Witness Name: Sir John Major
Statement No.: WITN5284001
Exhibits: None
Dated: 24/042022

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF SIR JOHN MAJOR

I, Sir John Major KG CH, **WILL SAY** as follows: -

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 02 February 2022.

I have adopted the table of contents used by the Inquiry in its request to me for ease of navigation through this statement:

Contents

Section 1: Introduction

1.1 My name is Sir John Major. My date of birth is GRO-C 1943. My address is C/O The Government Legal Department, 102 Petty France, Westminster, London SW1H 9GL. I studied at Rutlish grammar school in Wimbledon, London and did not attend a university. I have had various jobs before my Parliamentary career, mainly working for the London Electricity Board and in the banking sector.

1.2 I welcome the opportunity to assist Sir Brian Langstaff and his team with this inquiry into infected blood. I will endeavour to assist as much as I possibly can, noting that the extent of my involvement took place some 35 years ago. It should also be noted that it is unlikely I saw all documents which were copied to me in my roles; such documents are routinely circulated for information to civil servants in the relevant department in preparing briefing and tend only to be shown to Ministers as necessary. This is simply because of the sheer volume of paper involved.

1.3 In 1979 I won my first seat in the general election, in Huntingdon and became a Member of Parliament ("MP"). I have held various posts during my service, as set out below:

1979	Secretary of the Backbench Environment Committee
1981	Parliament Private Secretary to Patrick Mayhew and Timothy Raison
1983	Assistant whip
1984	Treasury whip
1985	Parliamentary under Secretary for the Department of Health and Social Security ("DHSS")
1986	Minister of State for DHSS
1987-1989	Chief Secretary to Her Majesty's Treasury ("HMT")
1989	Secretary of State for Foreign and Commonwealth Affairs ("Foreign Secretary")
1989-1990	Chancellor of the Exchequer

1.4 I can confirm that I am not a member of, nor have I been involved in any committees, associations, parties, societies, groups or organisations relevant to the Inquiry's Terms of Reference. I do not have any business or private interests which are relevant to the Inquiry's Terms of Reference.

1.5 I have not provided evidence or been involved in any other inquiries, investigations, criminal or civil litigation in relation to the human immunodeficiency virus ("HIV") and/or hepatitis B virus ("HBV") and/or hepatitis C virus ("HCV") infections.

1.6 I have provided the inquiry with a copy of my statement [**BSEI0000014**][1] made in relation to the Bovine Spongiform Encephalopathy ("BSE") Inquiry, given in 1999.

Section 2: Decision-making structures

Structure and organisation of the Treasury

2.1 I am asked (at Q. 7) how the ministers within the Treasury would receive information and submissions from their officials. I was Chief Secretary to the Treasury from 13 June 1987 to 24 July 1989. Thereafter I was Foreign Secretary until 26 October 1989, at which point I became Chancellor of the Exchequer, which I remained until 28 November 1990 when I became Prime Minister

2.2 The Chief Secretary to the Treasury is responsible for the conduct of Public Expenditure. The Chancellor of the Exchequer has overall control of Her Majesty's Treasury (HMT) and a specific responsibility for macro-economic policy.

2.3 The Chancellor's Junior Ministers – Chief Secretary to the Treasury, Paymaster-General, Financial Secretary to the Treasury and Economic Secretary to the Treasury – might often attend meetings for the Chancellor of the Exchequer, if necessary. They would rarely, if ever, attend meetings for one another. Some issues would be

[1] Also available at https://webarchive.nationalarchives.gov.uk/ukgwa/20060525120000/http://www.bseinquiry.gov.uk/evidence/ws/wsalpha4.htm; 6 May 1999.

discussed at collective meetings – usually as the first business of the day – when any Minister might comment on any issue affecting the work of the department.

2.4 I am asked (at Q. 10) how the Treasury interacted with the Department of Health. Ministers' interaction with Officials at the Treasury would mostly be with the senior echelon and with his own Private Office. Submissions would invariably come through the Private Office and be filtered by the Principal Private Secretary.

Her Majesty's Treasury/Department of Health

2.5 I am asked (at Q. 10a) how, in broad terms, the overall budget of the Department of Health was determined. The overall budget of the Department of Health was personally negotiated between the Secretary of State for Health and the Chief Secretary to the Treasury on an annual basis. (I am not sure whether it is done the same way now).

2.6 The Secretary of State for Health submits bids and he and the Chief Secretary to the Treasury then meet to discuss them. If they are unable to agree (usually because the bids are higher than the Chief Secretary to the Treasury will accept) the outcome was referred to a "Star Chamber" of senior Ministers for adjudication.

2.7 In these negotiations the role of the Chief Secretary to the Treasury is to keep overall expenditure within limits set by the Chancellor of the Exchequer and (depending on the Chancellor) agreed by the Prime Minister. The Secretary of State for Health will usually seek the highest sum he can obtain for his own budget.

2.8 If, within the financial year, the Department of Health seek additional funds, they would apply to the Chief Secretary to the Treasury for them. Typically, the Treasury would seek the transfer of funds from within the health budget.

2.9 If this was impossible, or opposed by the Secretary of State for Health, the Chief Secretary would either reject the bid or approve extra funding from the Contingency Reserve. The Contingency Reserve is held by the Treasury for emergency spending.

2.10 If the Chief Secretary rejected the bid, or wished wider approval for it (perhaps in view of setting a precedent) the matter might go either to the Prime Minister for a ruling or

to a Cabinet Sub-Committee of Ministers who would definitively rule on the claim. The criteria applied would be the strength of the case for extra money – and its affordability.

2.11 The Treasury might require the funding to be ring fenced to a particular use. The above procedure would apply irrespective of the size of sums sought. Self-evidently small one-off sums were the easiest for HMT to concede.

2.12 Expenditure from the Reserve did not require specific Parliamentary approval.

Scotland, Wales and Northern Ireland

2.13 I am asked (at Q. 11) how the Treasury would interact with the Scottish, Welsh and Northern Irish offices. Scotland, Wales and Northern Ireland were funded largely by a formula (the 'Barnett Formula') based as a fixed percentage of the money granted to the equivalent department in London e.g. health.

2.14 Usually, there would be discussions at 'official' level before claims for extra funding were sought. (The purpose of the spending Department in the official discussions would be to encourage Treasury Officials to recommend any additional funding sought to the Chief Secretary).

2.15 I am asked (at Q. 12) about my working relationships. My working relationship with successive Secretaries of State was formal – but friendly. My role was not to be an "abominable No-man" but to help where I could – consistent with the Government's overall expenditure ceilings.

Structure and organisation of 10 Downing Street

2.16 I am asked (at Q. 13) how the Prime Minister would receive information and submissions from officials and Cabinet Ministers. I was Prime Minister between 28 November 1990 and 02 May 1997.

2.17 The Prime Minister is often the final decision maker for disagreements on policy between Ministers and/or the formulation of new policy. He (or she[2]) might – also hold meetings on any issue of domestic or foreign policy, meet foreign dignitaries, pressure groups and would face extraordinary demands on his/her time. Given the scale of the role and the sheer variety of issues and people seeking the Prime Minister's time, his diary time is limited and carefully managed by his Private Office.

2.18 Information and submissions from Officials and Cabinet Ministers would come to the Prime Minister's Private Office and be submitted to the Prime Minister by his Private Secretaries – but only if they considered it necessary he should see them. Copy letters sent for information, for example, would be held in case they were needed at a later stage, or for a later submission, but would not invariably be shown to the Prime Minister.

2.19 The reason for this filtering is that it is frankly impossible for the Prime Minister to personally see everything sent to him. The Civil Servants selected to work in his Office are experienced and well able to judge what the Prime Minister needs to see. If in doubt, they might (and often would) consult the Principal Private Secretary and he might even refer to the Cabinet Secretary for advice, such was the need to keep the amount of information shown to the Prime Minister to that which was strictly essential at that time, in view of his extremely busy schedule.

2.20 The criteria for placing matters before the Prime Minister were – necessity, common sense, precedent, and issues that were judged, at that moment, to be politically sensitive.

2.21 I am asked (at Q. 14) when I, as Prime Minister, would have expected to be involved in a decision concerning blood and blood policy. As Prime Minister I would expect routine aspects of policy – even on such a matter as blood policy – to be primarily handled by the Departmental Secretary of State and, upon expenditure, the Secretary of State in consultation with the Treasury.

2.22 As both the Chief Secretary and the Secretary of State for Health are senior Ministers I would be unlikely to intervene unless I thought the matter was being handled poorly, or against broad Government policy.

[2] All generic references to he/him/his should be read to include she/her/hers.

2.23 I would expect any matter to be referred to me if the two Ministers and their departments could not agree on a united policy. If they did agree I might question their agreement but would be hesitant to change it since they were immersed in detail in a way that I, as Prime Minister, could not possibly be.

Section 3: Financial support for haemophiliacs infected with HIV

General

3.1 I am asked (at Q. 15-16) when the matter of financial support for haemophiliacs with HIV or AIDS was first brought to my attention. I cannot recall being aware of the issue of financial support for haemophiliacs infected with HIV while a junior Minister at the Department of Health (Department of Health and Social Security ("DHSS") at the time). As noted above, in 1985 I was the Parliamentary Secretary and between 1986 and 1987 I was the Minister of State. It might have been mentioned at morning meetings of Ministers but, if so, I have no memory of it.

3.2 My involvement must have begun as Chief Secretary to the Treasury but it was intermittent and restricted to approval of policy proposals on claims on the Reserve. I'm afraid that – 35 years on – I've no idea when it might first have been raised with me.

3.3 At no stage was I involved with any new financial details of policy on infected blood. My involvement was with issues of compensation to victims.

3.4 I am asked (at Q. 17) about an article in the Mail on Sunday. In June 2019, a Sunday tabloid newspaper published an article claiming that I, as Chief Secretary to the Treasury in September 1987, had persuaded Margaret Thatcher not to offer compensation to victims of "tainted blood" given by the NHS[3]. This is not true.

3.5 The article appears to have been written on the basis that the letter advising the Prime Minister to take a strong line on compensation is signed "*JM*" [**SCGV0000007_050**].

[3] Available at https://www.dailymail.co.uk/news/article-7095143/Sir-John-Major-convinced-Thatcher-not-compensation-tainted-blood.html

3.6 It was not written by me but by the then Secretary of State for Health, the late John Moore. As the letter is clearly headed "Secretary of State for Social Services" it is hard to understand how such a mistake in identification by the journalist could have occurred.

3.7 If the response to Geoffrey Podger [**DHSC0004541_141**] was copied to me in my role as the Chief Secretary, as is indicated on the document, then as explained above, it is unlikely that I actually saw it because it was merely an acknowledgement. I certainly do not recall seeing the response.

<u>The HIV litigation and the £20m increase of funds to the Macfarlane Trust</u>

3.8 I am asked (at Q. 18) about a letter from The Reverend Alan Tanner, Chairman of the Haemophilia Society. Reverend Tanner wrote to me asking for support for people with HIV in October 1987 [**HSOC0004760_001**]. He wrote to me at the House of Commons as a constituency MP and I replied that I would *"bring* [the issue] *to the attention of colleagues*" [**HSOC0003584**].

3.9 It may assist if I explain the correspondence process. A constituent will write to their local Member of Parliament ("MP") regarding an issue. The MP will then write to the relevant Minister, attaching a copy of the letter from their constituent. The Minister will reply to the MP, who then reports back to the constituent. So in this scenario, almost certainly, I or my office on my behalf would have written to John Moore, the then Health Secretary enclosing a copy of the letter from The Reverend Tanner, to determine the department's thinking. John Moore would have replied to me and I would have replied to the Reverend Tanner. I have no constituency correspondence records from 35 year ago and no recollection of the exchange.

3.10 Mr Watters, General Secretary of the Haemophilia Society also wrote and interpreted my reply as "supportive" of his campaign [**HSOC0003584, p.2**]. I wrote again to clarify I had written that "*I appreciated the serious nature*" of the issue, but since I was a Government Minister, the convention was that I could not "*support*" the campaign [**HSOC0003583**].

3.11 I was, however, sympathetic but conscious of the Government's reluctance to change long term policy and offer "no fault" compensation – because of the ongoing cost implications for tax-payers of adopting a different policy.

3.12 The Government was, as I understand it, offering social security support, although I do not know the details of it.

3.13 I am asked (at Q. 19) about a letter from the DHSS Minister of State, Tony Newton, to the Prime Minister, Margaret Thatcher. Mr Newton wrote to Mrs Thatcher to say that he and John Moore were meeting the Haemophilia Society on 3 November 1987 [**DHSC0002375_010**].

3.14 John Moore had said "*there was not a good case for compensation*" for reasons of precedent, but there were arguments for offering help in view of the circumstances of those infected. That was clearly right but raised many questions that fell directly within my responsibilities for control of public expenditure. Those questions were principally: how much money; to whom; when, and in what form? What trapdoors would we open to present and future claims on medical issues?

3.15 None of that had been considered or – certainly to my knowledge – had not been discussed with the Treasury.

3.16 If the Government – that is, the taxpayer – was to offer compensation, we needed to know an estimate of cost and any likely future costs such a precedent would set.

3.17 I, therefore, wrote to Tony Newton asking how much a precedent could be ring fenced – and other obvious questions [**DHSC0003961_011**]. I suggested Tony Newton and John Moore remain cautious about compensation until such issues were examined.

3.18 The issue was referred (Q. 20) – presumably by the Prime Minister or DHSS Ministers to the Cabinet Sub-Committee on AIDS (Chaired by Lord Whitelaw). The Committee agreed to an ex-gratia £10 million payment to haemophiliacs with HIV – to be administered by the Haemophilia Society [**CABO0100016_011**]. The full Cabinet agreed to this payment on November 12th 1987 [**CABO0000185**].

3.19 As Chief Secretary to the Treasury, I supported the payment but:- (a) warned it had to be ring fenced and (b) I would discuss with the Secretary of State whether the department could contribute to the cost from its existing financial settlement OR needed the full sum from the Reserve. If it was the latter I would accept that.

3.20 There were risks:

3.20.1 The Haemophilia Society were lobbying for a new benefit (cost: £60 million a year); and

3.20.2 Others – now or in the future – might ask for similar support and, once a policy was broken, it would be difficult to hold the line against other claims.

3.21 I should add that my information was that the Haemophilia Society had obtained Counsel's Opinion that the likelihood of a successful claim against the Government for negligence was remote. Lawyers gave the Government the same advice. (See Home and Social Affairs Sub-Committee 4.11.87 [**JEVA0000021**]).

HIV Haemophilia Litigation

3.22 I am asked (at Q. 21) when and how I first became aware of the HIV litigation brought against the Department of Health. I do not recall but – reading Official Papers – it seems to be during my time at the Treasury.

3.23 I am asked (at Q. 22) about Mr Saunders' minute of 13 November 1989 to my Principal Private Secretary at the Treasury [**HMTR0000001_005**]. The minute carries no confirmation from me that I ever saw it. (It was usually my habit to tick memos I'd seen, or comment on them, and Mr Saunders's memo had no such mark.)

3.24 I do not remember seeing the memo but, as it was 33 years ago, that is unsurprising. However, it was copied to the Chief Secretary to the Treasury (Norman Lamont (now Lord Lamont)) as it concerned funding to the MacFarlane Trust and it is entirely likely – but not certain – he discussed it with me although, in Treasury terms, it related to only a modest sum of money. I simply cannot remember.

3.25 The author of the minute suggested that a further payment of around £5m would be made the following year to the Macfarlane Trust, "to be found within the agreed provision for 1990-91". The term "*to be found within the agreed provision*" does imply the money referred to would come from the Department of Health budget and not the Contingency Reserve. As such, the Treasury would be more relaxed about the expenditure than if it were a claim on the Reserve.

3.26 I do not remember any discussions about an "out-of-court" settlement or a further payment of an ex-gratia of £20m to the MacFarlane Trust.

3.27 I am asked (at Q. 23-24) about a proposed meeting with the Prime Minister. I note that on 19th November 1989 the Prime Minister wished to discuss the matter with Mr Clarke and I [**HMTR0000001_007**] – but this fell away as she had a pre-arranged meeting with the Chief Secretary to the Treasury (Norman Lamont) on the 20th November [**HMTR0000001_009**]. As Mr Lamont's remit was public expenditure, I suspect the Prime Minister took the opportunity to discuss it with him. My meeting was then unnecessary (Mr Saunders's minute of 20th November seems to confirm this). The Prime Minister was, of course, due to meet the Haemophilia Society that week.

3.28 There is no indication I was copied in on exchanges about this – or the Secretary of State for Health's proposal to allocate a further £20m over several years to the MacFarlane Trust.

3.29 As this was all about expenditure, and from within the Department of Health budget, the exchange was properly with the Chief Secretary of Treasury.

3.30 The Inquiry suggests (at Q. 27) that R.B Saunders was my Private Secretary; he was not. To the best of my knowledge he was Lord Lamont's press secretary around that time. I have no idea how the proposed ex-gratia £20m became £19m charged to the Contingency Reserve. As far as I am aware, I did not see any correspondence about this, and nor would I have expected to do so.

3.31 I am asked (at Q. 28) about documents that illustrate difficulties initially faced with administering lump sum £20,000 payments to haemophiliacs. These payments were announced at the end of November 1989. I do not recall ever having seen these documents: and there is no reason why I would have done so.

3.32 I do not recall playing a role in the discussions about the way in which payments would be financed.

3.33 The challenges faced with administering payments of this nature were technical and had no bearing on policy. I would not have expected to be involved – although it is possible/probable that the Chief Secretary to the Treasury would have told me verbally at the morning meeting how the problem was being solved.

3.34 I am asked (at Q. 29-30) about documents [**HMTR0000001_043**, **HMTR0000001_042**,

and **HMTR0000001_046**] that detail preliminary discussions between the Health Secretary and Chief Secretary on a possible settlement. I do not recall seeing any of these exchanges, all of which fall within the responsibilities of the Chief Secretary to the Treasury. Nor are there any notes in my hand, or markings, to suggest I did see them. However, that said, I would be surprised if the Chief Secretary to the Treasury had not made me aware of this given the possibility of an out-of-court settlement or a court case.

3.35 In the documents listed above there is a reference to an "upper limit of expenditure". I do not recall conversations on this issue, though it is probable that it was official Treasury (or Health Department) advice. I cannot recall a conversation with Mr Lamont on this topic. The draft letter to Mr Clarke from Mr Lamont does, however, make clear that he and I were at one on this issue [**HMTR0000001_043**].

3.36 I am asked (at Q. 31-33) about my recollection of the settlement of the litigation. It includes the following factors:

3.36.1 A case brought by the victims against the Government was due to be heard in Court in March 1991. The Government believed it would win – but no outcome is certain;

3.36.2 The Judge – unusually – suggested a compromise settlement; and

3.36.3 The coordinating Counsel for the Plaintiffs' Solicitors themselves suggested such a settlement. (Like the Court, they were, no doubt, uncertain of the outcome and wished to ensure a fair settlement for their clients.)

3.37 The Secretary of State for Health (William Waldergrave) and the new Chief Secretary to the Treasury (David Mellor) agreed to the proposed settlement. I was asked to approve their decision and did so for fairly obvious reasons. Those included that it would settle a worrying issue and that it would be an agreed outcome which took into account the risks inherent in litigation. It was also a good outcome because everyone (including the Government) were sympathetic to the victims.

3.38 I made two stipulations; 1) that it must be clear the outcome was suggested by the Plaintiffs' Counsel and, 2) that it must be agreed by victims before it was announced. I did not wish for a backlash that it had been imposed on a "*take-it-or-leave-it*" basis.

3.39 I also accepted, as requested, that the payment would go to the MacFarlane Trust for them to pay so that it did not extinguish social security payments.

3.40 I am asked (at Q. 34) about Mrs Thatcher's statement that "the question of compensation has to remain a matter for the Courts to decide" [**HSOC0012332**]. I cannot answer for Mrs Thatcher's views, which to the best of my knowledge, we never discussed. However, if she had been presented with an acceptable outcome suggested by the Plaintiffs, I am sure she would have settled.

3.41 No one was resistant in principle to helping the haemophiliacs who had been dealt an awful blow through fate. It was sheer bad luck.

3.42 Mrs Thatcher's stance was about denying negligence – not refusing ex-gratia help. She, like her predecessors and successors, would have been concerned at the Government accepting the principle of "no fault" payments.

3.43 I am asked (at Q. 35) whether payments were "unduly delayed". As far as I can see, from the documents provided to me, I was not advised of delays/difficulties in making payments and I have no recollection of being told of any such thing.

3.44 I know now – but did not know at the time – that it took over a year to sort out eligibility for payments and to consider niche issues related to the agreement in principle of December 1990.

3.45 Over a year's delay in payment is plainly too long, for which Government and Plaintiffs must share the responsibility (the Plaintiffs made further requests relating to eligibility of payments).

3.46 As I say, I was not informed of delays but, as they were not wholly the fault of the Department of Health – and as there were constant and successful negotiations to solve the problems raised – I would not have expected to be informed, nor would I have needed to be aware of other agreements willingly made on practical issues (they were properly the responsibility of Health Ministers. If agreements had not been made, I would have expected to be informed). I understand that payments began in May 1991.

3.47 I am asked (at Q. 36) about a letter from David Watters. Following the Government's announcement that a settlement had been reached, David Watters wrote to me to express his gratitude in a letter dated 22 January 1991 [**DHSC0020824_054**]. Mr Watters kindly wrote to thank me for my part in agreeing a settlement. Of course,

victims would have liked a larger settlement – I dare say anyone in their position would do so; the effect of contaminated blood was awful.

3.48 I read Mr Watters's reference to "*disquiet*" without surprise – but I also noted his gratitude. The Government had moved a long way from its initial position – despite the risk of a "no fault" settlement to future claims.

3.49 I did not interact directly with the Haemophilia Society but, I do believe – from the vantage point of someone not in negotiations with them – that they presented their case fairly and in a responsible manner. The review of payments would have been done by the Health Department (and, perhaps, the Social Security department) and would, I assumed, be reflected in their public expenditure bids.

HIV Transfusion Settlement

3.50 I am asked (at Q. 38) about a letter I received from a journalist. On 12 October 1991 Callum McCrae of the Observer wrote to me [**DHSC0014989_053**] and on 07 January 1992 my private secretary responded [**DHSC0002934_004**]. Having reviewed my private secretary's letter, I see no sign (no tick or comment) to suggest that I saw it before despatch. At 30 years' distance I cannot recall whether I did see the reply or not, but I suspect that I did not since it is a Department of Health draft setting out long standing policy.

3.51 I cannot be certain but, if I had seen it, I think I would have picked up the inconsistency in the final sentence, which states "*If the NHS is proved negligent in a court, of course it accepts its liability to pay damages*", since, without negligence, we had agreed ex-gratia payments to Haemophiliacs who had been given contaminated blood.

Payments to non-haemophiliac HIV Patients

3.52 I am asked (at Q. 39) about discussions that took place between the Department of Health and the Treasury about the possibility of making payments to people who did not have haemophilia who had contracted HIV through the transfusion of blood or blood products. The Government is sometimes like a great tanker and takes time to turn around; an example of this is with regard to payments to non-haemophilia patients who contracted HIV through a blood transfusion.

3.53 The Government does have to go through arguments on precedent, need and affordability before alighting on the right policy. Treasury caution on expenditure cannot be lightly set aside because their responsibility to control overall expenditure is crucial to both the economy and the taxpayer.

3.54 It was possible – but not very convincing – to draw a distinction between haemophiliacs and non-haemophiliacs with HIV and as the discussion developed it became more clear the compensation should include both groups.

3.55 The concern over "no fault" compensation is real – money conceded for one good cause may imperil the budget on other deserving cases.

3.56 Once the Department of Health and Chief Secretary focused on fairness and risk to patients a decision was soon reached. The Secretary of State for Health advocated extending help, on similar terms to haemophiliacs, and with a similar commitment by recipients not to seek extra compensation.

3.57 For the avoidance of doubt – the handwriting of 7th February on Mr Chapman's note of 3rd February [**CABO0000044_011**] is mine; I do not have a copy of any reply to Mr Kinnock.

3.58 The Department of Health felt the line could be held to those who contracted HIV through transfusions – and I agreed. There was an innate resistance to going further.

NHS Blood or Tissue Transfer

3.59 I am asked (at Q. 40) about the extension of compensation to those infected with HIV through NHS blood or tissue transfer. Following the announcement on 17 February 1992, Gary Kelly, Chairman of the HIV Blood Transfusion Group, wrote to me in a letter dated 9 March 1992 [**DHSC0003570_068**] requesting initial payments be made.

3.60 I do not have a copy of a response to Gary Kelly, nor do I recall seeing it but this is unsurprising since it was on the eve of a General Election campaign I was expected to lose. A reply may have been held for a new Prime Minister. I have no idea whether Mr Kelly received a reply from an Official.

3.61 As the Department of Health had agreed to meet the costs of compensation for HIV patients as a result of blood or tissue transfer from within their budget allocations there

should have been no recourse to the Contingency Reserve. As to inflation, it had fallen, and if there were short delays to payment, it should not have materially lowered the value of payments due.

3.62 I am asked (at Q. 41) what influence the 1992 General Election had on policy regarding the financial support scheme. It had none.

Section 4: Financial support for Hepatitis C sufferers

4.1 I am asked (at Q. 42-43) about the campaign seeking support for hepatitis C sufferers launched in March 1995 – 3 years after those infected with HIV through blood or tissue transfer were offered assistance. Haemophilia patients who contracted HIV on top of their haemophilia were beneficiaries of an earlier scheme agreed in 1991.

4.2 The case for a third wave of support for hepatitis C sufferers was similar but, reluctantly and clearly, the Government resisted compensation. It was not an easy decision but the reasons for resisting a scheme were compelling and as follows:

4.2.1 After two sets of ex-gratia payments, the Government was concerned that a further such payment for non-negligent harm – and one that appeared less merited than its predecessors – would lead to a general "no fault" compensation scheme. The concept of "no fault" schemes had previously been rejected by Parliament in a free vote.

4.2.2 Moreover, medical opinion advised that hepatitis C sufferers were likely to enjoy long periods without symptoms and that, if/when cirrhosis of the liver developed, it might take 20 to 30 years to do so. Unlike HIV, only a small percentage of patients might lose their life (between 1988 and 1993 the Haemophilia Society believed eight patients had died each year).

4.2.3 Every death is tragic but hepatitis C is not comparable to the threat that haemophiliac HIV sufferers had faced – all of whom, in the early 1990s, had been expected to die.

4.2.4 The Government was not alone in refusing compensation. Most other countries with patients contracting hepatitis C did not offer compensation schemes.

4.2.5 The Haemophilia Society itself acknowledged hepatitis C did not have the same impact as HIV (see for example Graham Barker's letter to GRO-A dated 24 January 1996 [**HSOC0000144, p.6**]).

4.2.6 The Government's view was that money provided for health care was most productively spent on either treating patients or on research to improve treatments. Compensation is rare where there is no proven negligence and provided patients were given the best treatment then available.

4.2.7 To aid research the Department of Health offered £91k in 1995-96 and further sums thereafter to support the Haemophilia Society in researching the best ways of supporting sufferers of hepatitis C.

4.3 I am aware, in such an emotional matter, that any reasons for declining a compensation scheme may seem harsh but the Government's decision should be seen in the light of having an overall responsibility to use its limited resources to best effect.

4.4 I am asked (at Q. 44) about requests that I meet with a delegation of Conservative MPs led by John Marshall. I suspect the meeting was requested by the delegation because on two occasions I had approved schemes where I considered compensation was necessary – but both carried a risk. The delegation wished me to do so again. I was not keen to do this again for the reasons set out in paragraphs 4.2.1-7 and also because:-

4.4.1 The meeting would have served no purpose as I had nothing to say that Ministers had not already said.

4.4.2 Mr Marshall and his delegation knew the position (and some had discussed the issue with Ministers in conversations in the voting lobbies).

4.4.3 The purpose was simply to persuade me to overturn government policy.

4.4.4 Delegations often ask for meetings with the Prime Minister and I could fill my diary with them. Many are declined.

4.5 The handwritten annotation is in my handwriting effectively saying the above.

4.6 I am asked (at Q. 45) about a note from Mark Adams (my Private Secretary). Mr Adams' assessment is correct [**CABO0000007_004**]. A meeting would have raised hopes that could only have been dashed. This would have helped no one. The arguments were well known and so was the Government's policy.

4.7 The note "*I'd like to talk to the Chief Whip*" was mine. There is no special significance to this note. I talked often to the Chief Whip about the campaign, the interests, and much else of what was happening in the Commons. I would have wished to know, for

example, whether any debate or Early Day Motion was being planned (on this and other subjects!).

4.8 I do not recall, at 27 years distance, what the Chief Whip said – and notes were never taken at such meetings.

4.9 I am asked (at Q. 46) about the approach in October 1996 by Alfred Morris MP, a request that I declined [**HSOC0026600**]. I repeat what I said at paragraph 4.6, namely, a meeting would have raised hopes that could only have been dashed. This would have helped no one. The arguments were well known and so was the Government's policy

Treatment of Hepatitis C patients

4.10 I am asked (at Q. 47) what I thought "...the distinction was between the plight of those who contracted HIV as a result of NHS treatment and those infected with hepatitis C." I repeat, for convenience, paragraphs 4.2.1-7. The reasons for a different response to those suffering from hepatitis C were:-

4.10.1 After two sets of ex-gratia payments, the Government was concerned that a further such payment for non-negligent harm – and one that appeared less merited than its predecessors – would lead to a general "no fault" compensation scheme. The concept of "no fault" schemes had previously been rejected by Parliament in a free vote.

4.10.2 Moreover, medical opinion advised that hepatitis C sufferers were likely to enjoy long periods without symptoms and that, if/when cirrhosis of the liver developed, it might take 20 to 30 years to do so. Unlike HIV, only a small percentage of patients might lose their life (between 1988 and 1993 the Haemophilia Society believed eight patients had died each year).

4.10.3 Every death is tragic but hepatitis C is not comparable to the threat that haemophiliac HIV sufferers had faced – all of whom, in the early 1990s, had been expected to die.

4.10.4 The Government was not alone in refusing compensation. Most other countries with patients contracting hepatitis C did not offer compensation schemes.

4.10.5 The Haemophilia Society itself acknowledged hepatitis C did not have the same impact as HIV (see for example Graham Barker's letter to GRO-A dated 24 January 1996 [**HSOC0000144, p.6**]).

4.10.6 The Government's view was that money provided for health care was most productively spent on either treating patients or on research to improve treatments. Compensation is rare where there is no proven negligence and provided patients were given the best treatment then available.

4.10.7 To aid research the Department of Health offered £91k in 1995-96 and further sums thereafter to support the Haemophilia Society in researching the best news of supporting sufferers of hepatitis C.

4.11 I am aware, in such an emotional matter, that any reasons for declining a compensation scheme may seem harsh – and unfair to potential recipients – but the Government's decision should be seen in the light of having an overall responsibility to use its limited resources to best effect.

4.12 I am asked (at Q. 48) whether I still believe that the Government was right in refusing to provide financial support to people with haemophilia who had been infected with HCV through NHS treatment with blood and blood products. The decisions taken on financial support for those infected with HCV – and upon whether to meet delegations of MPs – were taken only after very careful consideration.

4.13 If the circumstances of the time were to re-occur I believe the same decisions would be taken – and for the reasons set out in response to earlier questions.

Section 5: Other issues

Public Inquiry

5.1 I am asked (at Q. 49-50) what consideration I gave, during my time in office, to calls for a public inquiry. To the best of my recollection the issue of a public inquiry was never raised with me and nor was it considered within government.

5.2 On haemophiliac and HIV infection the need for action would not have allowed for a contemporary public inquiry and, in the case of HCV it did not merit one.

5.3 At the time, no one – so far as I know – considered the issue of a public inquiry. The question of a public inquiry was not raised – and therefore, was not considered.

5.4 I am asked (at Q. 51) about the establishment and findings of inquiries in other countries. I have no recollection of the other inquiries playing any part in the Government's decision not to hold a full public inquiry. During my premiership, I do not recall the inquiries mentioned in other countries. Through the assistance provided to me in making this statement, I understand that the French, Canadian and Irish inquiries did not report during my years in Government.

5.5 I am asked (at Q. 52) about Lord Fowler's statement that the Government should have established a UK-wide public inquiry before now [**INQY1000144**; **INQY1000145**]. I am not sure that I can offer a dispassionate view. Campaigners did not raise the issue with me at the time, so far as I am aware, and I did not consider it after leaving Office – and politics.

5.6 Even now, the issues I was involved in were partial, covered only parts of the whole picture and, unlike Lord Fowler, I was never the Departmental Minister primarily involved in management of the issue.

Reflective questions

5.7 I am asked (at Q. 53) to reflect on how the Treasury, the Department of Health, and the Government handled the issues of concern to the Inquiry. The inquiry covers events from the 1970s. I was only involved in limited parts of the whole issue from the late 1980s. I do not feel able to comment on how the whole issue was handled.

5.8 Insofar as financial support was concerned, Health Ministers were sympathetic generally and the Treasury responded with the financial caution they were bound to exercise – but, once pressed, reached agreement with Health Ministers on sums accepted by victims of HIV.

5.9 As set out earlier the case of ex-gratia payments for Hepatitis C sufferers was less strong.

5.10 I am asked (at Q. 54) what aspects of the issues I and the Government handled well, and on which I/we could have done better. With respect, I think this question is best left to the Inquiry Report. I do not think – if I may put it this way – that I am best placed to mark my own homework.

5.11 I am asked (at Q. 55) about the relationship between the Treasury and the Department of Health and the role played by the Prime Minister. In my experience the Treasury and the Department of Health both reacted as I would have expected. I saw no rancour or ill-will between them – only a professional relationship. Both Departments understood the human stories behind the search for compensation.

5.12 Ultimately as Prime Minister I was happy to approve the compensation package which the Department of Health put together.

5.13 I do not believe I have any further comments that may be of value to the Inquiry: however, if any occur I will cover them in a further submission.

Statement of Truth

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

Signed GRO-C

Dated 26th April 2022