

Witness Name: JACKIE DOYLE-PRICE
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INFECTED BLOOD INQUIRY

FIRST WRITTEN STATEMENT OF JACKIE DOYLE-PRICE

Contents

Contents 1

Section 1: Introduction 2

Employment history 2

Section 2: The Alliance House Organisations (AHOs) 4

Section 3: The Devolved Schemes 7

Section 4: Psychological Support..... 12

Section 5: Infected Blood Inquiry Hearings 12

Section 6: Other issues 13

Section 1: Introduction

1. My full name is Jackie Doyle-Price. My address is known to the Inquiry. I was born on the GRO-C I have no professional qualifications of relevance.
2. Prior to becoming a Member of Parliament, I worked for the Sheffield Enterprise Agency and for South Yorkshire Police. Later I worked at City of London Corporation, for the Lord Mayor of the City of London and for the Financial Services Authority. I have been a Member of Parliament since the 2010 general election.

Employment History

Table 1 – Employment History

Dates	Position
6 May 2010	Member of Parliament
13 May 2015 to 14 June 2017	Assistant Whip (HM Treasury)
17 June 2017 to 8 January 2018	Parliamentary Under- Secretary (Department of Health)
08 January 2018 to 26 July 2019	Parliamentary Under-Secretary (Department of Health and Social Care)
27 July 2019 - present	Member of Parliament

3. I have outlined above the positions held since I became a Member of Parliament in May 2010. During my time as a Junior Minister at the Department of Health I attended meetings of the All Party Parliamentary Group on Haemophilia and Contaminated Blood ('the APPG'). I confirm that aside from this I did not have any roles within any committees, working parties or groups that are relevant to the Inquiry's Terms of Reference.
4. On joining the Department I was responsible for a range of functions. My primary responsibilities were for social care and mental health, which were both political priorities at the time. In addition, I inherited responsibility for Infected Blood from

FIRST WITNESS STATEMENT OF JACKIE DOYLE-PRICE

Lord James O'Shaughnessy. On my arrival at the Department of Health the Secretary of State was the Rt Hon Jeremy Hunt MP. He was subsequently replaced by Matthew Hancock. Other ministers who served in the Department of Health were Philip Dunne, Caroline Dinanage, Stephen Barclay, Edward Argar, Steve Brine and Baroness Nicola Blackwood. My Private Secretary Georgina Johnson co-ordinated my work in this area.

5. I cannot recall the name of all of the senior civil servants working in the Department of Health while I was there and I refer you to my disclosure bundle.
6. I have not held any relevant memberships, past or present or committee associations, parties, societies or groups that are relevant to the Inquiry's Terms of Reference. I confirm that I attended the APPG meetings as a Minister. I was not a member in my own right.
7. I have not provided evidence to or been involved in any other inquiry or investigation in relation to HIV, HBV, HCV or CJD in blood products.
- 7.1. I would like to begin my witness statement by making a few brief opening comments. These are:
 - a) I am grateful for the opportunity to contribute to the inquiry. I fully supported the establishment of this inquiry and made the case for it as soon as I entered the Department of Health.
 - b) I had been aware of ongoing requests for a public inquiry from those affected by contaminated blood products. I felt very strongly that these people had been failed by the State and that they deserved answers. Government must be held accountable when things go wrong in a liberal democracy. We trust the State to serve us and keep us safe.
 - c) Our state institutions operate within a culture of confidentiality. Where there is harm caused there should be a presumption of transparency so that the facts can be ascertained. The lack of openness employed by Government has led to a severe breakdown in trust between the infected community and the Department of Health.

- d) This community had been seriously harmed. They deserved the facts and the truth. I felt it was important that I engaged with them directly. I was aware that given the state of relations between the Department of Health and the community, that would not always be a comfortable process, but I engaged with them through the APPG and Dame Diana Johnson as Chair. I also made clear my view that there needed to be some sort of inquiry.
- e) I also believe that the differentiated pattern of payments across the United Kingdom as a consequence of devolution compounded the difficulty in relationships between the community and the Government. The pattern of payments was complex and did not invite easy comparison. These matters raise quite difficult questions about the impact of devolution on the rights and equalities of individuals.

Section 2: The Alliance House Organisations (AHOs)

- 8. I am asked to explain the extent of the information and briefing I was given about the AHO's on first taking office. On taking office I was appraised of the existence of the AHOs and the decision to bring all the schemes together. I joined the Department of Health after the consultation to establish the Special Category Mechanism ('SCM') had taken place. I recall James O'Shaughnessy advised me that the existing method by which payments were made to individuals required reform. That decision having been made before I arrived at the Department of Health, it fell to me to complete the execution of it. I was committed to making sure that the system we arrived at was fair, as generous as it could be within the financial envelope and that no one would be worse off as a result of being moved to the new scheme.
- 9. I am asked to explain my involvement with the beneficiaries of the AHO's and the new devolved schemes during my time in office. My involvement with the AHOs was limited for the reason outlined above. I recall that there were some complex cases which required intervention, some of which were being championed by Members of Parliament on behalf of their constituents. I remember that a particular concern involved cases in which individuals had been given loans operated by the

FIRST WITNESS STATEMENT OF JACKIE DOYLE-PRICE

MacFarlane trust. Ultimately it was for the trustees to manage their obligations in these circumstances. However, I did make clear the concerns of the beneficiaries in respect of loans.

10. I made a deliberate decision to engage with the beneficiaries and met with them at a series of meetings convened by Dame Diana Johnson MP in her capacity as Chairman of the APPG. I also met with the then Chancellor of the Duchy of Lancaster the Rt Hon David Lidington. I felt I had to do my best for them. Ultimately, they had suffered harm as a result of the actions of the State and it was important that they felt heard. I also felt it important to bring to life the advice I was receiving from the Department which was by necessity formal and practical. These meetings brought home the humanity of what we were dealing with and helped me understand the needs of the beneficiary community. I recall receiving regular correspondence from Mr Jason Evans. We issued letters between consultations and there is correspondence that I signed off which discusses how we merged the AHOs into the scheme that we now have.

11. I have been asked to comment on my knowledge and understanding of the needs of the beneficiaries of the AHO/devolved schemes. My knowledge and understanding came out of the results of the consultations, which were carried out before I joined the Department of Health, and subsequent analysis. I concluded that there was not always a united view amongst all the beneficiaries. It became clear to me was that the delay in devising and implementing these schemes had caused difficulties. Moreover, the discretionary nature of some of the support caused anxiety amongst those who were concerned that they might lose out. My understanding of the SCM was that it was intended to give a fairer pattern of payments. The schemes as designed reflected a time when treatment of HIV was far less good than today and the payments reflected that. Today Hepatitis C may have higher morbidity than HIV. Consequently, those living with hepatitis could be suffering worse ill-health and yet the schemes did not necessarily reflect that. Moreover, some suffered worse ill health than others and that wasn't reflected in a system of payments based on health condition. To reflect the needs of some beneficiaries the SCM was devised, although this was not universally welcomed within the community. I am aware of tensions between those who had HIV and those had HCV. The proposal to increase payments for those with HCV was

FIRST WITNESS STATEMENT OF JACKIE DOYLE-PRICE

complicated for this reason and it appeared that there was no way that the scheme would be satisfactory to everyone.

12. I became aware of issues regarding the MacFarlane trust and beneficiaries following a number of representations from parliamentary colleagues on behalf of constituents. I did not form a view beyond that. My focus was on implementing the new scheme. I am not aware of what the Department of Health did to address any tensions. My responsibilities were at policy level only. Operational aspects of delivery were implemented by departmental officials.

13. I did not form a view on whether the AHOs were well run, as by the time I joined the Department, the focus was on managing the transfer to EIBSS and making sure it would deliver an efficient and fair service.

14. My focus extended to implementing the changes to the England scheme. I did not come to a view on whether the devolved schemes were well run or otherwise. I did however reach the view very quickly that it felt unfair for beneficiaries to be entitled to different levels of support on the basis of where they lived in the United Kingdom. To me it raises real implications for equality and human rights. Ultimately Devolution is a model for decision-making. We have approached devolution on a very functional and institutional basis without really looking at the implications for human rights. The fact is that the contaminated blood products were administered at a time when there was no devolved government. In my view, it ought therefore to have been retained by the United Kingdom Government. I certainly was not happy to have to respond that this was a devolved matter when answering questions about why some payments were more generous than others. Whilst that response was factually and constitutionally the case, I could see just how unsatisfactory that answer was to those beneficiaries who posed it.

15. I was not involved in decisions to establish the devolved scheme so cannot advise why that particular model was chosen.

16. In relation to the decision to transfer MacFarlane Trust reserves to the Terrence Higgins Trust, I refer the Inquiry to MACF0000028_026 which is my understanding of what happened at the time. It was of course the right of the MacFarlane Trust Trustees to determine how to discharge their obligations and I had no control over the decision to transfer the loans to the Terrence Higgins Trust.

17. With regard to the letter I wrote to Alistair Murray [MACF0000028_051], as is apparent from the letter's contents, I was not satisfied with the openness with which the MacFarlane Trust was engaging with us. My letter was prompted by the lack of certainty given to those with outstanding loans to the MacFarlane Trust. There had been representations made that the loans should be written off however, that option was rejected. At the time of writing, it was still unclear how these loans would be managed in future. I had no influence over the Trust's decision to transfer the loans to the Terence Higgins trust. It was simply reported to me that that had happened.

Section 3: The Devolved Schemes

18. I believe that parity between the four schemes was an important objective, because looking at the financial schemes from the perspective of an individual beneficiary, there is a clear issue of fairness.

19. Nonetheless, while I was at the Department of Health I was also conscious that we were working in the context of devolution. The systems of payments in each Nation were all different and complex. They were made up of regular payments, lump sums and discretionary payments. It felt to me that we had to collaborate to achieve more consistency. It was also the case that the devolved administrations were entitled to jealously guard the autonomy they had acquired. Therefore, any collaboration needed to be advanced by a relationship based on dialogue and mutual respect. I believe this is what I would have been referring to when I referenced parity in the letter the Inquiry has directed me to at WITN5570024.

20. I am not aware if any steps were taken by the Department of Health to achieve parity when the devolved schemes were being set up. As far as I am aware the Department consulted with the England beneficiaries and the design of the scheme reflected the outcome of those consultations.

21. In so far as I was able to work towards parity among the schemes I did so by seeking to achieve stronger dialogue with the devolved nations. I had of course received direction from the Chancellor of the Duchy of Lancaster following representations made by the Chairman of this inquiry. The meeting held in January 2019 had impressed very strongly on all that the differences in payments were

seen as unjust. I was able to achieve an uplift in payments to achieve parity with Scotland, but it is fair to say that that caused issues for Wales and Northern Ireland.

22. I had instructed officials in the Department of Health to keep the administrations close as we developed the proposal to implement an uplift in payments. At the time Northern Ireland did not have a functional political administration, which made things difficult, but Health officials were advised of what we were about to do. I was however acutely conscious that our decision would have implications for Wales and Northern Ireland and I was keen to establish how much of a difficulty that would pose. I was also aware that the uplift in England had been achieved through existing budgets and the expectation by Treasury would be that the same should be achieved in Wales and Northern Ireland. The uplift in payments to beneficiaries in England was made on 30th April 2019. In making the announcement I made clear that in response to representations made by the inquiry and from beneficiaries I would be seeking to work collaboratively with the devolved nations to achieve greater parity of support. I was able to hold a four nation ministerial teleconference on 10th July 2019. I left office on 25th July 2019 so I cannot account for anything beyond then. I received firm representations from the administration in Northern Ireland that it could not afford to match the increase in the England scheme. I undertook to raise that issue with the Treasury and the Cabinet office.

23. The uplift in England meant that the administrations in Wales and Northern Ireland were then left reacting to a pace set elsewhere. I imagine it is for this reason that Lesley Heaney, Health Protection Branch, Department of Health Northern Ireland said that the increase in English payments resulted in an unforeseen and sudden disparity with Northern Ireland [WITN5570021]. This is an accurate summation following the decision to equalise the schemes.

24. I have been asked to comment on the Scottish Infected Blood Support Scheme meeting on 17 May 2019, [SIBS0000041] and explain my understanding of the "reaching out statement" referred to at that meeting. I can only assume that was a reference to the letter I wrote to Minister Joe Fitzpatrick, dated 2 May 2019 [DHSC0050698].

FIRST WITNESS STATEMENT OF JACKIE DOYLE-PRICE

25. Mr Hancock has stated in evidence to the Inquiry that the differences between the schemes were not justified. I would agree that from an individual perspective the payments were not fair and in hindsight this should have been pursued on a UK-wide basis. I cannot advise why that route was not taken. It does however teach us lessons about ensuring that in devolving decision-making we endeavour to ensure that individuals are not left disadvantaged. We remain in the United Kingdom. This is however a consequence of our current constitutional settlement.
26. The funding settlement had been established before I arrived at the Department of Health. In deciding how to allocate the funds to beneficiaries the Government undertook consultations. At the time I arrived those discussions were largely complete and we were in the delivery and execution phase of the policy. I cannot therefore advise what expert advice was received by the Government.
27. The government ran a consultation on support which commenced in January 2016. In July 2016 the Government announced it would introduce a new SCM to give enhanced payments to those with Hepatitis C. A subsequent consultation on the SCM took place from 6th March 2017 until 17th April 2017. These consultation processes took place before I joined the Department of Health so I cannot advise how beneficiaries were informed of this consultation.
28. As previously stated the decision to deliver an uplift in payments was taken before I arrived at the Department of Health.
29. I am asked why the SCM was designed the way it was and what consideration was given to self-assessment [WITN4688009]. My understanding is that it was designed to give enhanced support to those with HCV stage 1 who had developed stage 2 conditions. As this would lead to higher payments it would therefore be appropriate that some degree of medical evidence would be provided by applicants.
30. My understanding of the SCM was that it was designed to make additional support available to those with Hepatitis C. The support was intended to bring the benefits more in line with those with HIV.
31. During my discussions with the APPG, I was made aware of concerns in respect of all aspects of the scheme, including the SCM. I always made sure that concerns were investigated. I would always feedback in detail to the APPG on issues that

had been raised with me. My recollection was that there was general anxiety with the whole package of reform and some people were simply opposed to it.

32. I did not have much involvement in the discussions about the sharing of data between the AHOs and the devolved Schemes, as much of this arose and was considered before I joined the Department of Health in June 2017. Further, these issues were largely operational ones, and so I do not recall being kept abreast of the detail of them if/when they did arise.
33. I was obviously keen to facilitate the transfer of responsibility from the AHOs to the EIBSS in as simple a way as possible but mindful of statutory responsibilities. I am satisfied that the data should not have been transferred without the express consent of the beneficiary. I have seen no advice that challenges that view.
34. I recall that discussion did take place with AHOs to see how the process could be expedited and that this led to the AHOs proactively contacting their beneficiaries to establish consent for handing over the information. I do not recall any specific consideration of the Skipton fund.
35. I have been asked about my parliamentary response of 16 November 2017 and letter to Dame Diana Johnson dated 19 December 2017, stating that 2% of the AHO beneficiaries did not consent to their information being handed over to NHSBSA. I note that William Vineall in [WITN4688009] has now stated that the figure of 2% is not correct. This was the figure supplied to me by officials in the Department of Health. It is disappointing that I have inadvertently misled Dame Diana Johnson but I can only act on the advice given to me by Department of Health officials at the time.
36. In respect of how the payments were allocated by EIBSS, my understanding is that the levels of payment were set by the Department of Health and the role of the EIBSS was to administer them recognising the obligations they inherited from the previous schemes. There was some nervousness on the part of the beneficiaries particularly with regard to how the payments under the SCM should be assessed and the extent to which they would need to demonstrate their conditions.
37. Beneficiaries were also nervous that the EIBSS wouldn't understand their conditions. Whatever was wrong with the existing schemes there was a relationship. New relationships would have to be started from scratch. I responded

FIRST WITNESS STATEMENT OF JACKIE DOYLE-PRICE

to these concerns by arranging for those officials who would be managing the EIBSS to attend the APPG to reassure them on how they would be managing the payment system.

38. I gave an undertaking that that no one would be worse off under the new system.

I was advised at meetings with the APPG that some beneficiaries were concerned they would be worse off. Officials in the Department embarked on a very granular analysis to ensure that wasn't the case. As far as I am aware that work delivered for the most part but there were still some questions over the support for the bereaved.

39. I became aware of concerns about EIBSS and the beneficiary community generally through the APPG meetings and via representations that MPs made to be concerning their constituents.

40. As referred to at para 38, I was personally determined that no one should be disadvantaged by the new system and had issued instructions to the team accordingly. I gave a public undertaking at the meeting of the APPG on 9th May 2018. I wanted the beneficiaries to be confident that we were determined to do right by them and I was happy to put my reputation on the line to make that promise.

41. With regard to the APPG meeting on 31 January 2018, the introduction of the SCM was not universally supported. Some thought there should not be a distinction between stage 2 for HCV. The details of the scheme were established following consultation and the Department was satisfied that it was robust. The fact that there was disquiet raised at the January 2018 meeting of the APPG reflects that there is no unanimity of opinion within the community. Each beneficiary has their own experience. The Department could only do its best to establish the fairest possible scheme, and consultation was the method it chose to achieve that.

42. The views expressed at the January 2018 APPG meeting [RLIT0000638] that the ex gratia scheme was "wholly insufficient" reflects the general unhappiness amongst the community that neither the NHS or the Department of Health had ever admitted liability. There was a general discontent with the way the community was being treated by successive Governments.

43. In respect of payments to widows I gave a commitment that entitlements would be at least at the level of the best entitlements previously available. That was a clear steer given to the Department to ensure that this was delivered.
44. I left office in July 2019 so I did not consider undertaking a clinical review similar to the review undertaken in Scotland.
45. By the time I left the Department of Health we had received representations to extend payments to parents. I believe I asked colleagues in the Department to look at that. I wanted to understand the detail of the issue before coming to a view.
46. I was pleased to meet Su Gorman. Her account perhaps illustrates some of the individual complexities in these cases and how poorly a process based system can deal with them. When her husband died, his payments were immediately stopped but she was unable to get any widows payment until she could present a death certificate. I asked my office to raise the case with EIBSS and to make sure she was being treated appropriately and fairly. I was advised that a named officer had been put on the case and that she had been contacted and informed what could be done for her. I was extremely disappointed to hear from her at that meeting that what I was told was being put in place for her hadn't materialised. Ultimately it need not require a death certificate to verify cause of death. Her husband was a beneficiary of the scheme. She ought to have qualified for a payment without question. I was left struck by just how dehumanising the process was, notwithstanding my best efforts to intervene on her behalf.

Section 4: Psychological Support

47. I am not aware of any bespoke psychological support that was made available to the infected community. I would expect mental health needs to be met through access to NHS services in the usual way.

Section 5: Infected Blood Inquiry Hearings

48. I can confirm that in line with the evidence provided by Matthew Hancock in his oral hearing to this inquiry, I had day-to-day responsibility for this area of policy. Although I was in charge of policy, I met Matt Hancock every week regarding all matters of the Department of Health, and Matt Hancock was happy to leave me to

get on with it. I would give informal updates on all matters in my portfolio. Where there was a material change of policy I would report to the Secretary of State with a written submission which would afford him the opportunity to take a view or approve what I recommended. In respect of this area of policy, responsibility for the inquiry had passed from the Department of Health to the Cabinet Office and as such I was also reporting to the Chancellor of the Duchy of Lancaster.

49. At the meeting that Mr Vineall described as attending in January 2019 in his oral evidence, we heard a number of representations about the perceived deficiencies in the scheme and accounts of how some beneficiaries felt poorly treated when compared with their equivalents under the Scottish scheme. Mr Vineall attended that meeting as a senior official. It was a relatively new subject to him, but in terms of day to day policy management the infected blood policy team had a very thorough understanding. Over the course of my involvement with beneficiaries I have learned that a face to face meeting with those who have living, breathing experience of the issues can be very impactful. That is why I made a deliberate decision to engage with victims of contaminated blood through the APPG in order that I did fully understand what we were dealing with. I thought that those who attended the meeting were particularly dignified in describing the impact that contaminated blood had had on them.

50. The decision to make the uplift in payments was a result of that meeting. David Lidington as Chancellor of the Duchy of Lancaster and with responsibility for the Inquiry instructed me to bring the English scheme into line with the one in Scotland. I was very content to support that not least because it chimed with my own view. It remained the case however that there would still be disparity between the schemes. We had to meet the shortfall from within DHSC budgets and without additional funding Wales and Northern Ireland became outliers.

Section 6: Other

51. I would like to end by saying that I have huge respect and admiration for those people I have met who have been infected and affected by contaminated blood. I do think they have been treated poorly for many years. I appreciate that many witnesses have been critical of my role in events. They have every right to be so.

FIRST WITNESS STATEMENT OF JACKIE DOYLE-PRICE

I can advise the Inquiry that from the moment I took responsibility for this I was determined to give them the best support I could. I am pleased that the Prime Minister decided to hold this inquiry which has been a long time coming.

Statement of Truth

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

Signed	GRO-C	
	GRO-C	<i>JR</i>
Dated	<i>March 2022</i>	