Witness Name: Ms Christine Dora
Statement No: WITN7246001
Exhibits: 0
Dated: 13 October 2022

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF CHRISTINE DORA

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 08 August 2022.

I, Ms Christine Dora, will say as follows: -

Section 1: Introduction

1. My name is Christine Claire Dora. My address is GRO-C GRO-C and my date of birth is GRO-C 1964. I have no professional qualifications relevant to the duties that I discharged while working in the Health Planning and Quality Division of the Scottish Health Department.

Q2. Please outline your employment history including the various roles and responsibilities that you have held throughout your career, as well as the dates.

My employment history is as follows:

2.1 **1986 - 1988: General Register Office for Scotland, Edinburgh - Executive Officer computer programmer:** working on the Vital Events system, for recording births, deaths, marriages etc and compiling statistics.

2.2 **1988 - 1989: McDermott Scotland, Ardersier by Inverness: computer programmer:** stock control for a fabricator of offshore rigs.

2.3 **1989 - 2008: Scottish Office/ Scottish Executive/ Scottish Government, Edinburgh**: Government policy and administration, managing teams to support the Scottish Ministers in discharging their responsibilities, including the provision of advice in liaison with other policy colleagues, legal advisers and finance colleagues, communication with stakeholders including members of the public, support in the formulation and passage of legislation, and management of teams of colleagues to assist in delivering those responsibilities.

I do not hold exact details of dates for the various posts that I held, and the Scottish Government could not provide me with those details when asked, but, sequentially, the posts were as follows:

- Executive Officer, Scottish Development Department Rural Affairs Division: financial support for the Countryside Commission for Scotland and for environmental charities.
- Executive Officer, Scottish Development Department Local Government Division: reorganisation of local government from a structure of regional and district councils to one of unitary authorities.
- Higher Executive Officer, Scottish Office Agriculture and Fisheries Department: emergencies planning (including the Department's response to the effect of the MV Braer oil spill on farming in Shetland, liaising with local representatives and considering the results of testing for contamination); organisation of the Department's presence at the Royal Highland Show in summer; ministerial and VIP visit programmes.
- Secondment to the Prince's Trust (Volunteers) as Quality Development Manager for Scotland: supervision of and support to team leaders of personal development programmes for young people aged 16 to 25.
- B2 (Higher Executive Officer), Development Department, Local Government Division: correspondence and complaints from members of the public; councillor conduct and ethics; provision of Government support for a private members' bill to allow councils to use Gaelic names.
- B2 (Higher Executive Officer), Education Department (part time): lifelong learning.
- B3 (Senior Executive Officer), Education Department (part time): lifelong learning.

- C1 (Principal), Health Department (part time) – December 1999 – May 2001 (I remember these dates because the posting came between two periods of maternity leave): medical devices, including the chairing of the Scotland-wide Rehabilitation Technology Services Advisory Group, which comprised clinicians, technicians and users of wheelchairs and prosthetic limbs; blood and blood products, including liaison with Scottish National Blood Transfusion Service.
- C1 (Principal), Criminal Justice Division (part time): implementation of the Proceeds of Crime Act 2002, including criminal and civil asset recovery and guidance for police services; hate crime; preparation for the definition and introduction of a crime of corporate culpable homicide.
- C1 (Policy Director), Judicial Appointments Board for Scotland (part time) – accountable officer and leader of a team providing policy support to the Board that was responsible for recruiting to the judiciary.

2.4 **2008 - 2019: East Lothian Council, Haddington**. Sequentially:

- research assistant to administration councillors, providing briefing and analysis, liaising on their behalf with officers throughout the council, and assisting them in their consultations and deliberations on setting the Council's budget each year.
- executive assistant to the council's chief executive: providing research, briefing, speaking notes and presentations; providing support to the committee of the Society of Local Authority Chief Executives and Senior Managers, including the organisation of the Society's annual conferences and learning seminars for council chief executives.
- executive officer, community planning: support for the community planning structure, liaising with other statutory and voluntary organisations to deliver integrated community planning in the area; delivering learning for councillors and officers on the requirements of the Community Planning (Scotland) Act 2015; supporting the council in its deliberations on requests for community asset transfer under the 2015 act.

2.5 2019 - present: Scottish Parliament – Official Reporter: part of the team responsible for producing the official record of proceedings in the Parliament.

Q3. Please set out your membership, past or present, of any other committees, associations, parties, societies or groups relevant to the Inquiry's Terms of Reference, including the dates of your membership and the nature of your involvement.

3: None.

Q4. Please confirm whether you have provided evidence to, or have been involved in, any other inquiries, investigations or criminal or civil litigation in relation to human immunodeficiency virus ("HIV") and/or hepatitis B virus ("HBV") and/or hepatitis C virus ("HCV") infections and/or variant Creutzfeldt-Jakob disease ("vCJD") in blood and/or blood products. Please provide details of your involvement and copies of any statements or reports which you provided.

4.1 Other than what is covered by the Rule 9 request and detailed in this statement, I have not provided evidence to or been involved in any other inquiries.

4.2 The Inquiry has a copy of the report that I produced in 2000 on the history of the heat treatment of blood products for the prevention of the transmission of hepatitis C virus, and other relevant documents. Given the length of time that has passed, I do not well recall all the details of my involvement, but it included a study of relevant academic literature, interviewing people from the Scottish National Blood Transfusion Service, considering representations from individual haemophilia patients, consulting with then-current haemophilia directors, liaising with colleagues and ministers, and supporting the minister at a press conference and at her appearance before a relevant parliamentary committee.

4.3 Having read the material provided to me by the Inquiry, I requested a few further documents from the Scottish Government; those to which I refer in my statement are attached, and I understand from the Scottish Government that the Inquiry holds copies of them. I do not hold copies of any other material relevant to my investigation in 1999-2000.

Section 2: The Scottish Executive Report

Q5. Please describe your role in relation to the research, investigation and preparation of the Scottish Executive report ('the report') published in October 2000 titled "Hepatitis C and Heat Treatment of Blood Products for Haemophiliacs in the Mid 1980s" [GGCL0000010]. In particular:

a. please identity the person or people who conducted research or, investigations for the report;

b. please identify the person or people who drafted the report;

c. please set out the extent and source of the documentation made available to those carrying out investigations and writing the report including the steps taken to obtain relevant documentation;

d. please provide any instructions you may have received from Ministers or Chief Medical Officer/Deputy Chief Medical Officer with regard to scope and methodology of investigation.

You may find the following documents of use: SCGV0000170_078, SCGV0000170_070, SCGV0000170_071, ARCH0003312_020, SCGV0000171_053, SCGV0000171_054, SCGV0000171_068 and SCGV0000171_077; SCGV0000171_052.

5.1 I led on the production of the report, including the gathering and analysis of information, the conclusions reached, and the drafting and publication of the report. I would have had assistance from members of my team (in particular, from Mrs Sandra Falconer), but I do not recall the nature or extent of that assistance. I would also have sought and considered comments from other colleagues.

5.2 The remit of the exercise was agreed by the minister, Susan Deacon, and was based on a letter [HSOC0011771] from her to the Haemophilia Society, dated 9 November 1999 (which date was prior to my arrival in post in early December 1999). I do not recall in detail any further initial instructions to me on the scope and methodology of the exercise but, during the exercise, I was advised by Dr Aileen Keel, who was the Deputy Chief Medical Officer, and other colleagues, including Mrs Lynda

Towers in our solicitors' division and Miss Thea Teale, who, as head of division, was my line manager. However, apart from what is in the Inquiry papers that have been shared with me, I do not recall the details of their input.

5.3 I do not recall in detail all the steps that I took to conduct the relevant research. They included requesting and receiving information from the Scottish National Blood Transfusion Service (SNBTS) about scientific papers that set out knowledge about the subject at various points in time; information from haemophilia directors in Scotland; and information from the Haemophilia Society and from individual people with haemophilia who were affected by hepatitis C. I recall also visiting the SNBTS offices and being shown the packaging material for Factor VIII concentrate which had been available before the heat treatment of blood products. The packaging material had been retained by SNBTS.

Q6. What was the process for setting the terms of reference/remit of the Report? You may wish to refer to SCGV0000170_071, SCGV0000176_101, WITN4436005; SCGV0000170_015, HSOC0005179.
In particular please set out your understanding as to why the remit did not look at why people with haemophilia in Scotland were exposed to hepatitis, rather than considering only the impact on this issue of the introduction of heat treatment in the mid-1980s.

6.1 The minister's letters of 27 September [HSOC0005179] and 9 November [HSOC0011771] to the Haemophilia Society set out the issues that she wanted to have examined. Those predate my arrival in the relevant department. However, my understanding and recollection is that, for some time, the Scottish Executive had been resisting ongoing pressure from haemophilia representatives for compensation for the infection of haemophilia patients with hepatitis C through the use of blood products. The Scottish Executive's position was that, given what was known about the disease at the time of the events, the National Health Service had not been negligent; the general principle was that people were not paid compensation for harm resulting from their treatment if that harm was not due to negligence.

6.2 The Haemophilia Society made representations to the minister that a heat treatment of blood products to obviate the risk of hepatitis C infection had been successfully developed in England earlier than one had in Scotland. The implication was that the NHS in Scotland was negligent through delay and that, at the time in question, in the mid-1980s, patients in Scotland were exposed to risks for longer than they should have been, given the state of knowledge at the time. There was also a suggestion that haemophilia patients had been misled by clinicians as to the risks of using Factor VIII blood products; again, that might have given rise to an inference of negligence on the part of the NHS or of individual clinicians. My understanding is that this was a new angle to the Society's arguments for compensation. The minister agreed to look at the two issues described. She was keen to establish the facts around the development of the heat treatment of blood products.

6.3 As far as I recall, it was not in contention that some people had been infected with hepatitis C through the use of donor blood and blood products prior to the successful heat treatment of blood products, the isolation of the virus and the subsequent testing of donor blood.

> **Q**7. The Inquiry understands that members of the Scottish Executive Health and Community Care Department involved in writing the report met with clinicians on 1 September 1999 [PRSE0000978] and the SNBTS on 10 February 2000 [ARCH0003312_020]. Please explain the purpose of these meetings.

7.1 I was not yet in post at the time of the 1 September meeting, and have no recollection of it being discussed with me.

7.2 The meeting of 10 February 2000 covered by paper ARCH0003312_020 was of SEHD officials with clinicians, not with the SNBTS as stated in the question. The purpose of the meeting was to obtain information from the haemophilia directors pertinent to the investigation.

> **Q**8. The Inquiry has seen a memo dated 8 September 1999 to the Minister which has as an appendix the preliminary conclusions drawn by the

investigators thus far [SCGV0000043_047]. What was your role in drawing up this document? Did you have any concerns that preliminary conclusions had been drawn so early on in the investigation process, before there had been a meeting with the Haemophilia Society, or detailed consideration of their allegations?

8.1 I was not yet in post at the time of the memo of 8 September 1999 and had no part in drawing it up. Although I have no recollection of the memo, I suppose that I must have read it as part of my background reading on the task assigned to me, to conduct an investigation into the development of the heat treatment of blood products.

8.2 From my reading of that memo now, I infer that much of the information in its Annex B would have come from SNBTS, given that it comprises a history of events leading up to the successful heat treatment of blood products in the 1980s. SNBTS provided similar information to my investigation. My investigation was a fact-finding exercise, and I would not have been concerned that people in the department already had knowledge of some of those facts.

Q9. The Inquiry also understands that you did not meet with the patients who were making the allegations about their treatment that were being investigated. Please explain the rationale for this decision and set out how it was that you thought that their allegations could be investigated without such a meeting.

9.1 I had access to statements made by patients for the purposes of my investigation, which are mentioned in the report. I do not recall what consideration was given to meeting with individual patients. The statements of the Haemophilia Society and haemophilia patients were the starting point for the investigation, and I took patients' written statements at face value. Taking that into account, I am not sure what would have been gained by questioning them further.

Q10. Please set out the steps that you or to your knowledge others involved in the investigation took, to:

a. Probe and test the evidence you received from clinicians and the SNBTS about the matters being investigated in the report.

b. Probe and evaluate the evidence you received from or on behalf of patients about the matters being investigated in the report.

10.1 a. My investigation was billed as a fact-finding exercise, and I had no special powers of investigation. For example, I do not recall it ever being a realistic option for me to seek to examine patients' medical records. I recall asking questions of clinicians, to ascertain what they could recall or ascertain about the treatment of patients. I also asked questions of SNBTS representatives, in order to ascertain a timeline of events that led up to the successful heat treatment of blood products. They also pointed me towards relevant academic papers, which are listed in the report.

10.2 b. I do not recall what was done to probe and test the evidence that was received from patients; I would have taken their evidence at face value. I did not question individual patients, nor make an attempt to look at their medical records.

Q11. The remit of the report (as set out in the summary of the report) included the following: 'to examine evidence about the information given to patients with haemophilia in the 1980s about the risks of contracting hepatitis C virus from blood products'. Please explain:

a. Why the report did not consider the evidence from individual patients as to the information they had received about their treatment, when investigating this question. How was it anticipated that the question could be adequately investigated without doing this.

b. Why the findings were restricted to whether or not there was a policy 'by Haemophilia Centre Directors deliberately to mislead patients about the risk of hepatitis'.

c. What consideration was given to you when evaluating the evidence provided by the Haemophilia Centre Directors, of the fact that they had informed you that they were concerned about possible litigation? You may find SCGV0000171_077 of assistance.

d. Whether the fact that the findings were apparently much narrower than the remit, caused you, (or to your knowledge others), to advise the Minister that a different kind of investigation was required into this issue? If not, why not?

11.1 a. It is not the case that the report "did not consider the evidence from individual patients as to the information they had received about their treatment", as stated in the question. Paragraph 12 of the report summarises the concerns of haemophilia patients and their families who made representations, without ascribing those concerns to individuals. My recollection is that we took individual patients' representations at face value. I do not recall the extent to which we gave formal consideration to tracing their clinicians (or former clinicians) or attempting to access their medical records, other than that the record of the meeting of SEHD officials with haemophilia directors on 10 February 2000 (ARCH0003312_020) notes the following:

> "**Professor Lowe** pointed out that most patients would have been infected while [the haemophilia directors'] predecessors were in post and asked whether it was necessary to contact them to make them aware of the situation. **Mrs Towers** explained that this was a factual information gathering exercise but that it should be borne in mind that the information might be used in future Court actions."

11.2 My understanding is that written medical records would not necessarily contain a note of everything that is discussed during a consultation. The information that was available to the exercise, incomplete as it may have been, showed that risks were known about and that some information was available for clinicians and patients about them. The report did not and could not say which individual clinicians, if any, had neglected to give appropriate warnings to which individual patients.

11.3 b. The findings were not "restricted to whether or not there was a policy 'by Haemophilia Centre Directors deliberately to mislead patients about the risk of hepatitis'." That phrase occurs in the summary of the findings. There is more detailed discussion within the report's paragraph 12:

12. During this exercise, we received 28 letters from individual haemophiliacs, and 15 letters from friends and families of haemophiliacs, describing the effects of the hepatitis C virus on their lives. Some of the letters deal with the health problems encountered by sufferers. Most people who mentioned treatment said it had been unsuccessful. Three people mentioned funding problems with treatment. Many writers felt that haemophiliacs had not been adequately warned of the risks of infection from blood products, and that they had received inadequate advice and support. Some correspondents were the parents of haemophiliac children; they described how they felt after having consented to treatment which resulted in their child becoming infected. Many correspondents expressed great disappointment that

[1] The figure excludes patients who were also HIV positive, since HIV of itself causes immunosuppression which renders individuals susceptible to illnesses which they would otherwise be able to combat. The figure, however, includes individuals whose deaths from liver disease may not have involved Hepatitis C: for example, cirrhosis of the liver from another cause.

[2] Fewer than 10: more detailed information is withheld in the interests of confidentiality.

no apology had ever been offered to them. A few correspondents said that there had been a delay in their being informed that they were infected with HCV. A number of correspondents also mentioned the effect on their families. Some families had to cope with seeing a loved one suffer, physically and emotionally. Other families were financially disadvantaged because partners were unable to take up paid employment since they were caring for a hepatitis C positive relative. Sufferers said they had worried about the risk of infecting their loved ones. Some correspondents mentioned in addition the social stigma of hepatitis C; they did not want their neighbours to know they were infected. Others pointed out that people infected with hepatitis C may have difficulty in obtaining a mortgage or personal insurance, or may be subjected to increased payments.

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paragraphs 29 – 38:

Treatment

29. The second part of the remit of this exercise concerns the treatment of haemophiliac patients, and whether they were given sufficient information about the risks of using Factor VIII.

30. It should be repeated in this context that not all patients treated during the time in question were given SNBTS-produced Factor VIII. Some were given commercial products or cryoprecipitate (see paragraph 11 above).

31. Current Haemophilia Centre Directors recalled that hepatitis and abnormal liver function were well-known risks of Factor VIII and IX concentrates since their introduction in the mid 1970s. They believed that these risks were well-known to the scientific community, concentrates manufacturers, health departments and health boards, healthcare professionals, patients and relevant patient societies including the UK Haemophilia Society and its Scottish branch. They gave their opinion that the risk of hepatitis was a major, widely-publicised factor in pressure from the UK Haemophilia Society on UK Health Departments to progress self-sufficiency in the UK through production of concentrates from UK donor plasma through SNBTS and BPL. They believed that patients and parents were informed of the risk of hepatitis as part of general education on haemophilia and its treatments, including:

- use of educational material, including that produced by the UK Haemophilia Society;
- education for patients and carers about home treatment with factor concentrates (they sent us an excerpt from a document called "Haemophilia Home Therapy" (*Reference D*). produced in 1980 by Peter Jones, at the time Director of the Newcastle Haemophilia Reference Centre, which contains relevant reference to hepatitis);
- hepatitis warning signs and cross-infection precautions, in haemophilia centre treatment areas;
- national and local meetings of the UK Haemophilia Society.

32. We have seen a copy of the product insert leaflet included with SNBTS Factor VIII product NY (*reference E*). It carried a warning that the product could not be assumed to be virus-free. This document is headed "Human Antihaemophilic Factor – Factor VIII concentrate – HT (Lyophilised)", is dated 5/4/85 and carries the product licence number. It states that "the product has been heat treated at 68°C for twenty-four hours in the dried state but it cannot be assumed that the product is non-infective". It mentions among possible side-effects "the general complications of hepatitis". Patients treating themselves would have been able to refer to this leaflet, since it was packaged with each vial of the product intended for self-administration. However, not every person who takes a medicine at home is guaranteed to read or completely understand the product insert.

33. We have also found some examples of guidance available to clinicians.

In June 1983, the UK Haemophilia Centre Directors Organisation (UKHCDO) wrote to Haemophilia Directors about the risk of AIDS (*reference F*), and set out some recommendations for treatment, including the use of DDAVP [the drug Desmopressin Acetate] in treating mild Haemophilia A and von Willebrand's disease. In December 1984, the UKHCDO issued an "AIDS Advisory Document" (*reference G*), which mentioned that dry heat treatment of Factor VIII at 68°C inactivated the AIDS virus, but noted in passing that it was unlikely that the process would completely inactivate Non A Non B Hepatitis. In its Recommendations, it noted that "concentrate is still needed: bleeding is the commonest cause of disability and death."

There is also relevant material in the 1984 revision of Notes on Transfusion (*reference H*), issued by the DHSS, the Welsh Office and the Scottish Home and Health Department, intended for use by medical staff of hospitals. It describes some of the principles of practice of transfusion with blood and blood products, as well as suggested procedures. This document notes the phenomenon of post-transfusion hepatitis, saying that until suitable tests were available to identify the viruses concerned, there would continue to be a risk associated with the use of blood and blood products.

34. We are extremely grateful to current Haemophilia Centre Directors in Scotland, who met with us to discuss these issues. They felt that from the mid 1970s there had been a widespread awareness of the risks of contracting hepatitis. They recalled a generally-held perception in clinical circles until the late 1980s that NANBH was a mild non-progressive condition. From the mid 1970s, they said, patients were increasingly keen to be prescribed concentrate to allow them to treat themselves at home. Current Haemophilia Directors are obviously unable to speak for their predecessors, but they expressed the view on their own behalf that it was for the individual clinician to recommend a course of action to a particular patient, based on the clinician's assessment of benefits and risks of a particular product. They said their own practice was to give patients and parents current information on the benefits and risks of treatments at their clinic review visits.

35. Current Haemophilia Directors recalled that while there was an awareness of the risks of hepatitis, the main concern in the mid 1980s had been HIV. They said that they believed Haemophilia Centre Directors had at that time given patients advice on avoiding "risk" behaviour to prevent the spread of blood-borne viruses, including use of circulars and publications by the Haemophilia Society and others. We have obtained a copy of one of these: "AIDS and the Blood: A Practical Guide" (*reference I*), written by Dr Peter Jones and distributed by the Haemophilia Society. It contains advice about safe behaviour and advice to patients (and parents of young patients) about examining the possibility of modifying their treatment. It also sets out some of the issues surrounding the heat treatment of blood products, as understood at the time. Current Haemophilia Centre Directors recalled that they or their predecessor directors had liaised with the Scottish Office and SNBTS on the development of new products though not, they said, in a formal advisory capacity.

36. We also asked the Haemophilia Centre Directors to comment on the view that mild haemophilia sufferers might have been put at unnecessary risk through treatment with Factor VIII concentrate, when safer alternatives might have been available. They recalled that different treatments such as cryoprecipitate or desmopressin had indeed been available for so-called "mild" haemophiliacs. These alternatives could themselves produce severe adverse effects (e.g. anaphylactic reactions or thrombosis), so their use had to be a matter of clinical judgement in each case. The Directors took issue with the view that mild haemophiliacs need not be considered clinically serious cases – they explained that although mild haemophiliacs do not suffer spontaneous bleeds, they bleed seriously if subjected to trauma. In such circumstances, their situation can no longer be considered mild and use of factor concentrates would be necessary. There was still a severe risk of death or disability if the bleeding was not

stopped quickly and in many cases mild haemophiliacs presented with late bleeds which involved more treatment.

37. On the issue of testing, current Haemophilia Centre directors were quite clear that their general policy was to inform patients previously treated with blood products that they were being tested for hepatitis viruses and that results would normally be discussed at their next review appointment, as with all test results.

Complaints about individual treatment

38. Some correspondents have raised the issue that they are dissatisfied with the treatment they received at the time, and suggest it did not meet with the clinical policy on testing outlined above, but they understand they cannot now make a complaint through NHS complaints procedures for various reasons. This seems an appropriate place to clarify the current complaints procedure. The Scottish Executive's leaflet on The NHS Complaints Procedure makes clear that

"Usually the NHS will only investigate complaints that are either

Made within 6 months of the event; or
Made within 6 months of you realising that you have something to complain about as long as that is not more than 12 months after the event. These time limits may be waived if there are good reasons why you could not complain sooner."

The Directions to NHS Trusts, Health Boards and Special Health Boards on complaints procedures state that where a complaint is not made during the period specified it shall be referred to the complaints officer and if he is of the opinion that -

(a) having regard to all the circumstances of the case, it would have been unreasonable for the complainant to make the complaint within that period; and

(b) notwithstanding the time that has elapsed since the date on which the matter which is the subject of the complaint occurred, it is still possible to investigate the complaint properly.

the complaint shall be treated as though it had been received within the time limit.

The complaints system does not deal with events about which the complainant is already taking legal action.

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as well as a fuller conclusion in paragraph 40:

40. In relation to information given to patients about the risks involved with their treatment, we accept that knowledge of the effects of HCV would have been limited. We accept that clinicians would have had available to them information about the general risks of blood-borne disease, including hepatitis, and that they would have been able to pass this information on to patients. We accept that it would be good practice to offer people a test for HCV when it became available and to discuss the result with them. We have seen no evidence that clinicians had a policy to test without informing patients. Whether these policies may have failed in the case of any individual patient is outwith the scope of this exercise; we have outlined the complaints procedure in this report and we also note that some patients have started legal proceedings.

11.4 c. My recollection is that our main concern would be not to seek to interfere with litigation that did not involve the Executive.

11.5 I would not have considered that the report's findings were "much narrower" than its remit. The report makes it clear that there were limitations in what could be ascertained in respect of information that was given to individual patients. I was not

aware of any opinion among Scottish Executive colleagues that a different type of exercise was advisable.

11.6 d. I was aware of general ongoing pressure from the Haemophilia Society, and growing pressure from some MSPs, for a public inquiry and compensation. In the face of suggestions that the report was inaccurate, my advice to the minister was that none of its detractors had been able to demonstrate error in its findings. That opinion was borne out by subsequent scrutiny by the Scottish Parliament's Health and Community Care Committee, set out in its report on Hepatitis C of 3 October 2001 [WITN4436008].

> **Q**12. In March 2000, documents from Professor Cash appear to have been considered by the Department for the purposes of the investigation. In an email sent by you on 28 March 2000, you state that "as far as I can make out, "we" (in Scotland) were only getting around to seriously thinking about ALT testing of donations in March 1988 - after the period in question. I suppose we could try to emphasise about how unreliable it was - but that in itself is a big dollop of hindsight" [SCGV0000171_052]. You also note a letter from David McIntosh to Professor Cash dated 30th August 1991 [NHBT0000077_071)] suggesting that civil servants and government "had not got it together on a start date for testing donations for HCV" and you were concerned not to "be accused of having suppressed this letter". As to this:
>
> a. Was this information shared with the Minister?
>
> b. Why was your understanding of the position in relation to ALT testing not shared with the Haemophilia Society or included in the final report?
>
> c. What did you mean when you stated: "A certain amount of inherent ambiguity will always be required by civil servants - partly to protect Ministers and partly to protect themselves"?

12.1 An examination of the position on ALT testing was not part of the report's remit. I infer from the documents quoted that we were considering at one point whether to include it.

12.2 a & b. There is a handwritten note dated 30 March 2000 on Heather Lawson's copy of my email of 28 March (SCGV0000171_052). Although the signature is redacted, I infer that the note was written by Thea Teale, head of division and my line manager, since Heather Lawson was Miss Teale's personal assistant. The note was to the effect that there was a balance between sticking to what we were required to do in conducting the exercise (the remit of which dealt with heat treatment of blood products, not the testing of blood donations) and anticipating further demands (I understand this to mean further demands by the Haemophilia Society, which, it was to be anticipated, would not be satisfied with the facts about heat treatment and would turn its attention to allegations of other failings); and that the writer would prefer that we should not cover testing in the body of the report. Underneath that note, there is an undated manuscript note by me to the effect that the considerations mentioned should be noted in the ministerial submission and that material should be kept on file. Those considerations are not mentioned in the draft ministerial submission that is among the inquiry papers (SCGV0000171_077), nor in the final version, which was sent on 25 April, which I requested from the Scottish Government and attach [SCGV0000171_029] and [SCGV0000171_030]. I do not recall why that information was not included for the minister.

12.3 c. The words "A certain amount of inherent ambiguity will always be required by civil servants - partly to protect Ministers and partly to protect themselves" are not mine but those of David McIntosh in his letter of 30 August 1991 (NHBT0000077_071).

Q13. Why did you consider it appropriate to provide a draft of the report to the clinicians, whose treatment regime was under investigation, to enable them to provide comments? [SCGV0000172_114]. What consideration (if any) did you give to the fact this might be said to impugn the independence of the report?

13.1 We would have wanted to ensure that the report had not missed any crucial information. I did not see a problem with reporting what the various parties had told us during the investigation, and I would have wanted to make sure that I had not misrepresented them.

Q14. Why did the Haemophilia Society (who raised the allegations that were being investigated) not also get an opportunity to make comments on the draft report? You may wish to consider SCGV0000172_069.

14.1 In my submission to the minister dated 25 April (which I requested from the Scottish Government and of which I believe the Inquiry has a copy, but I attach it for ease of reference [SCGV0000171_029] and [SCGV0000171_03]), I proposed sharing a copy of the draft report with the Haemophilia Society. I do not recall why the Haemophilia Society was thereafter excluded from the group of people who were consulted on the draft.

Q15. The Inquiry understands that the initial time estimate given to the Haemophilia Society for the production of the report was one month. In fact it was not provided to them for over a year. Why did it take so long to finalise the report? You may wish to consider the following documents: SCGV0000172_114 and HSOC0020454.

15.1 I was not involved in making the initial estimate of one month, which was made before I arrived in post, and I would have considered it unrealistic. The report took longer to finalise for a number of reasons, including:

- the time needed to commission, collate and analyse representations and complex scientific information;
- the time needed to consult Scottish Executive colleagues on the content of the report, including its readability, and policy, legal and presentational issues;
- the time needed to prepare briefing for the minister, including information and clearance from relevant colleagues, and to secure her approval for suggested courses of action;
- my own availability (I worked three days a week, during which time I also covered other policy and managerial responsibilities).

15.2 In essence the report was ready in draft by late April 2000 (at which point I sent it to the minister); it was not published until October that year.

Q16. In an email to colleagues [SCGV0000172_114] you stated that 'unless the Minister bites the bullet now this issue is going to get more difficult'. What were you referring to and what did you think the Minister should do?

16.1 I infer that I would have meant the presentational problems that might be caused by delay or avoidance of meeting the issue head-on. I thought that the minister should explain matters to MSPs clearly and comprehensively. An example of a presentational problem was Dorothy-Grace Elder MSP's reference to "'Skid Row' blood", which was reported in the press.

Q17. In response to the circulation of the report, John Aldridge, Director of Finance, SEHD, commented on 19 April 2000 that the Minister should be "pointed very firmly in the direction of not agreeing to compensation or special priority treatment" for Hepatitis C sufferers who may have been infected by NHS treatment [SCGV0000171_031, page 2]; a few days later you replied: "I agree that the arguments tend against the award of compensation (or hardship payments). The Macfarlane Trust for people infected with HIV is an uncomfortable precedent [...] I am hoping they will decide the same thing and it won't be compensation" [SCGV0000171_031, page 1].

a. Was the question of compensation or payments to those infected with HCV by infected blood always connected with the question of negligence during your tenure? To what extent was there consideration at the SEHD of the moral case for payments to be made?

b. Why did you hope that compensation would not be pursued?

17.1 a. I cannot say for sure that the question of payments was "always" connected with the question of negligence, but the connection of the two was certainly strong. I do not recall the "moral case" being considered separately. Paragraph 6 of Michael Palmer's memo of 8 September 1999 to the minister (SCGV0000043_047) sets out the Department's position at the time on "moral liability".

17.2 b. I hoped that compensation would not be the outcome of ministerial deliberations (which, if I recall correctly, were separate from the exercise that had led to the report on heat treatment) because that would have furthered the notion that people should be compensated for events that were not the fault of the NHS - which would lead to damaging financial implications for the provision of services and open up the possibility of compensation for other adverse, albeit inadvertent, effects that

might be associated with NHS treatments in all sorts of areas that we might not be able to predict. Such a hope was in line with departmental thinking at the time.

Q18. Why was Professor Mike Greaves commissioned to take an independent review of the report? [SCGV0000172_054, SCGV0000174_027, SCGV0000174_078]. In addition:

a. How was he selected? Please explain what role, if any, you had in that process.

b. Was he the only academic who had been asked to review the report?

c. Document SCGV0000222_052 indicates that Professor Greaves was also Chair of the SNBTS Clinical Study Monitoring Committee. To what extent was there consideration as to whether his role on this Committee might impugn his independence?

18.1 The Presentation Strategy dated Monday 21 August 2000 included the suggestion that "Any eminent scientist willing to back our findings should be sought for third party endorsement". I commented on that strategy on 25 August to the effect that that we would need to find someone who was not directly involved with SNBTS or the haemophilia directors but who would have enough knowledge of the field to comment authoritatively, and I sought Dr Keel's input (SCGV0000172_069).

18.2 a. Dr Keel's memo of 1 September 2000 to Kate Cunningham in our press office (SCGV0000172_054) said that she had approached Professor Ian Franklin of SNBTS for suggestions, that he had suggested Professor Greaves, and that she had contacted Professor Greaves who had agreed to take the task on. I do not recall having any role in that selection.

18.3 b. I am not aware of any other independent academic having been asked to review the report.

18.4 c. I do not recall consideration of the possibility that Professor Greaves's role as chair of the SNBTS Clinical Study Monitoring Committee might impugn his independence. (The Inquiry might like to check the role and status of that monitoring committee, as I suspect that it monitored and oversaw what SNBTS was doing, rather than having been answerable to the SNBTS. However, I reiterate that I do not recall

consideration of the possibility that Professor Greaves's chairmanship of that committee might be a problem.)

Q19. Following publication of the Report on 24th October 2000, concerns were raised by the Haemophilia Society and campaigners that it was too limited in scope and that conclusions were reached without taking into account the evidence provided by those infected. (HSOC0011980, HSOC0012017, SCGV0000180_084, HSOC0011976, SCGV0000173_031) Please describe what immediate action the SEHD took in response to these criticisms, if any, and the role you played.

19.1 I have very little recollection of what the SEHD did in response to those criticisms. To the best of my recollection, we in the Department already appreciated that the exercise was smaller than the Haemophilia Society had wanted, and had predicted that it would not be happy with the outcome.

19.2 I can see from the papers to which I have been given access that Sandra Falconer, from my branch, advised the minister, both on a response to the Haemophilia Society and on a response to *The Scotsman* newspaper. I do not remember what role, if any, I played in that. I can see that the minister's response of 5 December 2000 to the Haemophilia Society (HSOC001976) explained that the investigation had stuck to its remit. I do not know whether the "line to take" set out in Sandra Falconer's memo of 7 December (SCGV0000173.031) was used.

19.3 Professor Ian Franklin of SNBTS proposed to write to *The Scotsman* newspaper in response to Nicola Sturgeon MSP's article of 12 December 2000, which sought to reiterate the Haemophilia Society's criticisms and contained a number of inaccuracies. Officials consented to his doing so, and he wrote to the newspaper on 13 December. However, his letter was not published. I attach a copy SCGV0000173_141 which I obtained from the Scottish Government, as it shows the thinking at the time.

Q20. On 26 January 2001 you circulated a memo regarding the Health and Community Care Committee and Hepatitis C [SCGV0000174_076]. It sets out the Haemophilia Society's unhappiness with the quality of the report and the request

for a meeting with Susan Deacon. What advice did you give about whether she should meet with the Society and what were your reasons for giving that advice? Document SCGV0000180_084 may assist in answering this.

20.1 I do not recall anything over and above the content of SCGV0000174_076 and SCGV0000180_084. The latter memo may be a draft, given the content of the yellow note on the front page. The Minister replied to the Haemophilia Society's request for a meeting on 5 December 2000 (HSOC0011976).

Q21. What did you mean when you said: "The circumstances surrounding hepatitis C infection of recipients of blood products and whole-blood donations are complex but, I think, neither a mystery nor a cover-up."
[SCGV0000174_076, para 7].

21.1 I meant that it was understandable that knowledge had developed over the years and that, while non-A non-B hepatitis was not completely well understood at first, it had come to be better grasped, and, collectively, we had a fair understanding of what had happened (in my case, even as a lay person). Given the extent of that knowledge, I did not consider that there was evidence of a cover-up.

Q22. The published report states, at page 5, para 6: "we have found it difficult to access relevant information from our own files. Some of them had been destroyed, presumably during routine procedures for the review and disposal of files". As to this:

a. What investigation took place, if any, to reach the conclusion that files had been destroyed as a result of "routine procedures"? Who undertook this investigation?
b. Was a log kept of the files that were destroyed?
c. Do you know which files were destroyed and when and why?
d. Do you know what the content of those files were?

22.1 a. I do not recall the details, but in order for me to assert that files had been destroyed, there would have to have been some documentary evidence.

22.2 b. In general, records were kept of the requirement to review official files, and there were protocols for retention or destruction. The destruction of files in line with those protocols was not unusual. I do not recall where or how such records were kept (whether centrally, departmentally or at branch level), and I do not recall the details of our access to such records in the case of the files in question.

22.3 c. I do not recall the details of what I knew at the time about which files were destroyed and why.

22.4 d. I do not recall what I knew about the content of those files.

Section 3: Calls for a public inquiry

Q23. Please outline, to the best of your recollection, your understanding of the reasons why the Scottish Executive refused to hold a public inquiry into infected blood and blood products during your employment at the SEHD.
Documents MACK0001929_017, SCGV0000178_004, HSOC0011830, DHSC0006562_259, HSOC0020387_015, SCGV0000174_027 and SCGV0000181_078 are provided for background.

23.1 To the best of my recollection, the Executive was wary of calls for public inquiries in general, as they occasioned substantial consumption of resources. If the Executive considered that the salient facts of an issue were already known, or could be got at in a less costly way, it would resist a call for a public inquiry.

Q24 In a memo written to you from Linda Towers dated 10th April 2000, she expresses a number of concerns surrounding the procedure of holding a public inquiry [SCGV0000171_038].
a. What event or events led you to seek the opinion of Ms Towers on the options for holding a public inquiry?
b. Was the Scottish Executive considering holding a public inquiry at this time?
c. In paragraph 6, Ms Towers states that an Inquiry would be possible under the Tribunals of Inquiry (Evidence) Act 1921 but she “would not have thought that this is the sort of power you would wish to invoke for an inquiry of this kind”. What was your understanding of this comment? Did you agree with it?

d. What action, if any, did you take on receipt of this memo?

24.1 a. I do not recall what event or events led to my seeking Mrs Towers's opinion on the options for holding a public inquiry.

24.2 b. I do not recall whether the Scottish Executive was actively considering holding a public inquiry at the time. It is at least equally likely that, on my own initiative, I was gathering information on the powers available for ministers if they were minded to go down such a route; in general, it was my practice to describe all the options that were reasonably available to them in determining a course of action.

24.3 c. I do not recall what my understanding was of that comment at the time but, reading the memo now, my understanding is that setting up an inquiry under the Tribunal of Inquiry (Evidence) Act 1921 would have been a more administratively cumbersome (and perhaps politically momentous) option than using section 76 of the National Health Service (Scotland) Act 1978.

24.4 I am not sure that it was for me to "agree" with the opinion of the department's legal adviser, but it is likely that I would have been inclined to accept her advice.

24.5 d. I do not recall what action, if any, I took on receipt of that memo.

Q25. In your view, was the Scottish Executive report referred to in Section 2 above, undertaken to deflect calls for an independent public inquiry?

25.1 I am genuinely unsure. I do not recall that I considered that calls for a public inquiry would in fact be deflected. My focus in conducting the investigation was to examine the difference between Scotland and England in the development of heat treatment for blood products and the experience of haemophilia patients in being able to access information. However, it is also the case that, insofar as the facts that the report set out were accepted, the rationale for holding a public inquiry would diminish.

Section 4: The Irish Tribunal

Q26. On 7th March 2000, representatives of SNBTS were invited to give evidence at the Lindsay Tribunal into HCV and HIV infection via contaminated blood (the "Irish Tribunal").

a. Please outline your role, if any, in the decision-making process regarding whether SNBTS witnesses should give evidence to the Irish Tribunal.

b. Were the Scottish Executive and those advising reluctant to allow the representatives to participate? If so why?

c. What was your understanding of the phrase: "the possible dangers of SNBTS becoming involved in areas we would not wish them to" [SCGV0000194_034, para 5]?

The following documents may assist in answering these questions: SCGV0000194_047, SCGV0000194_052, SCGV0000194_043, SCGV0000194_040, SCGV0000194_030, SCGV0000194_034, SCGV0000194_035 and SCGV0000194_028.

26.1 I have no recollection of these issues, other than what I have read in the papers that the Inquiry has shared. It seems from the documents that I and my departmental colleagues were inclined in favour of co-operation with the Tribunal, and I recognise that spirit of openness. It seems that our solicitor was concerned, not that there was information that the department would rather not be disclosed, but that SNBTS witnesses might be coerced in cross examination to erroneously concede points, provide personal opinion, or prejudice live litigation.

Q27. Following the publication of the Scottish Executive report referred to in Section 2 above, the issue of SNBTS witnesses appearing at the Irish Tribunal was revived (SCGV0000194_017, SCGV0000194_018, SCGV0000194_016, SCGV0000095_026). Please clarify whether or not you met with the Irish Tribunal solicitor and/or Irish officials as proposed by Sandra Falconer. If not, why not?

27.1 I do not recall whether I met with them.

Q28. If you did meet with the Irish Tribunal solicitor and/or Irish officials, please outline, to the best of your recollection, the discussion that took place, the

identity of those attending the meeting and any agreement reached.

28.1 I have no recollection of such a meeting.

Q29. On 19th January 2001 you sent a memorandum to Colin Troup of the Office of the Solicitor to the Scottish Executive (OSSE) seeking his advice [SCGV0000194_010]. On balance, your view was in favour of Dr Peter Foster of SNBTS attending the Irish Tribunal. Please expand upon how and why you reached this view. A response to your memorandum sent on behalf of Mr Troup is provided for background information at SCGV0000194_008.

29.1 I have no recollection of this issue other than what I have read in the papers that the Inquiry has shared with me.

Q30. In a further memorandum from you to Ministers dated 30th January 2001, you once again recommend Dr Foster's attendance [SCGV0000194_007]; responses from Ministers are provided at SCGV0000194_006, SCGV0000194_005 and SCGV0000194_004, including Health Minister Susan Deacon's agreement to your proposal.

a. Please expand upon your comment: "questions may be asked as to why Ministers have given their agreement to SNBTS' participation in an Irish tribunal, when they declined to operate a public inquiry in Scotland." Did you believe the two were inconsistent? Please explain your answer.

b. Please explain your phrase: "If Ministers decide the request should be declined, it should be possible to do so with grace".

30.1 a. I do not recall whether I personally thought the two were inconsistent, but I must at least have thought that there was a presentational disconnect between them.

30.2 b. I may have meant that the request could be declined for reasons that the Irish tribunal would understand.

Section 5: Other

Q31. Please provide any further comment that you wish to provide about matters of relevance to the Inquiry's Terms of Reference.

31.1 I have nothing to add.

Statement of Truth

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

Signed GRO-C

Dated 13 October 2022

Table of exhibits:

Date	Notes/ Description	Exhibit number
09/11/99	Letter from Susan Deacon to the Haemophilia Society	HSOC001177
25/04/00	Internal memo from Christine Dora to Minister for Health and Community Care (Susan Deacon) enclosing draft report and making recommendations for disclosure and consultation.	SCGV0000171_029, SCGV0000171_030
13/12/00	Letter from Ian Franklin (not published) to the Scotsman responding to article published 12 December 2000.	SCGV0000173_141