99/16 105/9 108/11 110/17 110/19 110/23 110/25 112/18 116/11 117/1 117/4 120/13 122/22 124/17 125/18 126/19 128/4 129/15 129/15 131/8 134/18 134/20 135/12 135/23 137/6 137/20 138/8 140/19 141/23 143/11 144/6 145/19 146/8 146/13 146/19 148/24 149/21 152/25 154/17 154/17 154/17 155/1 155/5 155/5 156/3</p> <p><b>yet</b> [3] 77/24 79/1 102/3</p> <p><b>York</b> [1] 79/18</p> <p><b>you</b> [442]</p> <p><b>you should</b> [1] 65/1</p> <p><b>you'd</b> [2] 118/8 119/20</p> <p><b>you'll</b> [2] 80/12 138/11</p> <p><b>you're</b> [20] 1/10 1/23 6/4 12/7 20/4 20/5 20/18 25/8 26/19 30/25 36/12 39/16 47/8 51/19 63/15</p>	<p>82/16 138/11 143/20 156/13 157/9</p> <p><b>you've</b> [32] 2/22 20/1 23/5 26/18 37/20 39/12 54/11 60/15 61/19 70/19 74/9 97/9 97/16 111/2 111/9 111/13 112/2 113/13 116/8 116/22 117/9 122/23 123/23 128/19 129/18 136/21 138/1 146/23 151/22 155/14 157/16 157/22</p> <p><b>your</b> [127] 2/23 3/1 3/3 3/22 3/25 4/19 4/25 5/9 5/20 8/7 9/7 11/9 11/22 12/8 12/23 13/2 13/4 13/25 14/3 15/3 15/5 15/19 16/8 16/24 19/6 19/8 20/24 22/14 25/11 25/12 25/25 28/15 30/21 32/14 34/8 35/13 38/2 41/24 42/8 42/13 45/15 45/20 46/17 47/7 47/19 47/24 48/2 48/4 48/6 48/10 53/10 53/10 54/14 57/12 60/17 61/19 61/21 63/13 64/1 64/6 70/10 72/18 73/20 73/21 74/2 74/25 75/8 76/6 82/6 84/11 85/14 90/7 92/20 93/25 94/16 95/1 95/3 97/6 99/4 99/22 105/12 109/3 109/12 110/20 110/22 117/2 119/7 119/9 119/22 119/24 120/4 120/9 121/16 122/1 125/16 126/4 126/18 127/2 127/4 130/12 131/4 131/7 133/10 133/12 134/3 136/5 139/25 143/8 143/10 143/12 143/21 145/8 146/11 147/9 147/11 147/22 147/22 149/22 150/15 150/18 152/5 155/11 156/1 156/9 157/9 157/15 157/22</p> <p><b>yourself</b> [3] 37/5 56/8</p>	<p>61/5</p> <p><b>yourselves</b> [1] 113/15</p> <p><b>YouTube</b> [1] 2/4</p> <hr/> <p><b>Z</b></p> <p><b>Z8</b> [3] 130/11 130/19 130/20</p>
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