

1 **Monday, 25 July 2022**

2 (9.59 am)

3 **SIR BRIAN LANGSTAFF:** Good morning, Professor Keel.

4 **THE WITNESS:** Good morning.

5 **SIR BRIAN LANGSTAFF:** You can hear me then. Can you see me?

6 **THE WITNESS:** I can.

7 **SIR BRIAN LANGSTAFF:** Good.

8 Now, in a moment or two I'm going to invite Mary

9 to ask you to take the oath, but let me first explain

10 the situation, and you can tell us before I do that,

11 even, what yours is. You're in the offices of your

12 lawyers, are you?

13 **THE WITNESS:** That's right.

14 **SIR BRIAN LANGSTAFF:** In Edinburgh, is it?

15 **THE WITNESS:** In Edinburgh.

16 **SIR BRIAN LANGSTAFF:** In Edinburgh. Are you on your own at

17 the moment in the room or not?

18 **THE WITNESS:** I am, the technician has just left.

19 **SIR BRIAN LANGSTAFF:** Thank you. You're talking to a small

20 audience here in Aldwych House in London, directly, that

21 is. A slightly greater number of lawyers than there are

22 participants, but beyond this room, you will be talking

23 to a very large number of participants, probably

24 numbering in three figures. I imagine quite a few

25 probably in Scotland. They follow on live stream and on

1

1 **Q.** Then we can see you began your haematology training in

2 1979 and undertook that until 1981. I'll come back to

3 some of these areas in due course. You were then

4 Leukaemia Research Fund Fellow at the Royal Hospital for

5 Sick Children in Glasgow between January 1981 and

6 January 1983; is that right?

7 **A.** Yes.

8 **Q.** Again, I'll have some questions in relation to that.

9 You then worked at the Royal Infirmary Glasgow as

10 a registrar in haematology between February 1983 and

11 August 1986; is that correct?

12 **A.** Yes.

13 **Q.** Then you moved to London and you had various posts at

14 senior registrar and consultant level, St Mary's

15 Hospital, Middlesex Hospital, and the Cromwell Hospital

16 and Central Middlesex Hospital in the second half of the

17 1980s and early 1990s?

18 **A.** Yes.

19 **Q.** You then moved to work in Government. You worked with

20 the Scottish Home and Health Department, first of all as

21 a senior medical officer between March 1992 and

22 December 1998; is that right?

23 **A.** Yes.

24 **Q.** You were then Principal Medical Officer, December 1997

25 to June 1999?

3

1 YouTube.

2 Now Mary, please.

3 **PROFESSOR AILEEN KEEL (sworn)**

4 **Questioned by MS RICHARDS**

5 **MS RICHARDS:** Professor Keel, can you see and hear me?

6 **A.** Yes, I can.

7 **Q.** I am going to start with an overview of your career,

8 which we can take from one of your witness statements.

9 Lawrence, could we have WITN5736003 on screen,

10 please. We can pick it up at the bottom of the page,

11 Professor Keel, where we can see you describe a number

12 of house officer positions in the late 1970s, and then

13 undertaking work as an honorary registrar in haematology

14 in Edinburgh, August 1979 to July 1981.

15 Just pausing there, is it right then to understand

16 that you qualified as a doctor, a medical doctor, in the

17 1970s and you undertook a range of house officer and

18 registrar posts between 1977 and '79?

19 **A.** Indeed, I qualified in 1976 from Glasgow University.

20 There are a couple of earlier posts, which are

21 acknowledged further down in this statement that are

22 missing. So I did -- JHO (junior house officer) posts,

23 the year after I qualified in the Victoria Infirmary in

24 Glasgow and in Dumfries and Galloway Hospital, before

25 these SHO posts that are mentioned.

2

1 **A.** I think it was December 1998.

2 **Q.** I'm sorry, yes, you're right. My apologies.

3 You were then Deputy Chief Medical Officer between

4 June 1999 and 2014 in Scotland?

5 **A.** Indeed.

6 **Q.** Then you were, for a year between April 2014 and

7 April 2015, Acting Chief Medical Officer to the Scottish

8 Government?

9 **A.** Yes.

10 **Q.** We can take that down, thank you, Lawrence.

11 You, from 1995, were an honorary consultant

12 haematologist with NHS Lothian. What did that entail,

13 in broad terms?

14 **A.** It entailed me doing one general haematology clinic per

15 week at Edinburgh Royal Infirmary.

16 **Q.** Okay, and what, in broad terms, was the purpose of

17 continuing to do that work whilst working primarily as

18 a medical officer within the Scottish Home and Health

19 Department?

20 **A.** Well, it's interesting, when I joined the Department in

21 '92, the idea of doing outside work to keep one's hand

22 in, so to speak, wasn't really thought necessary, but

23 I'd always thought that it would be a good idea for me

24 to maintain a clinical base, particularly given that

25 I was looking after, right from the beginning, blood

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1 transfusion, as well as the laboratory specialities,  
 2 including my own haematology. So I was keen to take up  
 3 this honorary post with Lothian and the then CMO agreed,  
 4 and that's how it came about.

5 **Q.** Over what period of time did you do that work? So from  
 6 1995 until when?

7 **A.** To 2017.

8 **Q.** Then, having stepped down as Acting Chief Medical  
 9 Officer, you were, from 2015 until recently, the  
 10 director of the Innovative Healthcare Delivery Programme  
 11 within the University of Edinburgh, and I think you're  
 12 now a senior advisor to that program but no longer  
 13 director. What, in broad terms, is that program?

14 **A.** Well, it's what it says on the tin, really it's  
 15 a programme aiming to make better use, innovative use,  
 16 of the data that's available. So I was seconded out,  
 17 because I'd a longstanding ambition, which was shared by  
 18 many of my senior colleagues, to make better use of  
 19 cancer data to improve cancer outcomes in Scotland.

20 So IHDP when it started had cancer as its focus  
 21 and we'd done a great deal to bring all the various  
 22 cancer datasets together in one accessible place so that  
 23 clinicians, researchers, Health Service managers can get  
 24 into the data and look at whatever aspect of cancer they  
 25 want to examine in a much easier way than was previously

5

1 **A.** Indeed.

2 **Q.** Does it follow you were not asked to give evidence to  
 3 the Penrose Inquiry on any other issue?

4 **A.** That's correct.

5 **Q.** Now, I want to ask you a little more about some of the  
 6 aspects of your clinical career in haematology. Under  
 7 which haematologists did you principally train?

8 **A.** Well, in Aberdeen that would have been Audrey Dawson and  
 9 Bruce Bennett, and in Glasgow it was George McDonald,  
 10 Isobel Walker and other colleagues. In the 'Sick Kids'  
 11 in Glasgow, it was Michael Willoughby. So yes, those  
 12 were the main people involved in my training.

13 **Q.** If I can ask you to just think back to your work at the  
 14 Royal Hospital for Sick Children at Yorkhill between  
 15 January '81 and January '83, what was your work? It's  
 16 described on your CV and in your statement as "Leukaemia  
 17 Research Fund Fellow". What in practice did it entail?

18 **A.** Well, in essence, it was a training programme in  
 19 paediatric haematology but the main focus of my work was  
 20 on the cancer side of paediatric haematology. I was  
 21 looking after children with acute leukaemia, with other  
 22 tumours that occur in childhood.

23 There was, of course -- there were, of course,  
 24 a number of, in the main, boys with bleeding disorders,  
 25 with haemophilia A and B, and I was involved in

7

1 available.

2 So most of those datasets either sit within the  
 3 Scottish Cancer Registry or are closely linked to it.  
 4 So using modern technology like data virtualisation,  
 5 it's very easy for someone going into the Cancer  
 6 Registry to link into other national datasets held by  
 7 Public Health Scotland.

8 So the aim was to optimise the data, which the NHS  
 9 is awash with, to better understand why, for example,  
 10 cancer outcomes in Scotland are not as good as in the  
 11 rest of the UK or, indeed, comparable other countries.

12 **Q.** During your time as medical officer, senior principal  
 13 and Deputy CMO, you attended a range of different  
 14 committees and working parties and groups, either as  
 15 an observer or participant. We'll come back to some of  
 16 those in more detail but, is this right, they included:  
 17 the Advisory Committee on the Virological Safety of  
 18 Blood; the Advisory Committee on the Microbiological  
 19 Safety of Blood and Tissue; SNBTS's Medical and  
 20 Scientific Committee; and the Coagulation Factor Working  
 21 Party?

22 **A.** Yes.

23 **Q.** You gave written and oral evidence to the Penrose  
 24 Inquiry. Is it correct that your evidence to the  
 25 Penrose Inquiry was confined to the issue of look-back?

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1 a peripheral way in looking after them, but actually  
 2 there was another couple of -- I guess it would be  
 3 described as associate specialists who came in part-time  
 4 to help Dr Willoughby manage that side of his practice.  
 5 So although I think I said in my statement, from time to  
 6 time, I would prescribe Factor VIII concentrates for  
 7 these boys, in the main, Dr Willoughby and the other  
 8 staff members took care of them. I was mainly looking  
 9 after children with malignancy.

10 **Q.** Do you recall what training or instructions or advice  
 11 you received from Dr Willoughby or from the other  
 12 associate specialists you refer to in relation to the  
 13 treatment of the boys with haemophilia?

14 **A.** Well, I'm afraid at this distance, not really is my  
 15 answer. I mean, obviously, over the course of my career  
 16 I gleaned -- because of my training, I gleaned  
 17 significant knowledge about bleeding disorders. So  
 18 I can't really pinpoint what component of that was  
 19 obtained at Glasgow Sick Kids.

20 **Q.** You've said in your statement that you were aware at the  
 21 time that Dr Willoughby preferred to use commercial  
 22 concentrates rather than PFC commercial concentrates.  
 23 Were you aware at the time of what might be described as  
 24 the prevailing view amongst other Haemophilia Directors  
 25 in Scotland that the exclusive use of domestic

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1 Factor VIII was safer than commercial concentrates?

2 A. Oh, yes, I was, because, having come from Aberdeen where

3 I was involved again in the treatment of haemophilia

4 patients, that was very much the view, that one used

5 homegrown products wherever possible. Dr Willoughby's

6 view was different for I think a variety of reasons.

7 One was I think he felt that the Scottish product was

8 less easy to make up from -- than the commercial

9 products and less easy to administer to children.

10 I didn't really have a view, and I don't now, on

11 that aspect. But I think also he felt that supplies of

12 Factor VIII and IX, Scottish Factor VIII and IX, were

13 perhaps not as reliable as he might have wanted, so his

14 back stop was commercial products.

15 Q. Do you recall ever having any discussions with him,

16 whether initiated by him or others or by you, about the

17 relative risks of the commercial concentrate versus the

18 domestic concentrate, particularly having regard to the

19 fact that the patient cohort comprised of children?

20 A. No, I'm afraid I can't remember any such conversations.

21 Q. And what advice or guidance or instruction were you

22 given as to the information you should provide to

23 patients or, if they were young children, parents, about

24 the risks of the concentrates which you were prescribing

25 or administering?

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1 Infirmary '83 to '86, what did that entail in broad

2 terms?

3 A. A whole variety of the gamut of haematological

4 conditions. Clearly I did clinics with consultants and

5 other junior colleagues, covering, you know, general

6 haematological conditions. I was asked by one of those

7 consultants who looked after the leukaemia side and the

8 bone marrow transplant side to set up a clinic for

9 myeloma patients, which I ran on my own towards the end

10 of my training. There was a lot of laboratory-based

11 work: reading blood films, bone marrow aspirates,

12 coagulation tests. So we were -- the room in which

13 I sat was populated by registrars and senior registrars

14 all sitting at their microscopes. The labs were along

15 the corridor. We'd be back and forth discussing results

16 with the technical staff. Consultants were nearby.

17 And we also -- or I also latterly began to do

18 haemophilia clinics or bleeding clinics with -- it was

19 a rather curious arrangement in Glasgow, in that the

20 clinicians who looked after the haemophilia patients

21 were not haematologists. They were physicians with an

22 interest in bleeding disorders. You have to remember

23 that haematology is actually a relatively young

24 specialty, only really developed in the 1960s. So what

25 had happened in Glasgow Royal was that the

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1 A. Well, I mean, I can't remember any specific conversation

2 with Dr Willoughby about this, but of course everyone

3 who was working in haematology at that time was aware of

4 the risk of viral transmission by these products. But

5 I should explain that at Yorkhill, I was never seeing

6 patients before they had been treated, patients and

7 their parents. Dr Willoughby saw all the new patients

8 and he would have had that conversation with the parents

9 before treatment was initiated.

10 So in fact my role in managing the haemophilia

11 patients was really very much restricted to prescribing

12 Factor VIII concentrates which were then administered by

13 the nursing staff.

14 Q. Now, Dr Willoughby left Yorkhill, as I understand it, at

15 the end of 1982. Did you have any knowledge of the

16 circumstances of his departure, of why he was moving on?

17 A. Other than that he was moving to Australia, no, he

18 didn't discuss his reasons for moving.

19 Q. And you then left or moved on in January 1983 and took

20 up a post in Glasgow Royal Infirmary. Why did you move

21 from Yorkhill to the Royal Infirmary?

22 A. Well, I needed to complete my haematology training and

23 I'd done two years in paediatrics. That's plenty.

24 I needed to get back into adult haematology.

25 Q. Then in relation to your work at the Glasgow Royal

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1 laboratory-based aspects mainly, and the general

2 haematological conditions, were looked after by

3 haematologists, Dr McDonald I've already mentioned being

4 the most senior, and the haemophilia patients were

5 looked after by Professor Charles Forbes and his team.

6 And in the latter part of my training at Glasgow

7 Royal, I think the senior clinicians thought, well, it

8 would be a good idea if we could deliver joint -- more

9 joint training, using the haemophilia clinics for the

10 haematology registrars. So I would do I think it was

11 a weekly clinic with, mainly, Professor Gordon Lowe, so

12 that we were still getting experience of managing

13 haemophilia patients.

14 Now, most of these were very, very longstanding

15 patients, mainly with -- well, the problems that arise

16 from bleeding into joints. Many of them were very

17 disabled, with arthritic elbows and knees and hips, as

18 well as, you know, other general medical problems that

19 arise in any -- anybody.

20 So that was the sort of range of haematological

21 areas that I was exposed to in the course of my training

22 at Glasgow Royal. And it was then that I sat the exit

23 exam, if you like, for haematology, the membership for

24 the Royal College of Pathologists.

25 Q. The clinic that you've referred to participating in

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1 towards the latter part of your time there, doing the  
 2 best you can, what year do you think that commenced?  
 3 A. Um ... well, I'm really guessing here. I would think  
 4 maybe '84.  
 5 Q. And understanding that that's a guess or an estimate  
 6 rather than a precise recollection, do you have any  
 7 recollection of what, if any, information was provided  
 8 to patients about the risks of transmission of HTLV-III?  
 9 A. No, I'm afraid I've no clear recollection. I mean,  
 10 patients would certainly have been told their results of  
 11 blood tests, you know, various blood tests in the clinic  
 12 but I can't remember -- I can't remember anything in the  
 13 way of written information being provided for them, if  
 14 that is what you're asking.  
 15 Q. The question was a broader one. I appreciate it's  
 16 a considerable period of time ago. But it's whether you  
 17 have any recollection of you or Professor Lowe or any  
 18 others giving information to patients about the possible  
 19 risks of what might have been referred to then as AIDS  
 20 or, at a point in time, HTLV-III from the concentrates  
 21 with which they were being treated?  
 22 A. I'm afraid I've no clear recollection of any such  
 23 discussions.  
 24 Q. Okay.  
 25 Moving then to your roles in Government. How did

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1 Scottish Home and Health Department or, later, the  
 2 Scottish Executive Health Department?  
 3 A. No.  
 4 Q. And what other areas of responsibility did you have and  
 5 how did that change over time?  
 6 A. Well, I've already mentioned laboratories, so, from very  
 7 early on, those were the areas that I was looking after.  
 8 But it didn't take very long for additional things to be  
 9 added. For example, general medical specialities, which  
 10 cover the whole gamut of diabetes, respiratory, cardiac,  
 11 you know, so I had responsibility for those, and later  
 12 on cancer. And from, I think -- certainly the early  
 13 2000s I was chair of the Scottish Cancer Taskforce.  
 14 So, apart from surgery, which was looked after by  
 15 another SMO, and apart from women and children's health,  
 16 which again were the responsibility of others, I covered  
 17 a wide range of what I'd call "medical issues".  
 18 Q. And during the course of the 1990s, roughly how many  
 19 medical officers, whether senior medical officers or  
 20 principal medical officers, were there in the Scottish  
 21 Home and Health Department?  
 22 A. I think -- I should have done this sum. I could have  
 23 done this sum earlier if I'd known it was -- the  
 24 question was going to arise. I think probably about 15,  
 25 in total. Because --

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1 you come to apply for the role which you took in 1992?  
 2 What led you to move into governmental advisory work  
 3 from full-time clinical work?  
 4 A. Well, in 1991 I had my son, who is now 31. So I was in  
 5 London with my to-be husband and we made a collective  
 6 decision that me coming back to Scotland with Alexander,  
 7 educating in Scotland, would be the best move. So I was  
 8 also keen to move out of full-time clinical work with  
 9 on-call commitments that that obviously entails. So  
 10 I began to cast my net wider, and this opportunity came  
 11 up. I was encouraged to apply for it, and got the job.  
 12 Q. And encouraged by whom to apply?  
 13 A. The people who were working in the Scottish Office at  
 14 that point. You know, obviously in one context people  
 15 do a chat about jobs before one applies, and from what  
 16 they gleaned about my background, they encouraged them  
 17 to apply.  
 18 Q. Now you've said in your statement that part of your  
 19 portfolio of responsibilities was responsibility for  
 20 medical advice in relation to blood and blood products.  
 21 And was that the case from the beginning, in terms of  
 22 your role as Senior Medical Officer, through to the end  
 23 when you became Acting Chief Medical Officer?  
 24 A. Yes. Yes.  
 25 Q. Were there any other haematologists working within the

14

1 Q. And -- sorry.  
 2 A. -- one area which was looked after by suitably qualified  
 3 PMO and SMOs, was that of mental health.  
 4 Q. Then post-devolution, so into the 2000s, was it broadly  
 5 a similar number of medical officers or was there  
 6 a significant increase or, indeed, decrease in the  
 7 number of medical officers?  
 8 A. Well, there wasn't a significant increase, but my  
 9 recollection is that round about that time, we were  
 10 bringing in -- I use the term "we" loosely, and I'll  
 11 explain why in a minute -- clinicians were being brought  
 12 into Government on NHS secondment terms rather than  
 13 being employed as civil servants. So policy leads would  
 14 often see the benefit of having specific clinical advice  
 15 in a given area, and they would therefore approach  
 16 someone working for the NHS, offer them a secondment to  
 17 come in on a part-time basis, usually, to help out, give  
 18 advice. So the overall number of doctors employed  
 19 directly by the Civil Service didn't grow, but the  
 20 overall cohort of medical advisers to the Department  
 21 did, round about that time.  
 22 And I mentioned in my submission that as DCMO  
 23 I held weekly meetings with all of the doctors, or as  
 24 many as were available on a Monday morning to come  
 25 along, and I think usually the room had -- well, at

16



1 least 15 people in it, and there would be others who  
2 couldn't attend every week. So those were roughly the  
3 numbers.

4 Q. In terms of infectious diseases, was that something  
5 which fell within your portfolio of responsibilities in  
6 the '90s or was that the responsibility of a different  
7 SMO or PMO?

8 A. It was not my responsibility, other than in the -- in  
9 relation, for example, to blood transfusion. I mean,  
10 clearly there's an overlap, and -- but, no, infectious  
11 diseases were dealt with on the Public Health side of  
12 the House. The structure of the Department has changed,  
13 you know, over -- morphed over many years through  
14 different forms.

15 When I joined in 1992 it was split into the  
16 Management Executive under a chief exec from the NHS,  
17 who would have been appointed from the NHS, which looked  
18 after the NHS side of the House and was very much into  
19 the operationalisation of Health Services and then the  
20 other side of the House was the Public Health division,  
21 which was headed up by a career civil servant, and  
22 under -- in that bit of the business, infectious  
23 diseases of all types would be looked after. And there  
24 were number of those, a PMO and a number of SMOs  
25 involved in looking after those areas.

17

1 Q. Don't worry, we'll look at various documents over the  
2 course of your evidence and if that triggers your memory  
3 please say so, or if, overnight, any names come to you,  
4 please, you can let us know tomorrow.

5 Just to get a sense of your work in the 1990s, is  
6 it possible for you to give us a flavour of your average  
7 week as a Senior Medical Officer, what kind of  
8 activities it might entail?

9 A. Well, I always used to say to new recruits that the  
10 wonderful thing about working in government is no one  
11 day is like another. There was enormous variety. So  
12 are you asking me to look back to the beginning of my  
13 career?

14 Q. Well, just in the 1990s, as a Senior Medical Officer,  
15 what might a typical week look like, to the extent that  
16 there was one?

17 A. Well, loads and loads of paperwork; looking at documents  
18 of a variety of kinds, some coming from policy  
19 colleagues who were looking for a view on perhaps  
20 submissions that they were going to put up to ministers;  
21 helping to answer Parliamentary questions which might  
22 have cropped up; going out and about and visiting  
23 clinicians; going to laboratories; various meetings, for  
24 example, with SNBTS; attending committee meetings in  
25 Scotland, and south of the border, such as ACVSB;

19

1 Q. Then, in terms of those who had responsibility for  
2 policy, in the course of the 1990s, in matters relating  
3 to blood, blood products and the issues that were  
4 arising in relation to blood and blood products  
5 including issues about -- issues will come on to  
6 explore -- but look-back, financial support, and so on,  
7 who were the civil servants responsible for policy  
8 development that you were primarily interacting with?

9 A. Probably George Tucker and his -- of the office that --  
10 I think George was an assistant principal secretary.  
11 Actually, I can't remember the terms, it would have  
12 changed anyway over the years, but yes, George Tucker  
13 and his team were the ones that I interacted with most  
14 over that period.

15 Q. Then when we get into the period when you were  
16 Deputy Chief Medical Officer, in particular the first  
17 decade of this century, who were you primarily  
18 interacting with on the policy or administrative civil  
19 servant side, again in relation to issues relating to  
20 blood, blood products and infected blood?

21 A. Well, a whole range of different people, because people  
22 came in, moved on and so, at more junior level -- I'm  
23 struggling now to remember who, during that period, was  
24 the most senior person I -- I'm sorry, my memory just  
25 isn't all that good.

18

1 supporting ministers as required; you know, attending  
2 events that ministers might be speaking at or meetings  
3 with the NHS that ministers were attending.

4 So a very wide range of activities and, as I said,  
5 never a dull moment.

6 Q. Then just picking up on interactions with ministers,  
7 again, concentrating on the 1990s first of all, as  
8 Senior Medical Officer, Principal Medical Officer, to  
9 what extent and with what degree of regularity would you  
10 have direct interaction with ministers?

11 A. Infrequently, would be the word I'd use.

12 Q. Did that change when you became Deputy Chief Medical  
13 Officer?

14 A. Yes, and that was exactly at the time of devolution  
15 anyway, so things were going to be changing, more as --  
16 well, I would have had more exposure as DCMO anyway but  
17 that, combined with devolution, gave rise to a very  
18 significant change in exposure to ministers after 1999.

19 Q. You told us that whilst blood, blood products was your  
20 responsibility, infectious diseases was the  
21 responsibility of other medical officers. Did that  
22 demarcation run the risk of insufficient attention being  
23 paid to the risks of transmissible disease from blood  
24 and blood products, when ministers were being advised or  
25 when policy was being formulated?

20

1 A. No, I don't recollect that being any barrier to briefing  
2 ministers accurately. The meeting that I referred to  
3 earlier was -- with the SMOs, and I instituted -- was  
4 actually, in the main, to overcome such potential  
5 barriers to easy communication, because everybody who  
6 attended would share their headline issues with  
7 everybody else and, very often, we picked up an overlap  
8 that hadn't previously been identified, and whoever the  
9 individuals were would (unclear) out of the meeting.

10 So that was one very visible way where any  
11 potential barriers to communication between the Public  
12 Health side of the House and the NHS side, if I can use  
13 that phrase, were bridged.

14 Q. Does it follow from the fact that you said you  
15 instituted that arrangement that, in the 1990s, pre you  
16 taking on the role of Deputy Chief Medical Officer, that  
17 there was not an equivalent arrangement in place then?

18 A. No, I don't mean that. There were different  
19 arrangements. When I started in 1992, the way that the  
20 medical division was structured was under, I think, four  
21 principal medical officers, who each had a small team of  
22 SMOs working to them. And those four PMOs met weekly  
23 with the CMO and the DCMO on the Monday morning,  
24 actually, and they would go into that meeting with the  
25 CMO having already met with their team of SMOs so they

21

1 a minister or not, or was it very ad hoc?

2 A. I wouldn't say "ad hoc". I mean, anything with -- and  
3 I've said this in my written statement -- the potential  
4 to impact on individual health or public health would  
5 have been drawn to the attention of ministers. It's  
6 really impossible to define criteria for that action  
7 but, you know, the issues of the day, the crisis, you  
8 know -- for example there's something in the news this  
9 morning, a report from the Health Committee down south  
10 about NHS workforce, you know, that's the kind of thing,  
11 of course, the ministers would be briefed on, you know,  
12 if there was a perceived problem/issue with the NHS or  
13 indeed with Public Health. Those are the issues that  
14 would have merited ministerial briefing.

15 Q. Can I ask you to look at a document with me. It's  
16 ARCH0003312\_020. If we just zoom in on the top half of  
17 the page, please, Lawrence.

18 You'll see, Professor Keel, this the "Note of  
19 meeting ... on 10 February 2000 ... to discuss  
20 information required to assist in the examination of  
21 circumstances surrounding the safety of SNBTS blood  
22 products from hepatitis C".

23 Am I right in understanding that this is part and  
24 parcel of the investigation that was commissioned by the  
25 Scottish Executive in 1999?

23

1 were fully briefed on issues that were on our radar  
2 screen, they then could be a DCMO and the CMO. And they  
3 would cascade any other information arising in that CMO  
4 meeting with us as SMOs. Occasionally, if the PMO  
5 wasn't able to attend, an SMO such as myself would  
6 attend instead at the CMO meeting.

7 So by the late '90s, that PMO structure had begun  
8 to change and there was -- there were much less discrete  
9 teams, if you like, looking after, for example, mental  
10 health, women's health, general medical conditions, such  
11 as I was looking after. As PMOs retired, they weren't  
12 automatically replaced so it was more of a team of --  
13 a big team of SMOs. So by the late '90s, the need for  
14 a weekly meeting of some sort was obvious, and that's  
15 why I instituted it.

16 Q. Now, how was it determined whether a particular matter  
17 or decision needed to be drawn to the attention of  
18 ministers?

19 A. Well, that decision would, in the vast majority of  
20 cases, be for policy leads in a given area and not for  
21 the medical team to be deciding.

22 Q. Did you, from the many years you worked there, and  
23 inputting into the formulation of policy, inputting into  
24 briefing to ministers, did you get any sense of what the  
25 criteria might be for something needing to go to

22

1 A. Yes. I imagine it is. Yes.

2 Q. I'm going to ask you about that at a later stage of your  
3 evidence, in terms of the detail of the process, but for  
4 present purposes, could you just help us understand the  
5 relative roles of some of those who are identified as  
6 attending this meeting.

7 First of all, we can see a reference there to the  
8 Health Care Policy Division. This is now obviously  
9 early 2000, what was the Health Care Policy Division?  
10 What was its remit and role?

11 A. Clearly it covered blood transfusion but I honestly  
12 can't remember what else Thea Teale looked after but  
13 that would not be the only area she was responsible for.  
14 You can see, further down the list, Christine Dora,  
15 Health Care Policy Division Branch 3. So clearly in  
16 Thea Teale's area of responsibility there were many  
17 branches, but I can't really remember, apart from blood  
18 transfusion, what they covered.

19 Q. Do you recall what the role within branch 3 of that  
20 division was of Christine Dora? If we leave aside for  
21 the moment her role in relation to the report and the  
22 investigation, which we'll come on to, do you recall  
23 what her general responsibilities were?

24 A. I think Christine at that point -- and this is one of  
25 the many posts that changed over the years, the

24

1 individuals occupying that post -- she was what you  
2 might -- she was head of branch, the branch that looked  
3 after blood transfusion --

4 Q. And --

5 A. -- and Sandra Falconer was one of her staff.

6 Q. We can take that down, thank you.

7 When devolution took place/came to fruition in  
8 1999, what, if any, systems were in place to ensure that  
9 the Scottish Executive had access to the paperwork and  
10 sources of information that had been held by the  
11 Scottish Home and Health Department as part of the  
12 Scottish Office?

13 A. Well, all of those files would have been there, and --  
14 I mean, there was no enormous gear change in 1999, in  
15 terms of the office operations. So the files that had  
16 been available to Scottish Office were, of course,  
17 available to the SE.

18 Q. Then, in terms of Public Health more generally, you've  
19 referred to, in the 1990s, the division that you  
20 described in broad terms between Public Health, on the  
21 one hand, and the NHS Executive and the organisational  
22 NHS matters on the other. Over your time as a medical  
23 civil servant, so starting with the '90s, coming through  
24 into this century, what individuals or entities were  
25 particularly responsible for the protection of public

25

1 I can't quite remember when Andrew came into post, but  
2 Andrew was public health trained, and he was more  
3 focused on the Public Health side of the House, if you  
4 like. And then Peter Donnelly, again, I can't remember  
5 when he came in.

6 So there were periods when there were two DCMOs, even  
7 during the time that I was DCMO. At the beginning,  
8 there was only me and, towards the end of my tenure,  
9 there was only me. I understand now there may be three  
10 DCMOs. So it did vary, and depending who -- both  
11 Andrew Fraser and Peter Donnelly, had public health  
12 backgrounds. So, naturally, their focus was more on  
13 that side of the House, but we always worked very, very  
14 closely together, particularly in areas that, you know,  
15 weren't strictly speaking NHS or Public Health.

16 There's a great -- clearly a great overlap between  
17 the two in all sorts of ways and we may come onto that  
18 later when we talk about variant CJD, for example.

19 Q. Were there any bodies or organisations external to the  
20 Scottish Home and Health Department, so sticking with  
21 the '90s for the moment, that provided advice to  
22 Government specifically on Public Health in Scotland?

23 A. Well, there's another committee that I attended that  
24 isn't actually on the list of committees you highlighted  
25 earlier, and that was the Advisory Committee on

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1 health?

2 A. You mean the names of the people that were involved in  
3 running that side of the House?

4 Q. Well, it's a slightly broader question than that. So if  
5 I break it down into two periods, if we start with the  
6 period from 1992 to 1999, would it be right to  
7 understand from your earlier evidence that  
8 responsibility for Public Health rested primarily with  
9 the division that you'd described?

10 A. That's right, yes.

11 Q. Who, as far as you can recall, headed that division?

12 A. Well, one senior civil servant Nicky Munro did, for  
13 a long number of years.

14 Q. Was there, in terms of the roles of Deputy Chief Medical  
15 Officer and the Chief Medical Officer in the 1990s, was  
16 there one individual who had any particular  
17 responsibility for Public Health more than any other in  
18 those roles?

19 A. Well, the CMO always had to cover everything. So, you  
20 know, whether it was NHS or Public Health related, that  
21 role covered everything. As far as DCMO was concerned,  
22 when I joined, Andrew Young was DCMO and he covered  
23 everything.

24 During the ensuing years, there was a period when  
25 there was more than one DCMO, and Andrew Fraser --

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1 Dangerous Pathogens, which was, again, a Department of  
2 Health committee, and it kind of illustrates the overlap  
3 that I've been trying to describe.

4 I attended because of the blood transfusion and  
5 the risk of transmission by that means of pathogens, but  
6 round that table it was mainly my recollection that it  
7 was mainly individuals from a public health or  
8 laboratory background who were round the ACDP table, and  
9 indeed, on occasions, my Public Health Scottish  
10 colleague would attend that committee as well, for, you  
11 know, specific items, or if I couldn't be there.

12 So it was a kind of mixed economy, if you like.  
13 But I think that that sounds as if it might have been  
14 a bit of a guddle. It wasn't. It was really aiming to  
15 make sure that all the bases were covered and that  
16 communication within the Department and between the  
17 Department and, for example, the Department of Health,  
18 really was as good as it could be, and covering all the  
19 issues, not just compartmentalising them into Public  
20 Health or NHS.

21 Q. Can I ask you to look at your statement again.

22 WITN5736003, page 6, please, Lawrence.

23 It's the paragraph numbered A10, (a), (b), (c),  
24 (d) and (e), if we can just have had a little closer on  
25 the screen. Thank you.

28

1 So you're describing there the role in broad terms  
 2 of the DCMO and the CMO. I just wanted to ask you  
 3 something further arising out of the third paragraph  
 4 there. You say:  
 5 "The DCMO and CMO would be involved in advising  
 6 NHS clinical colleagues on relevant issues, through the  
 7 issuing of CMO letters, which were regarded as  
 8 authoritative advice from the centre, to be implemented  
 9 by the service."  
 10 Then you say:  
 11 "Advice to the patients and/or the general public  
 12 was largely the responsibility of Health Boards."  
 13 Now, if we leave aside the question of individual  
 14 advice to patients, put that to one side, you suggest  
 15 there that advice to the general public was largely the  
 16 responsibility of health boards. Was advice to the  
 17 general public therefore not regarded as the  
 18 responsibility of the DCMO and CMO?  
 19 A. No, I wouldn't say that. It's -- I think this paragraph  
 20 really relates to the vehicles by which advice was got  
 21 out to the general public. And in the main, that was  
 22 not directly from the CMO or DCMO. Very often the CMO  
 23 letters that I referred to, for example, would be asking  
 24 the directors of Public Health to further cascade that  
 25 advice through their boards, and maybe to the general

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1 post-devolution periods, so starting with the 1990s,  
 2 essentially up to 1999.  
 3 What measures were in place to try to ensure  
 4 co-ordination or consistency of medical advice as  
 5 between the Scottish Home and Health medical officers  
 6 and the Department of Health medical officers?  
 7 A. Well, obviously, there were the official committees that  
 8 were run out of Department of Health, but it was  
 9 absolutely recognised by all the SMOs, by all the  
 10 doctors in, I think, both departments, that that did not  
 11 go far enough in terms of ensuring timely communication.  
 12 So we all built our own mini networks, if you like. In  
 13 my case, if I can talk about the committees I was  
 14 involved in, with the secretariat of ACVSB and later  
 15 MSBT. You know, one would really try to get to know  
 16 those individuals thorough the meetings, through  
 17 telephone conversations, so that one could be sure of  
 18 being alerted to information that was emerging or  
 19 whatever, well in advance, so that, in turn, I could be  
 20 ready to provide briefing for our ministers. So we all  
 21 built our own networks.  
 22 Q. And was there an objective to try to ensure consistency  
 23 of medical advice, that whatever was being advised by  
 24 the medical officers in the Department of Health in  
 25 London, you would want to be saying similar things in

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1 public.  
 2 The CMO letters, of course, were by no means the  
 3 main vehicle by which the Department communicated with  
 4 the NHS. You know, there were Health Department  
 5 letters, which later became chief executive letters, and  
 6 they were much more frequent than the issuing of CMO  
 7 letters.  
 8 Q. Then, in relation to the CMO letters themselves, did you  
 9 recall there ever being a reticence on the part of DCMOs  
 10 or CMOs in Scotland to issue such "Dear Doctor" or "Dear  
 11 Director of Public Health" letters, on the basis it  
 12 might be seen as an interference with the clinical  
 13 freedom of medical practitioners?  
 14 A. Well, I think that was always -- we were always  
 15 conscious of that, because individual clinicians are  
 16 responsible for their patients and, you know, whatever  
 17 decisions they make around their management, and it  
 18 would not be appropriate for a CMO or a DCMO to be  
 19 getting down to that level of detail.  
 20 So yes, the advice would be -- or the content of  
 21 the CMO letters would certainly take that into account.  
 22 Q. We can take that down, thank you.  
 23 Can I turn then to ask you a little about the  
 24 relationship with the Department of Health in London,  
 25 and I want to divide this into pre-devolution and

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1 Scotland? Or was that not part of any objective?  
 2 A. Well, I think consistency of clinical advice is very  
 3 important. But if you mean by that were we, you know,  
 4 in Scotland, trying to accommodate to English views?  
 5 No. I mean, I can't remember any occasions when there  
 6 was any disagreement between me and my counterparts in  
 7 the Department of Health around the clinical advice that  
 8 was being offered. There was consensus and, if there  
 9 were any minor disagreements, we had conversations and  
 10 ironed them out, so that the advice going to ministers  
 11 north and south of the border from a clinical point of  
 12 view was consistent. That was very important.  
 13 Q. What's your impression of the freedom that the Scottish  
 14 Home and Health Department had in the 1990s to take  
 15 steps in relation to blood or blood products or infected  
 16 blood, that was different from what was being done by  
 17 the Department of Health in England?  
 18 A. Well, since 1948, the Scottish NHS has always been  
 19 a very distinct entity, very different in structure from  
 20 down south and often in operational delivery. So  
 21 I never felt, in the '90s, pre-devolution, that there  
 22 was really any inhibition of Scotland making its own  
 23 decisions in relation to health and health policy. And  
 24 I suppose a good example of that would be the HCV  
 25 look-back, which took place in the mid-'90s.

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1 In the early '90s, before I came into Government,  
2 there had been a lot of discussion clearly around  
3 whether an HCV look-back would be feasible or not, and  
4 the general view was that it wouldn't be, and therefore  
5 that it would not be -- a look-back would never be  
6 undertaken.

7 That began to change in the early '90s with the  
8 work in South East Scotland, the -- it was latterly  
9 called a pilot study, lead by Jack Gillon, who  
10 demonstrated by 1994 that it was indeed feasible to  
11 conduct a look-back exercise. Not easy, not at all  
12 easy, but feasible.

13 Now at that point the view south of the border was  
14 still resistant, if you like, to the idea of conducting  
15 a look-back, but through what happened in Scotland, we  
16 were able to persuade the Department of Health  
17 colleagues, and indeed ministers, that a look-back  
18 should go ahead.

19 So that's one example of Scotland, if you like,  
20 kind of leading the way, and ultimately ending up with  
21 a UK-wide hepatitis C look-back exercise.

22 Q. I'll come on to ask you in due course some more about  
23 the look-back.

24 Just sticking, then, with the relationship between  
25 Health Department in Scotland and the Department of

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1 interaction with Professor Cash?

2 A. Well, the meetings -- the MSC meetings that you have  
3 referred to, obviously saw him there. In terms of how  
4 frequently I met him, I don't know, maybe half a dozen  
5 times a year.

6 Q. Then could we look at an example of another type of  
7 meeting with SNBTS.

8 Lawrence, could we have SCGV0000095\_035, please.  
9 And if we just look at the top part of the page. Thank  
10 you.

11 This is described as a "Note of an SNBTS general  
12 issues meeting". This particular meeting is  
13 24 November 2000. We've plenty of examples of other  
14 general issues meetings in the material that you've been  
15 supplied with. What was the purpose of these general  
16 issues meetings? What did they encompass?

17 A. Well, I suppose, as the name implies, anything that was  
18 an issue of interest. I mean, blood transfusion,  
19 particularly during the '80s and '90s, was a field of  
20 great activity: discovery of new viruses that could be  
21 transmitted by blood, such as HIV, hepatitis C, the  
22 issue of variant CJD later on. So there were always  
23 things to be discussed, hammered out, with SNBTS. So  
24 this was a general catch-all meeting, if you like, that  
25 we felt was very valuable in the Department, keeping

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1 Health in London, how did that relationship change  
2 post-devolution?

3 A. Well, my impression was that we needed to work even  
4 harder in Scotland to make sure that communications were  
5 good with the Department of Health. There was the  
6 potential danger of England thinking: well, they've got  
7 devolution now they'll be looking after their own health  
8 related issues, the need for our -- you know, our input  
9 will be less. But clearly that was not the case. So  
10 I think I certainly felt that I needed to reinforce the  
11 links that I had, through the various committees, and  
12 ensure that the Scottish voice was still heard and that  
13 they would let us know of developments that were taking  
14 place.

15 Q. Can I ask you just a little next about your relationship  
16 as a medical officer with SNBTS, the Scottish National  
17 Blood Transfusion Service.

18 You've told us in your statement that you would  
19 regularly attend meetings of the SNBTS Medical and  
20 Scientific Committee. What was the purpose of your  
21 attendance at those meetings?

22 A. Well, to act as a conduit for any important blood  
23 transfusion related issues back into Government.

24 Q. You also describe having various ad hoc meetings with  
25 those at SNBTS. To what extent did you have regular

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1 close the kind of issues I've mentioned.

2 Q. We can take that down, thank you.

3 What about relationships with Haemophilia Centre  
4 Directors? First of all, the UKHCDO, what was the  
5 extent of your dealings and interactions with UKHCDO in  
6 the '90s and beyond?

7 A. I had very limited direct dealings with UKHCDO.  
8 I certainly didn't attend any of their meetings.  
9 I think there was a letter in the papers from me at one  
10 point to Brian Colvin, who was then the chair of HCDO,  
11 around hepatitis C or haemophiliacs who had potentially  
12 been exposed to hepatitis C.

13 But no, very few direct dealings with UKHCDO.

14 Q. Then, in terms of dealings with Haemophilia Centre  
15 Directors in Scotland, if we can look at another example  
16 of a meeting.

17 LOTH0000051\_067, please, Lawrence.

18 Again, we can look at the top half of the page.  
19 So we can see this is the Coagulation Factor Working  
20 Party, and this is a meeting on 1 May 1992 -- we can see  
21 that you were in attendance -- and under the heading  
22 "Apologies and Introduction", we can see from the second  
23 paragraph it says:

24 "Dr Ludlam welcomed the group and in particular  
25 Dr Keel in her role as SOHHD representative."

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1 Why was it thought necessary to have  
2 a representative of the Scottish Home and Health  
3 Department at the meetings of the Coagulation Factor  
4 Working Party?  
5 A. Well, I can't answer that very directly because I wasn't  
6 in the genesis of the Coagulation Factor Working Party,  
7 but I imagine that it was thought that it would be  
8 helpful to have someone there from Government, again to  
9 act as a conduit for any information or any issues that  
10 had been discussed in this meeting back into Government.

11 And as I've already said, I mean, there were what  
12 might be described as hot topics in the area of blood  
13 transfusion. I mean, the AIDS virus had been discovered  
14 in the mid '80s, and clearly Haemophilia Directors had  
15 been very exercised about the potential for transmission  
16 of that virus, and others, in coagulation factors, so it  
17 was a hot topic, and I imagine that they thought someone  
18 from the Scottish Office round the table could be  
19 helpful.

20 Q. Do you have any recollection of the frequency with which  
21 the Coagulation Factor Working Party met? The documents  
22 I've seen suggest that there may have been several  
23 meetings in the course of a year.

24 A. Hazy recollection. I think maybe four a year?

25 Q. And so throughout the 1990s you would have regular

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1 A. Yes, I did. I mean, these were, if you like, kind of  
2 a set piece annually, and the Haemophilia Directors were  
3 always very keen that the CMO of the day chaired this  
4 annual meeting, and you're right, it brought together  
5 the Haemophilia Directors with SNBTS and Government.  
6 But it was by no means a way of gleaning intelligence  
7 throughout the course of the year. It was a bringing  
8 together of issues that had been discussed, for example,  
9 in the Coagulation Factor Working Party.

10 Q. We can take that down. Thank you.

11 Can I then just ask you --

12 I note the time, sir. I'm sorry. We're  
13 trespassing into the morning break. I'll pick it up  
14 after the break if we could take the break now.

15 SIR BRIAN LANGSTAFF: Yes, well we'll take a break now until  
16 11.45.

17 Now, this is the first break in what will be  
18 a number of breaks in your evidence. You're under oath.  
19 What you must not do is discuss with anyone, whoever  
20 that anyone is, the evidence you have given or any  
21 evidence which you think you may yet be asked to give,  
22 but you can talk about anything else you like.

23 A. Thank you.

24 SIR BRIAN LANGSTAFF: 11.45.

25 (11.17 am)

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1 interaction, then, with the Scottish Haemophilia Centre  
2 Directors through this route?

3 A. Yes.

4 Q. And was there any other forum or working party or  
5 committee or anything of that kind which provided  
6 another means for regular interaction with the Scottish  
7 Haemophilia Centre Directors or was this the route for  
8 that?

9 A. This was the route.

10 Q. If we just look at LOTH0000082\_009.

11 I think it's right to say that there may also have  
12 been an annual meeting. This is described as the  
13 "Minutes of the annual meeting of the Scotland and  
14 Northern Ireland Haemophilia Directors, SNBTS Directors  
15 and Scottish Executive Health Department", and we've  
16 certainly heard evidence, Professor Keel, from other  
17 witnesses, dealing with earlier time periods, that there  
18 was a system of annual meetings bringing together the  
19 Haemophilia Centre Directors, SNBTS, and the Scottish  
20 Home and Health Department or, by now, the Scottish  
21 Executive Health Department. We can see you're in  
22 attendance.

23 As far as you can recall, did you generally attend  
24 these annual meetings as a representative of the  
25 Scottish Health Department?

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(A short break)

2 (11.45 am)

3 SIR BRIAN LANGSTAFF: Yes?

4 MS RICHARDS: Professor Keel, you've told us that you were  
5 an observer at the ACVSB meetings and the meetings of  
6 the successor committee which took over from the ACVSB.  
7 We've heard from other witnesses that those meetings  
8 were intended to be confidential and that the chair  
9 would not infrequently remind participants of the  
10 confidentiality of the meetings and what was discussed  
11 at those meetings.

12 Did you feel able to pass on what was discussed at  
13 ACVSB meetings to colleagues within the Scottish Home  
14 and Health Department?

15 A. Absolutely.

16 Q. So you were not inhibited from sharing information that  
17 you'd gleaned at those committee meetings? What about  
18 more broadly? Did you feel able to share what you'd  
19 picked up from ACVSB meetings with, for example, SNBTS?

20 A. Well, there were members of SNBTS around the ACVSB table  
21 anyway so I didn't have to act as the conduit for that  
22 information.

23 Q. If we look at RCPE0000203\_002, you'll see,  
24 Professor Keel, this is a letter from Professor Cash  
25 19 June 1992 to Dr Kendall, Chief Medical Officer, and

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1 he says in the first paragraph:  
 2 "As know you are aware, the safety of blood  
 3 transfusion is a matter of considerable professional  
 4 importance, political sensitivity and also of interest  
 5 to the media and the law courts.  
 6 "Such interest and sensitivities were recognised  
 7 by the Departments of Health some years ago and there  
 8 was established a Committee, chaired by Dr Metters, to  
 9 advise Ministers of this topic."  
 10 Then he says this:  
 11 "I have a number of concerns with regard to the  
 12 track record of this Committee, but on this occasion  
 13 I write to request that you invite members of your team  
 14 to give consideration how best those responsible for the  
 15 management of the SNBTS can provide a more effective  
 16 input into this Advisory Committee and that its output  
 17 is more readily available to SNBTS management. In both  
 18 these matters current arrangements are wholly  
 19 inappropriate."  
 20 If we go over the page he continues:  
 21 "You will be aware that there has in recent times  
 22 been serious difficulties in France with regard to  
 23 arrangements for advice on the safety of blood and blood  
 24 products. Some of these difficulties are about to be  
 25 the subject of very high profile court actions in Paris.

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1 always insisted that the Committee's discussions should  
 2 be regarded as confidential. However, I can assure you  
 3 that we will keep you advised in good time of any matter  
 4 affecting the organisation and administration of the  
 5 SNBTS. If there is any matter you want raised at  
 6 a meeting perhaps you could let Dr Keel know and she  
 7 will take the necessary steps."  
 8 Did you recall any issues thereafter being raised  
 9 by Professor Cash with you about matters being discussed  
 10 at the ACVSB?  
 11 A. No, I don't recall any specific conversations with John  
 12 about ACVSB in the context of this correspondence, but  
 13 I think the response from the CMO highlights -- well, it  
 14 seems to me rather odd that, with the SNBTS having two  
 15 members, Ruthven Mitchell and Bob Perry on ACVSB, that  
 16 John Cash should have said that the committee really  
 17 wasn't considering SNBTS views, or whatever form of  
 18 words he used. I find, as so often with Professor Cash,  
 19 his correspondence rather cryptic and difficult to  
 20 untangle.  
 21 Q. But, in any event, you did not feel that the  
 22 confidentiality requirement prevented you from relaying  
 23 to colleagues within the SHHD what was being discussed  
 24 and decided by the ACVSB; is that correct?  
 25 A. Oh, absolutely, otherwise what would the point of me

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1 My knowledge of the French tragedy leads me to request  
 2 that you use your good offices to persuade DoH  
 3 colleagues that steps be taken to ensure that all  
 4 members of the Advisory Committee on the Safety of Blood  
 5 are invited to declare whether they have any financial  
 6 interests in commercial institutions contributing to the  
 7 safety of blood."  
 8 Before we look at Dr Kendell's reply, do you have  
 9 any recollection or understanding of what in particular  
 10 Professor Cash was concerned about that led to the  
 11 inclusion of that last paragraph?  
 12 A. No, I don't. I mean, I'd only been in post three months  
 13 when this letter written. So I don't know what John was  
 14 alluding to in terms of the track record of the  
 15 Committee and I certainly don't know anything about  
 16 declaration of financial interests and why he felt that  
 17 was important.  
 18 Q. For the sake of completeness, if we look at Dr Kendell's  
 19 reply at SBTS0000645\_016. Dr Kendell said in his  
 20 response of 3 July 1992, in the second paragraph he  
 21 refers to Dr Mitchell and Dr Perry being members of the  
 22 Advisory Committee, and then in the third paragraph  
 23 says:  
 24 "I understand, for reasons which have been  
 25 explained to me, that the Chairman of the Committee has

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1 have been -- of me being there as an observer had been,  
 2 you know. Of course, I was there to observe, take notes  
 3 and brief colleagues back at base.  
 4 Q. Okay. We can take that down. Thank you.  
 5 Can I then -- before I turn to ask you about some  
 6 of the substantive areas of decision making in which you  
 7 were involved during your time with the Scottish  
 8 Government, can I just ask you a little more about the  
 9 work you undertook from 1995 onwards? In one of your  
 10 statements you have responded to a suggestion that you  
 11 worked in a laboratory with Professor Ludlam and have  
 12 explained you did not work in a laboratory with  
 13 Professor Ludlam but you carried out a weekly general  
 14 haematology clinic with him in the Edinburgh Royal  
 15 Infirmary; is that correct?  
 16 A. It is.  
 17 Q. Did you ever work on any laboratory samples from  
 18 Professor Ludlam's patients?  
 19 A. No.  
 20 Q. In terms of the ongoing work that you undertook with him  
 21 through the general haematology clinic, did that  
 22 continue until Professor Ludlam's retirement?  
 23 A. Yes, it did.  
 24 Q. Did you ever discuss with Professor Ludlam the  
 25 possibility of there being a public inquiry -- sorry,

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1 into matters relating to infected blood in Scotland,  
 2 I should say?  
 3 A. No.  
 4 Q. Did you ever discuss, once the Penrose Inquiry was set  
 5 up, the Penrose Inquiry with Professor Ludlam?  
 6 A. Not that I recall.  
 7 Q. Did you ever discuss with Professor Ludlam any of his  
 8 patients who'd been infected with HIV or hepatitis C or  
 9 the circumstances of their infections?  
 10 A. No.  
 11 Q. Did you ever discuss the issue of paying financial  
 12 support or compensation to those infected or affected  
 13 with Professor Ludlam?  
 14 A. Not that I recollect.  
 15 Q. Can I then ask you to turn to a passage in your  
 16 statement at WITN5736003. And it should be page 3,  
 17 please, Lawrence.  
 18 The bottom half of the page, the paragraph  
 19 numbered A5. You say there -- so it should be the top  
 20 of what's on your screen, Professor Keel. You refer to  
 21 starting training in haematology, which we've discussed,  
 22 and then you say this:  
 23 "During the course of my training, I became  
 24 increasingly aware of the risks of viral transmission  
 25 through use of blood and blood products, particularly

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1 you left Yorkhill, do you have any recollection, again,  
 2 of the issue of AIDS and its potential for transmission  
 3 by blood or blood products being the focus of  
 4 discussions and concerns in the course of 1983, whether  
 5 with Dr Forbes or Dr Lowe or any others?  
 6 A. No, I can't recollect any specific conversations with  
 7 any of them about that.  
 8 Q. Then turning to hepatitis C. You've recorded there the  
 9 discovery of hepatitis C in 1989. Should that be  
 10 a reference to 1988 or was your understanding that it  
 11 was 1989?  
 12 A. I'm sorry if that's a mistake. If 1988 is the correct  
 13 date I've made a mistake, sorry.  
 14 Q. And what was your understanding, do you think, in the  
 15 first half of the '80s of the seriousness of  
 16 non-A, non-B hepatitis, as it was then known?  
 17 A. I think the general view was that it was a relatively  
 18 benign disease that disrupted liver function tests but  
 19 really had no particularly adverse effects. That was  
 20 the general view at that point, which of course, by the  
 21 late 1980s and certainly the early '90s, had changed.  
 22 Q. Your understanding at the time that it was relatively  
 23 benign, would that then have reflected -- given that you  
 24 were still a relatively junior doctor and still  
 25 undergoing haematology training at the time, would that

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1 after the discovery of HIV in 1984 and HCV in 1989."  
 2 Can I just ask you a little more about your  
 3 knowledge of risks of viral transmission. First of all  
 4 in relation to HIV.  
 5 We've already discussed your work at Yorkhill with  
 6 Dr Willoughby, and he left in December 1982. Can you  
 7 recall whether you'd had any discussions with  
 8 Dr Willoughby, or within the Department at Yorkhill,  
 9 about the possibility of transmission of an agent  
 10 responsible for AIDS?  
 11 A. No, I've no recollection of any such conversations.  
 12 Q. And can you recall how and when you became aware of the  
 13 possibility that blood or blood products might transmit  
 14 an agent responsible for AIDS?  
 15 A. Well, in the early '80s there were articles in the  
 16 medical journals about this new entity, AIDS, about  
 17 which very, very little was known other than that it was  
 18 a very, very unpleasant disorder which led to death in  
 19 pretty short order. So I'd been aware through the  
 20 medical journals that what eventually turned out to be  
 21 HIV was occurring, and I suppose, after the virus was  
 22 identified in 1984, it very quickly became clear that it  
 23 was transmissible by blood.  
 24 So I suppose the early to mid '80s.  
 25 Q. When you moved to the Royal Infirmary in Glasgow after

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1 have reflected what you were picking up from  
 2 haematologists in Aberdeen and then at Yorkhill and then  
 3 at Glasgow? Was that a shared view, as far as you can  
 4 recall, at those institutions?  
 5 A. Yes, I think that would be fair to say, but also the  
 6 medical literature reflected that view.  
 7 Q. One of the pieces of research which the Inquiry has  
 8 considered with witnesses from time to time, and it's  
 9 not a document that has been provided to you,  
 10 Professor Keel, so it may not be something that you  
 11 recall, but was work undertaken at Sheffield under  
 12 Dr Preston, Professor Eric Preston, and publication in  
 13 1978 of research that he'd undertaken? Without having  
 14 provided you with the document, you may not be able to  
 15 assist but does that ring any bells at this stage?  
 16 A. Only insofar as I think Eric Preston's view was perhaps  
 17 different from the majority of the profession. There  
 18 were individuals who fairly early on said this -- well,  
 19 anticipated that this disease was going to be more  
 20 serious than the majority of the profession, and I think  
 21 Eric Preston was one of them but, as you say, I haven't  
 22 seen the article.  
 23 Q. Can I ask you to look at a ministerial briefing from  
 24 2005. It's SCGV0000044\_024. So we can see it's  
 25 entitled "Minister's Meeting with Scottish Haemophilia

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1 Groups Forum on 1 February", and we can pick up the year  
2 from paragraph 2, it refers to the meeting scheduled for  
3 1 February 2005. Annex A is said to contain lines to  
4 take and additional information and background notes,  
5 and then Annex B, additional background notes on issues  
6 previously raised by Mr Dolan.

7 Then if we -- we can see it's from Sandra  
8 Falconer, if we go to the copy list, at the bottom half  
9 of the page, we can see that you are there listed as one  
10 of those who would have received this briefing.

11 I just wanted to ask you about couple of passages  
12 in it Professor Keel. If we go to the second page, so  
13 this is part of Annex A. It's in the context of  
14 a discussion about a public inquiry. But I'm going  
15 to -- if we leave aside the question of public inquiry  
16 for now. Under the heading "Lines to take", it says:

17 "Prior to 1985 there was no consensus amongst  
18 clinicians that HCV infection was a serious condition."

19 Then if we go to the next page, I want to show you  
20 another paragraph and then ask you about this. So we've  
21 got the heading "Background", and then if we pick  
22 matters up in the paragraph beginning "The hepatitis C  
23 virus was first identified in 1989", thank you. So that  
24 reads:

25 "The hepatitis C virus was first identified in  
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1 alongside the risks which subsequently emerged."

2 Can we just have those two paragraphs on screen,  
3 thanks -- sorry, the two paragraphs I read out. Thank  
4 you. Perfect.

5 So, Professor Keel, first of all, would it be  
6 right to understand that, in terms of the medical input  
7 into this briefing, that you would be likely to be the  
8 source of medical advice?

9 A. Yes.

10 Q. I just wanted to pick up on, I think, three matters  
11 revealed by these paragraphs. The first is the  
12 reference to consensus. We saw it on the previous page  
13 the reference to there being no consensus amongst  
14 clinicians that HCV was a serious condition, and then  
15 that's picked up here:

16 "... no real scientific consensus at the time as  
17 to the health effects or risks associated with this  
18 condition ..."

19 Why was consensus the way in which this advice was  
20 being put? Was there a need for consensus before action  
21 would need to be taken?

22 A. No, and not in a very clinical situation, but I think in  
23 this area, you know, there was a growing body of  
24 evidence by the mid-to late 1980s such that the majority  
25 of clinicians by the end of that decade would have

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1 1989. Prior to that, scientists and clinicians were  
2 aware of a new form of liver disease which occurred in  
3 haemophiliacs being treated with blood products. This  
4 caused inflammation of the liver revealed on blood  
5 testing usually asymptomatic. It became known as  
6 Non-A, Non-B Hepatitis. There was no real scientific  
7 consensus at the time as to the health effects or risks  
8 associated with this condition, and no way in which  
9 blood or blood products could be screened for its  
10 presence. SNBTS introduced heat treatment for blood  
11 products to minimise the risk of [non-A, non-B]  
12 transmission in 1984, and screening for HCV in blood  
13 donations in 1991. Both of these developments were  
14 introduced as early as they reasonably could be in light  
15 of the current scientific knowledge and technical  
16 capabilities at the time."

17 Can we have the next paragraph on screen as well,  
18 please, Lawrence.

19 "There was therefore an awareness of the potential  
20 risks associated with blood products in the early 1980s  
21 and the need for precautions but no evidence that might  
22 cause serious disease. On the other hand, the blood  
23 products being developed at this time offered real  
24 advances in treatment for haemophiliacs. These  
25 potentially life-saving benefits have to be considered

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1 agreed that this was indeed a serious form of liver  
2 disease that they hitherto had thought was benign.

3 Q. Then in the second paragraph that's on the screen,  
4 you've referred to the awareness of potential -- or,  
5 sorry, the briefing refers to the "awareness of the  
6 potential risks", and then in the second line says this:  
7 "... but no evidence that might cause serious  
8 disease."

9 Is it right to say that in the 1980s there was no  
10 evidence that non-A, non-B hepatitis might cause serious  
11 disease? What's the source for that statement?

12 A. Well, I can't reference it, but I'm sure there would  
13 have been some evidence in some patients that the  
14 majority of the evidence pointed to a relatively benign  
15 course for patients who were infected with what was then  
16 called non-A, non-B hepatitis, and whose main  
17 manifestation of whatever that organism was, was raised  
18 liver function tests, but otherwise they were well. And  
19 that was the observation, therefore, that the majority  
20 of patients -- that in the majority of patients this  
21 disease ran a benign course. In fact, what was being  
22 observed was a very long prodromal course before the  
23 disease really manifested itself in terms of liver  
24 damage.

25 Q. Then we can see, again in that first paragraph that's on

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1 screen, after the reference to "no real scientific  
2 consensus", the briefing continues:  
3 "... no way in which blood or blood products could  
4 be screened for its presence."  
5 And then there's reference to the introduction of  
6 screening for hepatitis C in 1991.  
7 There's no reference in this narrative here to  
8 surrogate testing, and the possibility of surrogate  
9 testing, which was available in the 1980s, although not,  
10 as we know, introduced in any systematic way.  
11 Can you assist in understanding why surrogate  
12 testing doesn't feature as a factor to flag up to the  
13 ministers' attention?  
14 **A.** Well, it may not be flagged in this briefing but I seem  
15 to recollect that there was indeed specific briefing on  
16 more than one occasion on surrogate testing. So  
17 ministers were aware of it. I guess it wasn't an issue  
18 for this specific meeting, which I think was with  
19 Philip Dolan, so presumably Philip Dolan hadn't raised  
20 the issue of ALT testing.  
21 **Q.** Then the last question on these paragraphs, the last  
22 sentence of the first paragraph says:  
23 "Both of these developments ..."  
24 And that refers to heat treatment and then  
25 screening for hepatitis C.

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1 Transfusion Service never introduces just one test  
2 without having available the technology to confirm that  
3 by another scientific method -- so until both of those  
4 things improved specificity and sensitivity, and the  
5 means of confirming a positive test were available, the  
6 transfusion services -- other than in little sort of  
7 areas that introduced it on an ad hoc basis -- the  
8 transfusion services waited -- preferred to wait until  
9 the science was in a better state and those tests were  
10 much more reliable than the initial ones produced in  
11 1989 and '90.  
12 **Q.** In the period 1989 to 1991 when the question of  
13 introduction for screening for hepatitis C was under  
14 consideration by the ACVSB, you were, of course, not  
15 then on -- not then working for the Scottish Home and  
16 Health Department, and not attending meetings of the  
17 ACVSB. What's the basis, the factual basis for your  
18 views, as you've just described to us? What are they  
19 based on?  
20 **A.** Well, on many of the papers that you supplied for this  
21 Inquiry to me, and it's historical knowledge gleaned  
22 from those papers and from colleagues that were in post  
23 during this period and I later came into contact with  
24 when I was appointed in '92.  
25 **Q.** I'm going to turn to now a different topic, but one

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1 "... were introduced as early as they reasonably  
2 could be in the light of the current scientific  
3 knowledge and technical capabilities at that time."  
4 Now, of course, this is 2005 and this is  
5 four years after the judgment of Mr Justice Burton, in  
6 the case of *A v National Blood Authority*, not, as we've  
7 heard, a decision focusing on negligence but a decision  
8 under the Consumer Protection Act. But having regard to  
9 the findings of Mr Justice Burton, which I know you were  
10 aware of, we see references to it in the documentation,  
11 was it correct to tell a minister in 2005 that screening  
12 for HCV was introduced as early as it reasonably could  
13 be, in light of current scientific knowledge and  
14 technical capabilities?  
15 **A.** I believe it was accurate. The virus was only  
16 identified in 1989 or if that date is wrong, 1988.  
17 Anyway, there then ensued a period of very intense  
18 scientific focus on developing a test that could be  
19 applied routinely to blood transfusion -- screening of  
20 donors. The first tests were indeed available earlier  
21 than 1991 but they were non-specific and lacking  
22 sensitivity and specificity, with the result that many  
23 false-positive results were generated.

24 So until those tests improved and indeed  
25 confirmatory tests were available -- because the Blood

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1 which would have come across your desk fairly early on  
2 in your role as senior medical officer, and that's the  
3 introduction of the payment scheme for HIV infected  
4 recipients of blood and tissue.  
5 If we could go, please, to SCGV0000239\_024. So  
6 this is a minute from Mr Tucker, it's dated  
7 9 April 1992. We don't need to turn to it but his name  
8 and the date appears on the final page. We can see it's  
9 addressed to the private secretary of the chief  
10 executive. Would that be the chief executive of the --  
11 of the National Health Service you've referred to  
12 earlier?  
13 **A.** Yes, and the head of the Management Executive that  
14 I mentioned earlier. So, really, the head of department  
15 at that point.  
16 **Q.** Then we can see it's copied to you and if we look at  
17 the -- I don't need to read all of it but if we look at  
18 the second paragraph, we can see the context. It says:  
19 "The Secretary of State has agreed to the broad  
20 principles of the scheme in response to my submission of  
21 20 February 1992. There has been an inevitable delay  
22 while the scheme has been worked out in detail but we  
23 have worked closely with the DoH officials and the  
24 timetables have been coordinated. In the form now  
25 proposed the Scottish scheme does not depart from the

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1 basic principles and also follows closely the terms of  
2 the settlement for haemophiliacs. There are differences  
3 between the Scottish and English schemes but these are  
4 mainly a reflection of the separate Scottish legal views  
5 and are mainly presentational."

6 Then there's reference to the panel that was going  
7 to be set up, which was a different panel in Scotland to  
8 the panel set up by the Department of Health in England.

9 Then if we go, if we just go over the page,  
10 please, to paragraph 5, it says:

11 "Neither scheme makes mention of lifestyle of the  
12 claimant as a factor in determining entitlement, this is  
13 a sensitive issue and needs to be dealt with carefully.  
14 Decision on entitlement will however be taken on  
15 a balance of probability test and therefore lifestyle  
16 may be a relevant consideration in cases of doubt. Our  
17 application form in common with the DoH form does seek  
18 to elicit some factual information on background  
19 lifestyle. Then it asks the applicant's doctor whether  
20 the applicant had attended a drug dependency clinic or  
21 genito/urinary medical clinic. The DoH form goes  
22 further in asking whether the applicant had been in  
23 contact with persons from countries where AIDS is  
24 prevalent. They consider that if they did not do so it  
25 might be thought that they were closing their minds to

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1 "Where there is any doubt the cases will be  
2 referred to the panel for a decision and payment will be  
3 made by us if appropriate thereafter."

4 Then I think we don't need to put it up on screen,  
5 but when the letter was in due course sent out to  
6 Directors of Public Health drawing attention to this  
7 scheme -- and for the transcript it's at MACK0000044 --  
8 it says that any medical enquiry should be addressed to  
9 Dr Keel.

10 Can you recall what your involvement was in  
11 assessing claims for payment under the Scottish scheme  
12 for those infected with HIV through blood or tissue?

13 A. I'm afraid, given the passage of time, my memory is  
14 really not very clear on this. I mean, obviously my  
15 name was on the letter as the medical contact, but in  
16 all honesty I can't remember ever scrutinising any  
17 applications.

18 And I note that it says:

19 "When the claims are received, these will be  
20 scrutinised in the Department in consultation with  
21 medical and legal advisers."

22 So I imagine not many of them crossed my desk  
23 because they were straightforward and were just going to  
24 be paid without any further views needed on the  
25 application.

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1 the possibility of other risk factors. The advice which  
2 we have received has been to the effect that we should  
3 avoid direct reference to this and leave it to the panel  
4 to use their discretion to seek further information  
5 which an applicant undertakes in any event, in making  
6 the application to supply."

7 Now, so there's one difference identified between  
8 the Department of Health approach in England and the  
9 Scottish approach.

10 Had you been involved in providing the advice  
11 that's referred to here or involved in the development  
12 of the scheme in Scotland?

13 A. No. I mean, this was, again, very, very early on in my  
14 role as SMO, and I wasn't involved in developing this  
15 advice.

16 Q. If we then just go to the next page and paragraph 10,  
17 just to pick up on what your involvement might then have  
18 been in assessing claims. Paragraph 10, if we pick it  
19 up in the fifth line:

20 "When the claims are received these will be  
21 scrutinised in the Department in consultation with  
22 medical and legal advisers. Where the cases are  
23 straightforward the Department will make the payments  
24 due in accordance with the claimant's wishes ..."

25 And then:

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1 Q. Okay, right. We can take that down. Thank you.

2 I'm going to turn then to a separate topic and the  
3 topic of look-back, which you have referred to in the  
4 course of your evidence earlier this morning.

5 If we go to perhaps your witness statement,  
6 WITN5736003, page 19, if we pick it up in your answer at  
7 A33, so roughly halfway down the page you say:

8 "I was unaware of the decision not to undertake  
9 a lookback exercise at the time I took up post as SMO  
10 in 1992. I have no clear recollection of when I became  
11 aware of the decision."

12 Now, having referred you to that, I'm going to  
13 take you, if I may, to some of your evidence to the  
14 Penrose Inquiry, and just pick up a little more about  
15 your understanding of the position prior to 1994, when  
16 look-back, as it were, came on the agenda.

17 If we go, please, to PRSE0001169.

18 This is your written statement to the Penrose  
19 Inquiry, and you were asked -- if we look at the bottom  
20 half of the page, you were asked the question why  
21 a look-back exercise was not commenced in Scotland in  
22 September 1991 when hepatitis C -- anti-HCV testing  
23 commenced, and you've said in your answer there:

24 "[You] cannot answer this question from first hand  
25 knowledge as I was not a government Medical Officer in

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1 1991. As far as I can gather from reading papers  
2 subsequently, it was not thought feasible for logistical  
3 reasons. There was a feeling that a look back exercise  
4 would be very difficult to undertake. The first step  
5 which would be required to be taken would be for SNBTS  
6 to check their donor records to ascertain whether  
7 retained samples existed. If retained samples were  
8 held, they would require to be tested. The next step  
9 would be to check hospital records to trace the  
10 recipients. It was not always possible for hospital  
11 records to be located. The third step would have been  
12 tracking down and testing the recipients."

13 Then there's a reference to Dr Gillon's pilot  
14 study, and then you say:

15 "A separate issue was that, in 1991 and for  
16 several years thereafter, there was no available  
17 treatment for HCV."

18 Can I ask you first of all about the logistical  
19 reasons and the thought that it was not feasible. What  
20 was it that was thought to be so problematic that  
21 look-back couldn't even be attempted until the pilot  
22 study revealed otherwise?

23 A. Well, a number of issues are highlighted in this  
24 paragraph. Perhaps it would be easier if I start by  
25 explaining why I think in the South-East Scotland

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1 moved house. So all of these reasons contributed,  
2 I think, to the feeling that this just wouldn't be  
3 possible.

4 Q. Well, something not being possible is obviously rather  
5 different from something being difficult. Would you  
6 accept in principle, would you consider in principle,  
7 that the state has an ethical obligation to undertake  
8 a look-back to find and help those infected with blood  
9 transfusion -- infected through blood transfusion?

10 A. Yes.

11 Q. And so clearly if that's not simply not possible, it  
12 can't be done. But the steps that you've outlined here,  
13 the three steps outlined here, may well not be easy, may  
14 well involve quite a lot of work, but were they good  
15 enough reasons in your view, looking back now,  
16 recognising you weren't involved in a decision in 1991,  
17 were they good enough reasons not to initiate  
18 a look-back?

19 A. Well, hindsight's a great thing. Clearly the look-back  
20 did eventually take place and was demonstrated to be  
21 feasible, although the difficulties encountered in other  
22 bits of Scotland, particularly the west, I've already  
23 mentioned, and indeed the rest of the UK, were very,  
24 very considerable, and I think that Jack Gillon, in the  
25 publication on his study -- I think it was in '94,

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1 Transfusion Centre it was demonstrated as feasible.  
2 Because that centre was based within Edinburgh  
3 Royal Infirmary, and had very close links, therefore  
4 direct links to the clinical service.

5 So the checking of hospital records to trace  
6 recipients would have been much easier in that setting  
7 than in many hospitals or in many settings throughout  
8 Scotland, the rest of Scotland, and indeed the UK,  
9 because most transfusion centres are at a distance from  
10 the main hospitals that they supply. For example, in  
11 Glasgow, the Regional Transfusion Centre was based in  
12 Law Hospital, which is miles outside of Glasgow, so it  
13 was separated by many miles from the main hospitals in  
14 Glasgow that it supplied. So that's one of the  
15 difficulties.

16 Dr Gillon also, he had been a gastroenterologist  
17 before he moved to the Transfusion Service, so he had  
18 very, very good clinical links with hepatologists who  
19 might be looking after patients with -- who had been  
20 transfused. So the logistical difficulties were very  
21 considerable, not least checking hospital records to  
22 trace recipients, and then of course the tracking down  
23 and testing of those recipients. The fact is that --  
24 and this emerged in the course of the look-back -- many  
25 patients of course would have died of other causes or

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1 I can't quite remember -- absolutely acknowledges the  
2 fact that where he was placed, in south-east Scotland,  
3 it made it easier to do the look-back exercise than in  
4 many other areas.

5 However, the look-back exercise of course in  
6 principle, or our look-back exercise, should always be  
7 undertaken, and it was clear that -- history  
8 demonstrates that -- and -- the difficulties that are  
9 described in this paragraph were indeed overcome, and  
10 the UK look-back took place.

11 Q. The second factor you've identified in this paragraph is  
12 in the last sentence, the issue of there being no  
13 available treatment for hepatitis C in 1991 and for  
14 several years thereafter. Now that may, of course, be  
15 correct, but is it not important for people to know if  
16 they've been infected with hepatitis C, even if there  
17 are no available treatments for that condition, because  
18 they may, for example, be able to make choices about how  
19 they are living, choices to try to safeguard their  
20 health as much as possible. It might provide an  
21 explanation to them for symptoms that they're  
22 experiencing and can't understand and it may, of course,  
23 mean that they are more likely to be -- to go for  
24 checks, and for, for example, liver disease to be picked  
25 up an earlier stage than might otherwise be the case.

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1 Would you accept that?

2 A. I would accept that.

3 Q. Then can I just ask you to then look at the passage in

4 your oral evidence to the Penrose Inquiry --

5 **SIR BRIAN LANGSTAFF:** Well, before you do that, can I just

6 understand the particular difficulty that comes about

7 when somebody who is performing a check is not in the

8 same hospital as the records that they're looking to

9 check? So if you're in hospital A and in a department

10 which is separate from the Records Department, plainly,

11 physically, it's easier to walk down the corridor and do

12 the check if you're doing it yourself. The way the

13 look-back would work, would that not be asking the

14 Records Department itself to do the check?

15 A. Well, I think, as was said, my Lord, that if the

16 Transfusion Centre is juxtaposed with the clinical

17 service that it is supplying with blood and blood

18 products, then it's easy for the SNBTS clinician to walk

19 down the corridor, speak to whatever consultant in

20 charge of the identified recipient and ask them to

21 facilitate the examination of the hospital records.

22 It would have to be done at clinical level. You

23 couldn't just send a request to another hospital to

24 Medical Records saying, "Can you look through these?"

25 I think, in most cases, it would be direct contact

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1 people's reasoning?

2 A. Yes.

3 **SIR BRIAN LANGSTAFF:** Would you, for yourself, having

4 listened to counsel's questions, still think that -- if

5 you ever thought, I don't know if you did -- that the

6 question of available treatments had anything to do with

7 whether there should really be a look-back or not?

8 A. I think probably my view would have been as counsel has

9 outlined, that, even though there was no available

10 treatment, there were perhaps other things that those

11 recipients could be doing, keeping an eye on their own

12 health, attending clinics, et cetera, even in the

13 absence of treatment. And, indeed, we now know that,

14 for example, hepatitis C is transmissible through sexual

15 activity, so -- in a small number of cases. So

16 individuals could have made adjustments to their

17 lifestyle as well as staying in closer touch with the

18 Health Service, I guess.

19 So, yes, I don't think anybody felt that the lack

20 of availability of treatment was the main problem here.

21 The main issue identified, as far as I can see from my

22 reading of the papers of the time, is the logistical

23 reasons rather than the absence of treatment. That was

24 just another issue.

25 **SIR BRIAN LANGSTAFF:** Yes, thank you very much.

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1 between the Transfusion Service and whoever they thought

2 was in charge of the person at the time they received

3 the transfusion.

4 So that physical distancing just adds to the

5 difficulties. And, as I said earlier, Jack Gillon had

6 his own clinical network within the environment in which

7 he was based, which made, I would imagine, his pilot

8 study much easier to undertake.

9 **SIR BRIAN LANGSTAFF:** What would prevent the use of the

10 telephone?

11 A. Well, nothing. No, nothing. I just -- this was not my

12 personal experience. I wasn't in post at this time. So

13 my understanding, based on the papers provided, is that

14 others thought that in other bits of the country it

15 would just be too difficult and -- of course there are

16 means of contacting people other than face-to-face, even

17 back then.

18 **SIR BRIAN LANGSTAFF:** So what is set out here as your own

19 view is actually really saying, well, this is what

20 others thought at the time, is it?

21 A. That's exactly so, and I say it at the top of the

22 paragraph: I can't answer the question from firsthand

23 knowledge, but from reading papers, this what I've

24 garnered.

25 **SIR BRIAN LANGSTAFF:** I see. So you're reflecting other

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1 **MS RICHARDS:** Can I ask you to look at a passage in your

2 oral evidence to the Penrose Inquiry, Professor Keel.

3 It's PRSE0006086 -- and if we can go, Lawrence, to

4 page 157.

5 If we pick it up in line 2 onwards, you say there

6 that you hope you made it clear in your earlier evidence

7 that:

8 "... having heard Jack Gillon present, I was

9 absolutely convinced that proceeding with look-back was

10 the right thing to do for a whole raft of reasons."

11 That's referring to a meeting in May 1994, which

12 we'll come on to. Then the question is, "I'm talking

13 about before that", and you say this at line 7:

14 "I suppose I share the collective mindset of the

15 time, that the look-back would not be feasible, that

16 logistically it would be impossible to conduct

17 a look-back."

18 I just wanted to explore with you, Professor Keel,

19 that idea of a collective mindset, which is a theme

20 across a range of areas of decision making that the

21 Inquiry has explored it other witnesses.

22 There are obviously dangers to a collective

23 mindset, which is that things don't get looked at again

24 or don't get looked at as quickly as they should do

25 again. Did you have any observations on that and on

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1 how, having regard to your time advising the Scottish  
2 Home and Health Department and the Scottish Executive's  
3 Health Department, how that collective mindset, whether  
4 on this issue or other issues, can or should be  
5 challenged by civil servants?

6 A. Well, yes, collective mindset has got a horrible feeling  
7 of groupthink about it, doesn't it? So absolutely it  
8 needs to be challenged. And I think, as a new SMO  
9 coming into the post, my feeling is that I'd a pretty  
10 open mind on a lot of these issues but, you know, there  
11 was a very firm view, a prevalent view at that time,  
12 both north and south of the border, that a look-back  
13 would just not be feasible.

14 And I know you're going to come on to it, but when  
15 it became clear to me, as an individual, based on  
16 Jack Gillon's presentation of 18 May 1994, I absolutely  
17 bucked the collective mindset and made sure that the  
18 look-back was initiated.

19 Q. Let's look, then, at the meeting in May 1994. It is at  
20 PRSE0003685. So we can see it's a meeting of the SNBTS  
21 Medical and Scientific Committee, 18 May 1994 and we can  
22 see number of attendees there, including yourself and,  
23 of course, Dr Gillon.

24 If we turn to page 5, we can see under the heading  
25 "AOCB", at the bottom of the page, "HCV Look-back":

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1 advise National Blood Authority [et cetera, et cetera].  
2 "If SHHD agreed that SNBTS should develop and  
3 implement a look-back policy for HCV, AK subsequently  
4 would communicate this to DoH."

5 Now, first of all, Professor Keel, what's your  
6 recollection, if any now, of that meeting, and of what  
7 you described elsewhere and in your Penrose evidence as  
8 being Dr Gillon's presentation?

9 A. Well, actually my memory of it is very vivid because it  
10 was such an important event in this saga of should there  
11 or should there not be a look-back.

12 Two things strike me about these minutes. First  
13 of all, that this matter is considered under AOCB,  
14 rather than as a full agenda item, I think that's  
15 curious. You have to bear in mind this was SNBTS's  
16 meeting, nothing to do with Scottish Government.

17 And the other thing too is that the minuting  
18 launches into the decision that had been made by the  
19 Committee, rather than saying Dr Gillon gave  
20 a presentation of his South East Scotland pilot study in  
21 HCV look-back. And that's what I remember about the  
22 afternoon, for the very first time, I saw clearly from  
23 what Jack Gillon presented, what had been found and,  
24 most importantly, the fact that it was indeed feasible.

25 I further remember that we broke for tea after

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1 "This very complex and extremely important issue  
2 was discussed at length. The Committee unanimously  
3 agreed that on finding a 'known' (or regular) donor who  
4 was now anti-HCV pos, the SNBTS should ..."

5 Then there are a number of steps set out in  
6 paragraphs i through to iv, and paragraph iv refers to  
7 the forthcoming application from Dr Gillon, who was  
8 going to circulate a pre-publication copy.

9 Then this is recorded at paragraph v:  
10 "From an SHHD perspective, AK [that's you,  
11 Professor Keel] expressed a view that the SHHD may not  
12 have a locus in this matter and that the SNBTS should  
13 make a decision on look-back for HCV that was based on  
14 their professional judgement. However, before SNBTS  
15 took any action AK asked to be given the opportunity to  
16 discuss the issues with SHHD colleagues to seek their  
17 views and ask that the SNBTS take their formal action  
18 until she had subsequently contacted JDC [that, I think,  
19 is Professor Cash, I take it].

20 "Once AK had communicated the SHHD position to JDC  
21 and provided SHHD were in agreement that the SNBTS  
22 should implement this policy, JDC would write to DMcl  
23 [that's Mr McIntosh, I assume] to provide details of the  
24 SNBTS policy, thereby allowing a decision to be taken on  
25 a starting date for the process. JDC would formally

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1 this segment and an SNBTS colleague told me at tea that  
2 Professor Cash intended to speak to Harold Gunson, his  
3 opposite number in England, the head of the National  
4 Blood Association, to tell him that Scotland had made  
5 a decision and that we were going ahead with look-backs.  
6 Well, that absolutely horrified me because, as you can  
7 see from the minutes, although I naively said -- and  
8 this is recorded in Penrose -- I naively said SHHD  
9 doesn't -- may not have a locus, you know, it's up to  
10 you, professionally, as to whether you think you should  
11 be able to go it -- or you should go ahead with this.

12 So, parking that naively, I made it very, very  
13 clear that, before they took any action, I needed to  
14 discuss with colleagues back in St Andrew's House and  
15 that they should take no formal action until I'd  
16 subsequently contacted John Cash. So when I heard that  
17 he might, at that very moment, be on the phone to  
18 Harold Gunson I packed up my things, jumped in the car,  
19 went back to St Andrew's House, sought out my colleague,  
20 Rab Panton, who was one of George Tucker's team, told  
21 him what had happened, I probably said, "I put my foot  
22 in it, by the way, by saying we didn't have a locus".  
23 Clearly we had a locus, an enormous locus, in deciding  
24 whether this should go ahead.

25 I think we then went in to see George Tucker, and

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1 that, to me, was the tipping point for the decision made  
 2 at UK level, ultimately, to proceed with HCV look-back.  
 3 Q. If we just go back to those three paragraphs in the  
 4 bottom half of page 6, please, Lawrence, if we just zoom  
 5 in on those paragraphs again.  
 6 Leaving aside the issue of the SHHD's locus, what  
 7 appears to be contemplated here is that the introduction  
 8 of a look-back in Scotland would be a matter for  
 9 Scotland, if I can put it that way, and it would be for  
 10 the Department of Health to take its own separate  
 11 decision. That appears to be what's envisaged in the  
 12 last paragraph:  
 13 "If SHHD agree that SNBTS should implement  
 14 a lookback policy for HCV, AK subsequently would  
 15 communicate this to DOH."  
 16 Is this right: that this was indeed regarded as  
 17 something Scotland could do on its own?  
 18 A. Well, I think that paragraph, subparagraph (vii) is  
 19 really a further reflection of my naivety at this point.  
 20 I was not steeped in the background to resistance to  
 21 conducting a look-back, as perhaps many round that table  
 22 were, and I certainly was not fully aware of the  
 23 resistance that there had been not just in Scotland, but  
 24 across the UK, to undertaking this. So yes, I naively  
 25 said that, you know, if we agreed in St Andrew's House

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1 transfer because of deficiencies in hospital recording.  
 2 There also appeared to be variation between centres in  
 3 the treatment given to HCV positive haemophiliacs."  
 4 Then there's a reference in 6.5 to an SNBTS paper,  
 5 and then, 6.6, to members submitting written comments  
 6 which would be considered before the next committee  
 7 meeting.  
 8 Are you able to help us understand a little more  
 9 Mr Tucker's contribution: "approaches to institute HCV  
 10 lookback in Scotland had been resisted". It's slightly  
 11 curious wording. Resisted by whom? By the Scottish  
 12 Home and Health Department? Or by others?  
 13 A. Um ... well, it's always difficult to interpret someone  
 14 else's remarks, especially at this distance. But  
 15 I think perhaps he was reflecting the view of the  
 16 Transfusion Service, that it wouldn't -- it would not be  
 17 feasible to conduct a look-back exercise.  
 18 I mean, I've already mentioned the west of  
 19 Scotland in particular, where it was thought that the  
 20 logistical hurdles that have to be overcome would be  
 21 insurmountable. But -- and clearly that view would have  
 22 been reflected to Government over the years. So I think  
 23 perhaps George Tucker was saying that Government and the  
 24 Transfusion Service had resisted until now -- until  
 25 then -- the idea of undertaking a look-back exercise.

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1 that they would be -- we'd go ahead with it in Scotland  
 2 and tell DoH. Of course, that would never have been  
 3 a good position for the recipients of HCV-infected  
 4 products to be in. We needed to tackle this at UK level  
 5 and, indeed, that's what subsequently happened.  
 6 Q. If we pick matters up then in September of 1994 at  
 7 PRSE0003670.  
 8 This is a meeting of the Advisory Committee on the  
 9 Microbiological Safety of Blood and Tissues for  
 10 Transplantation at 29 September 1994 and we can see the  
 11 observers on this occasion, in terms of the Scottish  
 12 representation, Mr Tucker is there. And at paragraph 2,  
 13 if we go further down the page, we can see you were not  
 14 there: "Apologies for absence were received" from,  
 15 amongst others, yourself.  
 16 If we go on to page 4, paragraph 6.4 records  
 17 Mr Tucker's contribution:  
 18 "Mr Tucker said that approaches to institute HCV  
 19 lookback in Scotland had been resisted, and that it was  
 20 important that a UK wide approach was adopted.  
 21 Dr George and Dr Mock said that WO and DHSS NI were also  
 22 in favour of a UK wide policy on HCV lookback.  
 23 Dr Rejman said that there had been difficulties in  
 24 tracing back in the context of the Scheme of payments  
 25 for those infected with HIV through blood and tissue

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1 Q. If we then move, in terms of the sequence of decision  
 2 making, to the next meeting of the Advisory Committee on  
 3 Microbiological Safety of Blood and Tissues for  
 4 Transplantation.  
 5 It's PRSE0003635, please, Lawrence.  
 6 These are the minutes of the meeting on  
 7 15 December 1994, and you were back present as an  
 8 observer on behalf of SHHD.  
 9 If we go to page 5, the bottom half of the page,  
 10 section 7 of the minutes, is where the discussion on HCV  
 11 look-back commences (and we've looked at this before,  
 12 Professor Keel, in the Inquiry, so I'm not going to read  
 13 it out) but we can see there's a discussion there set  
 14 out.  
 15 If we go to your contribution, which is page 7, if  
 16 we pick it up first of all in the third paragraph --  
 17 it's the first of two paragraphs numbered 7.10,  
 18 curiously:  
 19 "CMO said that in the public interest an urgent  
 20 decision on a UK wide basis was needed on the matters of  
 21 principle. The detail was important, but less urgent."  
 22 Then 7.10 records you saying:  
 23 "... the view in Scotland was that the Secretary  
 24 of State was vulnerable as look back was feasible since  
 25 donors could be identified and traced, and advice from

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1 Scottish Office lawyers was that look back should start  
2 immediately. The Chairman stressed the need for  
3 maintaining uniformity in the UK, but said that it was  
4 for the Secretaries of State, not the Committee to  
5 decide whether Scotland should go ahead early."

6 Then there's a discussion in the next paragraph,  
7 and then paragraph 7.12, I'm not going to read it out,  
8 but refers to the Committee's advice to ministers, which  
9 was essentially to go ahead with a look-back exercise.

10 What was it that underpinned your contribution to  
11 this discussion, Dr Keel? A sense, is it, that the  
12 Secretary of State for Scotland could be subject to  
13 legal action if a look-back did not now take place?

14 A. Well, that was one element, but by no means the most  
15 important. I firmly believed by this stage that, having  
16 demonstrated at one point in Scotland that a look-back  
17 was feasible, we were all duty bound to make it happen  
18 across the rest of the country.

19 I think it's indicative that the CMO, Ken Calman,  
20 attended this meeting. He didn't usually -- in fact he  
21 never, apart from this occasion, was at the meeting. So  
22 it was obviously a very, very important topic. By this  
23 stage in Scotland we had legal as well as medical advice  
24 that the look-back was feasible, and their legal advice  
25 to Secretary of State, understandably, was, "Well, if

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1 We can see the heading "Hepatitis C virus  
2 look-back exercise", and it records in the first  
3 paragraph, as follows, perhaps just picking it up  
4 halfway down that paragraph:

5 "Part of the reason for this lack of any follow-up  
6 action was a concern that it would be impossible to  
7 identify all recipients of infected blood and even if it  
8 were possible there was a lack of accepted treatment  
9 which would be beneficial."

10 We've already discussed that issue,  
11 Professor Keel. But then it continues as follows:

12 "It was accepted that if no effective treatment  
13 was available, informing those patients who were unaware  
14 of their situation could not be justified, since this  
15 would cause further distress and anxiety without any  
16 benefit."

17 Now, that's not the view that you expressed,  
18 Professor Keel, a few minutes ago in response to my  
19 questions and the questions of the Chair. But it would  
20 seem, from this, that it was at least part and parcel of  
21 the thinking within the Scottish Home and Health  
22 Department, otherwise it wouldn't have found its way in  
23 a ministerial letter. Do you have any recollection of  
24 this issue featuring in discussions of deliberations  
25 about look-back?

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1 you don't go ahead with this in Scotland you may be  
2 vulnerable."

3 But that wasn't the main driver. The main driver  
4 was the increasing view -- I think -- I may as well say  
5 instigated by me -- that we needed to do this because it  
6 had been demonstrated that it was feasible to undertake  
7 look-back.

8 Q. I explored with you a few minutes ago your thoughts as  
9 to why a look-back hadn't been initiated earlier. Do  
10 you have any sense of whether a fear of litigation  
11 played a part in that earlier decision making not to  
12 have a look-back, in other words a fear that those who  
13 were traced through a look-back might have a cause of  
14 action arising out of their infection?

15 A. I don't know, is the answer. But from my reading of the  
16 papers, that did not emerge as a reason.

17 Q. Can I then just pick up the decision making,  
18 specifically in relation to Scotland, with a couple  
19 of -- or two or three further documents.

20 PRSE0001781, this is a letter dated  
21 22 December 1994, it's from Lord Fraser who was the  
22 Minister for Home Affairs and Health within the  
23 Scottish Office, and it was addressed to Tom Sackville,  
24 the Parliamentary Under-Secretary of State at the  
25 Department of Health.

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1 A. No, I think this sentence really reflects previous  
2 thinking, which may well have pre-dated my arrival in  
3 the Department, around the reasons that were proffered  
4 against conducting a look-back but I don't remember  
5 distress and anxiety being a feature of the discussions  
6 around this time.

7 Q. The next paragraph then refers to the work of Dr Gillon,  
8 and if we pick it up again in the fourth line:

9 "The advice which I have received from medical and  
10 legal staff is that as such a look-back exercise is  
11 practicable then the Secretary of State and I have  
12 a duty to undertake the exercise as soon as possible."

13 Then there's a reference to the possibility of  
14 liability. Then it says this:

15 "I am conscious that the matter of a look-back  
16 policy for HCV was considered by the [MSBT] at their  
17 recent meeting and that they have advised that  
18 procedures should be put in place to identify those at  
19 risk but 'whatever is done, should be done equally and  
20 uniformly throughout the UK'."

21 That's a quote from the MSBT recommendations:

22 "The Committee has also recommended that guidance  
23 should be drawn up but this leaves unresolved the  
24 question of the timing of the introduction and the  
25 implementation of the look-back exercise. The advice

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1 which I have received from my medical and legal staff is  
2 such that I consider it is no longer a matter of policy  
3 but of legal liability, and that the look-back should  
4 take place as soon as possible in Scotland. I am  
5 informed that the [SNBTS] is ready to carry out such  
6 an exercise and I have no alternative but to instruct  
7 them to proceed.

8 "I appreciate that there are sensitivities in  
9 proceeding in advance of the rest of the UK, but given  
10 that it may be some time before all parts are ready,  
11 I consider that I have little choice but to take this  
12 forward in view of the position in Scotland. I shall  
13 ensure you will be kept informed of the progress of this  
14 exercise since I recognise that this may have value as  
15 a pilot for any similar exercise elsewhere in the UK  
16 (although I would not, of course, wish our action to be  
17 presented or seen as a pilot exercise)."

18 Then he says:

19 "I accept that any exercise may encourage any  
20 further pressure for compensation for those infected but  
21 we shall continue to resist this robustly in line with  
22 our general policy."

23 Then this:

24 "We shall not of course be publicising the  
25 look-back exercise and shall do all we can to avoid

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1 weren't at that stage.  
2 **Q.** Then the second point arising out of this letter really  
3 emerges from the paragraphs above. If we just look back  
4 over the documents that we've looked at together,  
5 Professor Keel, we've got you -- or, sorry, we've got  
6 the meeting in May 1994, suggesting the possibility of  
7 Scotland going ahead of other parts of the  
8 United Kingdom. We have Mr Tucker in September 1994  
9 appearing to discourage that and saying, "No, it should  
10 be UK-wide", and now we have Lord Fraser here saying,  
11 "Well, we're ready in Scotland, we want to go ahead",  
12 rather than necessarily wait for the rest of the  
13 United Kingdom.

14 Are you able to assist us in understanding that  
15 slightly shifting picture or whether, in truth, was  
16 there any impediment to Scotland ever just going it  
17 alone? Was there ever really a need to wait for the  
18 rest of the United Kingdom to catch up?

19 **A.** No, in terms of policy. And clearly, Lord Fraser's  
20 views on this were informed by the legal adviser, who  
21 said it's no longer a matter of policy but of legal  
22 liability. So he had absolutely no choice but to press  
23 the green button, to roll out the exercise across  
24 Scotland. But it was always -- and Scotland was  
25 included in this -- considered absolutely desirable to

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1 media interest. If, however, direct questions are  
2 asked, it would be difficult to avoid answering them."

3 Then he says he hopes that Mr Sackville will  
4 understand the Scottish circumstances make it imperative  
5 that action is taken now.

6 So two questions, Professor Keel. The first  
7 arises out of that paragraph about not publicising the  
8 look-back exercise, avoiding media interest. Do you  
9 have any thoughts or observations about that paragraph,  
10 given what might be said to be the advantages in Public  
11 Health terms of them doing the opposite of what  
12 Lord Fraser is here recommending?

13 **A.** Well, I think this represents -- this paragraph reflects  
14 the place we are in the chronology of developing the  
15 look-back. This was very, very early stages. Only  
16 South East Scotland had done the exercise. The rest of  
17 Scotland, and indeed the rest of the UK, had some  
18 considerable catching up to do. So I imagine that that  
19 was what was in Lord Fraser's mind when he says that we  
20 won't be publicising the look-back exercise. But the  
21 look-back exercise, once it got under way, was indeed  
22 very well publicised.

23 I suppose my view would be that there's no point  
24 in announcing something with a big fanfare if the  
25 operational arrangements are not in place, and they

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1 do this on a UK basis. And we saw in the minutes of  
2 MSBT that both Wales and Northern Ireland were keen to  
3 do that too. So the push from the start was that this  
4 should end up a UK exercise, however recognising that  
5 bits of the country would take longer to get up to speed  
6 in order to participate.

7 **MS RICHARDS:** I note the time. I was about to go to another  
8 document but we won't finish this topic before lunch,  
9 sir, so I can pick it up at 2.

10 **SIR BRIAN LANGSTAFF:** Well, we're already breaking into the  
11 lunch hour.

12 **MS RICHARDS:** I'm sorry.

13 **SIR BRIAN LANGSTAFF:** And I understand that there will be  
14 a slightly shorter period after lunch than we normally  
15 have, not least because there's going to be a fire  
16 alarm, I gather, where you are at three o'clock and  
17 therefore we need to finish the first session before  
18 3.00 to avoid being cut off by noise in the middle of  
19 a question -- or the middle of an answer, which would be  
20 even worse.

21 We'll take a break now, then, until 2.00.

22 **MS RICHARDS:** Thank you, sir.

23 (1.02 pm)

(The Luncheon Adjournment)

25 (1.59 pm)

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1 **SIR BRIAN LANGSTAFF:** Yes, Ms Richards?  
 2 **MS RICHARDS:** Professor Keel, we looked before the break at  
 3 Dr Fraser's December 1994 letter about the look-back  
 4 exercise. If we pick matters up in early 1995, please.  
 5 Lawrence, could we have PRSE0003115. This is a letter  
 6 dated 6 January 1995, it's from Professor Cash to  
 7 Mr McIntosh, the general manager at SNBTS. If we go  
 8 over the page we can see it was copied to, amongst  
 9 others, Mr Tucker and to you.  
 10 If we go back to the first page, please. I just  
 11 want to pick it up in the penultimate paragraph where  
 12 Professor Cash says this:  
 13 "I still believe a simultaneous UK approach to HCV  
 14 look-back has much to commend it for the patients' and  
 15 donors' sake and indeed various responsible  
 16 institutions. If we get significantly out of  
 17 synchronisation with the rest of the UK, there could be  
 18 some quite worrying developments."  
 19 Then he suggests that it may be appropriate to  
 20 continue with current planning processes. Do you have  
 21 any understanding -- did you have any at the time of  
 22 receiving this, do you have any now -- of what  
 23 Professor Cash was referring to when he talked about  
 24 there being some quite worrying developments if Scotland  
 25 was significantly out of synchronisation with the rest

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1 of acting as quickly as possible.  
 2 Do you have any recollection of whether that piece  
 3 of reasoning was known to you or discussed within the  
 4 Scottish Home and Health Department at the time?  
 5 **A.** I'm afraid I don't recollect that. I'm not sure if  
 6 I was aware of it. I don't remember any discussion  
 7 about it.  
 8 **SIR BRIAN LANGSTAFF:** May I just ask, did it strike you at  
 9 the time that the last four lines are effectively saying  
 10 "We want to say we acted as quickly as possible so we  
 11 are going to ask you to act more slowly"? That is what  
 12 it's saying, isn't it, in effect?  
 13 **A.** I think that's a valid interpretation, yes. However, we  
 14 have to remember that Lord Fraser really had  
 15 an imperative, based on the legal advice he'd  
 16 received --  
 17 **SIR BRIAN LANGSTAFF:** This isn't a criticism of Lord Fraser,  
 18 it's a criticism of the logic of the last four lines,  
 19 seeking to maintain a line, which is "We acted as  
 20 quickly as we could", and in order to maintain that  
 21 line, say to someone else "Slow down a bit, please".  
 22 **A.** Yes --  
 23 **SIR BRIAN LANGSTAFF:** It's a comment, really. I'll leave it  
 24 there.  
 25 **A.** Okay, okay.

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1 of the UK?  
 2 **A.** No, I've no idea what he means.  
 3 **Q.** Then if we pick it up next in January at  
 4 DHSC0032208\_136. Now, this a letter from Tom Sackville,  
 5 the Parliamentary Under-Secretary for the Department of  
 6 Health to Lord Fraser, 4 January 1995, and it's  
 7 obviously in response to the letter Lord Fraser had  
 8 written.  
 9 I just want to invite your observations on the  
 10 last paragraph on this page, where Mr Sackville says  
 11 this:  
 12 "I understand your wish to move quickly in  
 13 Scotland to put in hand the look-back exercise. I hope  
 14 however you will recognise the overwhelming advantage of  
 15 us moving forward on a UK-wide basis. Any piecemeal  
 16 approach, quite apart from giving all the wrong signals  
 17 and causing confusion to the public, will seriously  
 18 compromise the Government's defence that we have acted  
 19 as quickly as possible on the basis of the best advice  
 20 available and uniformly."  
 21 Now, it might well be said, having regard to that  
 22 paragraph, that a principal reason put forward by the  
 23 Department of Health to Lord Fraser for a UK-wide  
 24 approach rather than Scotland going first, was to, as it  
 25 says there, avoid compromising the Government's defence

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1 **MS RICHARDS:** I think it's fair to say we don't know whether  
 2 Professor Keel would have seen this letter at the time.  
 3 **SIR BRIAN LANGSTAFF:** No.  
 4 **MS RICHARDS:** I don't know, professor, you are able to  
 5 recall that not --  
 6 **A.** No, I --  
 7 **SIR BRIAN LANGSTAFF:** No, it's really a question,  
 8 ultimately, for those who wrote it, rather than those  
 9 who received it, I think.  
 10 **MS RICHARDS:** Yes. Then just to pick up on -- to complete  
 11 the exchange of correspondence, Lord Fraser's response  
 12 back to Mr Sackville, DHSC0002551\_110. So this is  
 13 Lord Fraser, 9 January 1995, responding to the letter  
 14 that we've just looked at. We can see he says in the  
 15 second paragraph:  
 16 "I am glad you have given the go ahead for  
 17 a look-back exercise in England and I too hope that  
 18 colleagues in Wales and Northern Ireland will also give  
 19 similar approval.  
 20 "While the Scottish Blood Transfusion Service is  
 21 already under instruction to proceed I agree there are  
 22 benefits to be gained from a common UK approach and  
 23 I have asked my officials to ensure there is maximum  
 24 co-operation and harmonisation of arrangements."  
 25 The next paragraph refers to the setting up of

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1 a working party and wanting Scottish clinicians to be  
 2 involved. I understand, Professor Keel, that you were  
 3 a member of that working party, the Ad Hoc Working Party  
 4 on the Look-Back?  
 5 A. Yes, indeed.  
 6 Q. Then the last paragraph on this page says:  
 7 "With regard to an announcement, I am content for  
 8 this to be made on a UK basis by an Inspired PQ. The  
 9 Press Statement should indicate that I have asked the  
 10 Scottish National Blood Transfusion Service to take the  
 11 look-back exercise forward in Scotland in consultation  
 12 with the other Blood Transfusion Services in the UK."  
 13 Then it suggests there will be a separate  
 14 statement issued after 3.30 pm on 11 January.  
 15 So whether or not you would have seen  
 16 Mr Sackville's letter to Lord Fraser, is it likely that  
 17 you would have seen Lord Fraser's letter back to  
 18 Mr Sackville at the time?  
 19 A. Yes, I think it would be likely.  
 20 Q. What we can see from this is that Lord Fraser is now  
 21 agreeing to Scotland -- or the timing of Scotland's  
 22 introduction matching the timing of England's  
 23 introduction. Is it right, then, to understand that,  
 24 although there had been, as we've seen, contemplation of  
 25 Scotland going it alone earlier than the rest of the

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1 September 1991? What consideration, if any, was given  
 2 to how recipients who had been infected by a donor who  
 3 had not subsequently donated might be identified?"  
 4 If we go over the page to your response, you say  
 5 this:  
 6 "My recollection is that there was general  
 7 agreement that extending the exercise to recipients of  
 8 blood donated by donors who did not return, would be  
 9 logistically extremely difficult for the [Blood  
 10 Transfusion Service]. The view was that any benefit  
 11 would be disproportionate to the effort required by both  
 12 the BTS and the wider NHS. Instead, it was agreed that  
 13 individuals who had received a transfusion prior to HCV  
 14 testing being introduced in 1991 should be offered  
 15 a test as the most effective way of addressing this  
 16 issue."  
 17 If we leave aside that last sentence with the  
 18 moment, Professor Keel, you refer there to your  
 19 recollection of general agreement as to the scope of the  
 20 exercise. Was it recognised, as far as you can recall  
 21 at the time, that setting the parameters of the  
 22 look-back in the way that the UK did, would mean that  
 23 there would be potentially a significant number of  
 24 individuals who had been infected with hepatitis C but  
 25 who would not be identified?

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1 United Kingdom, that did not, in fact, happen?  
 2 A. I think we have to remember here that all of this really  
 3 started off in the autumn, I think with the September  
 4 meeting of MSBT, and then the December meeting where DH  
 5 agreed that they would be going to their ministers to  
 6 seek agreement to the look-back. So there wasn't really  
 7 a big gap between that meeting and this correspondence  
 8 taking place, or indeed the announcement of the  
 9 look-back, early in January.  
 10 I think what has to be borne in mind here, that  
 11 any perceived delay was really about allowing the  
 12 Transfusion Services, both in Scotland and in England,  
 13 to get their act together to operationalise the policy  
 14 that had been agreed, and that was no mean undertaking,  
 15 as I've already hinted earlier on in my evidence today.  
 16 Q. We can take that down, thank you. I'll turn from the  
 17 timing of the look-back, then, to the scope of the  
 18 look-back, Professor Keel, and invite your attention  
 19 back to your witness statement, WITN5736003, page 21,  
 20 please, Lawrence.  
 21 You will see at the bottom of the page the  
 22 question that was posed to you, at question 39:  
 23 "Why, to the best of your knowledge, was the  
 24 decision taken to limit the look-back exercise to those  
 25 donors who had returned to give blood after

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1 A. Yes. I don't know whether we felt that there would be  
 2 a significant number who would be missed by not  
 3 extending it to those donors who didn't return, but it  
 4 certainly was recognised. And the thinking was that the  
 5 best way to deal with those individuals was really to  
 6 raise awareness as far as possible that anybody who'd  
 7 received a transfusion prior to 1991 could come forward  
 8 and ask for a test and that indeed is what happened,  
 9 that publicity.  
 10 Q. And can you recall, in relation to that last point,  
 11 professor, what steps were taken at this point, so we're  
 12 talking now about the mid '90s and the course of the  
 13 remainder of the '90s, what steps were taken to  
 14 publicise this issue in Scotland so that individuals who  
 15 had received a transfusion might be aware of the  
 16 possibility of having been infected and of the  
 17 availability of a test for them?  
 18 A. Certainly it was contained in, I think, a CMO letter to  
 19 Directors of Public Health. Now I'm really finding it  
 20 difficult to recall quite what the vehicle was, but I do  
 21 remember at least one letter suggesting that if anybody  
 22 came forward who had been transfused they should  
 23 automatically be offered a test, and that view was  
 24 certainly also promulgated, I think through committees,  
 25 to the general practitioner community.

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1 Q. For the sake of completeness, if we just look at  
2 PRSE0000412, this was the Scottish CMO's letter  
3 announcing the scheme -- or drawing the scheme to the  
4 attention of general practitioners, 11 January 1995.

5 We see reference in the first paragraph to the  
6 announcement of the look-back, and then, the second  
7 paragraph, to the action that was going to be taken by  
8 Regional Transfusion Centres.

9 If we just go a little further down that  
10 paragraph, so there's reference half way down that long  
11 paragraph to a helpline being set up for members of the  
12 public who want further information about HCV and blood  
13 transfusion and the look-back exercise.

14 Then reference to the likelihood that some  
15 patients would turn to GPs for information and  
16 reassurance. So that's certainly one communication by  
17 the CMO to GPs.

18 Is it your recollection that there were further  
19 communications?

20 A. I thought there were but maybe I'm wrong. At this  
21 distance I can't be sure.

22 Q. You may be right, Professor Keel. It was intentionally  
23 an open question, and we can no doubt check the position  
24 ourselves.

25 Do you recall whether there were any broader

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1 Now that didn't happen, as I understand it, the  
2 extension of the scheme. Again, if I just ask you to  
3 look at one letter and then I can invite your comment on  
4 it.

5 DHSC0002557\_005.

6 I think there'd been some further correspondence  
7 in the interim, but you then wrote to Professor Ludlam,  
8 23 October 1995, on this issue. You refer to it having  
9 been "discussed again at the most recent meeting of the  
10 Ad Hoc Working Party", and then you say this:

11 "It was pointed out that the initial terms of  
12 reference for that working party referred to a lookback  
13 involving blood and unfractionated blood products only.  
14 Any revision of these terms of reference would therefore  
15 require a Ministerial decision. The working party  
16 thought that it would not be logical to extend the  
17 lookback only to Defix, as clearly other fractionated  
18 blood products also had the potential to transmit HCV,  
19 prior to 1991. The working party were also concerned  
20 about the enormous logistical difficulties in extending  
21 the lookback ..."

22 Then the last sentence of that paragraph refers  
23 to:

24 "... implicit in the whole lookback exercise is  
25 the understanding that any individual who has received

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1 public awareness campaigns in the second half of the  
2 1990s in relation to hepatitis C and how to recognise  
3 the symptoms and the importance of coming forward to  
4 one's GP?

5 A. No, I don't recall any.

6 Q. An issue arose in the course of the look-back about  
7 extending it to non-haemophiliacs who had received  
8 DEFIX, is that right?

9 A. Yes.

10 Q. And we can pick that up just, I think, with a couple of  
11 letters, SBTS0003833\_084, please.

12 This was Professor Ludlam raising the issue with  
13 you in May 1995 and if we just look at the text of the  
14 letter, he said in the first paragraph:

15 "As it has been decided that there should be  
16 a 'lookback' in relation to the transfusion of fresh  
17 blood components preferred from possible hepatitis C  
18 positive donors I think it would also be appropriate to  
19 assess non haemophiliac individuals who received Defix.  
20 I think it would be reasonable to confine this to those  
21 who required it for warfarin reversal because it is  
22 likely that patients with liver disease requiring PCCs  
23 will no longer be alive."

24 And he suggested a pilot study perhaps in  
25 Edinburgh in the second paragraph.

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1 blood products not covered by the exercise, prior to  
2 September 1991, and who may be concerned about his or  
3 her HCV status can request an HCV test."

4 As far as you can recall, is that how that issue  
5 then rested: it wasn't essentially a matter for the  
6 working party because their remit didn't extend to use  
7 of products in that way and the matter was left there?

8 A. As far as I recollect, I suspect there may have been  
9 ongoing discussions but the main point in this letter is  
10 I refer to the enormous logistical difficulties in  
11 extending look-back in this way, because DEFIX was  
12 a fractionated blood product, which was widely used not  
13 to address factor deficiencies but to reverse the  
14 effects of warfarin, and other anti-coagulants, where  
15 people had too much warfarin and were at risk of  
16 bleeding.

17 So that would have been tens of thousands of  
18 patients, so the volume is one thing. But more  
19 importantly is the lack of a link between the  
20 prescription of DEFIX for that purpose in any  
21 centralised database. There was no way of identifying,  
22 other than going to do through leads -- thousands of  
23 medical records, whether people had received this  
24 product or not. So I think, again, the view --  
25 widely-held view was that it would be impossible to do

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1 this without really imposing an enormous burden,  
 2 particularly on the NHS.  
 3 Q. Was any consideration given either to a public education  
 4 campaign in relation to this cohort of patients,  
 5 identifying the possibility of being able to request  
 6 an HCV test, or a CMO letter to GPs or others flagging  
 7 this up as an issue?  
 8 A. Not that I recollect.  
 9 Q. Can I then turn to the course of the look-back, and pick  
 10 that up with a progress report. If we go to  
 11 NHBT0088395. So this is -- looks like it's a progress  
 12 report for the MSBT. We can see at the top of the page  
 13 it says, "MSBT, 25 May 1995, HCV Look-Back: Scottish  
 14 Progress Report", and then the position is set out in  
 15 the relation to the North: it's said all donations have  
 16 been traced back as far as records would allow.  
 17 In relation to the West, it says this:  
 18 "Concern has been expressed by West of Scotland  
 19 Consultant Haematologists at the amount of time and  
 20 effort the look-back process will demand of them.  
 21 Apparently the Chair of that Group will be writing to  
 22 Dr Keel to request that SOHHD provide funding for this  
 23 work."  
 24 Do you know what happened in relation to that  
 25 request: was it made and granted?

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1 to try to address this apparent reluctance on the part  
 2 of haematologists and GPs? Because, otherwise, as we  
 3 see from this, the burden of counselling was going to  
 4 fall on the Regional Transfusion Centre, rather than  
 5 what might be thought to be the more appropriate route  
 6 of the doctors and GPs involved?  
 7 A. Well, I certainly agree with you that that would have  
 8 been the most appropriate route, but I can't remember  
 9 whether we made any efforts to get consultants and GPs  
 10 more engaged with the counselling aspects of the  
 11 exercise. I suspect we did, but I can't honestly say  
 12 that I remember what those actions were.  
 13 Q. Then we can see in relation to the East:  
 14 "All donations have been traced back to 1985.  
 15 Patients not yet contacted.  
 16 "South East  
 17 "All relevant donations traced. All recipients  
 18 contacted", which may reflect the advantages the  
 19 South East had that you've already referred to,  
 20 professor.  
 21 Then the summary:  
 22 "Implementation process has been problematic.  
 23 Apparent delays/misunderstandings in receipt of  
 24 documentation from SOHHD and typographical/factual  
 25 errors in the content of standard letters. However,

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1 A. I don't remember. I suspect if funding was requested  
 2 I would have referred the writer of the letter back to  
 3 their board to look for additional funding, if required.  
 4 But I think the point that strikes me here is what I've  
 5 already mentioned about the West of Scotland and the  
 6 fact that, right from the beginning they felt that --  
 7 and not surprisingly because they supplied blood to half  
 8 of Scotland -- that the amount of effort that they were  
 9 going to have to put in to the look-back exercise would  
 10 be much greater than the rest -- the other transfusion  
 11 services and, equally, by extrapolation, that what they  
 12 would be asking for from NHS consultants, in terms of  
 13 haematologists, would be greater in proportion than the  
 14 rest of the country.  
 15 Then if we look at the North East, it refers to  
 16 the donations having been traced back, and then the  
 17 second paragraph says this:  
 18 "Reluctance encountered on the part of consultant  
 19 haematologists and GPs in respect to 'seeing' patients.  
 20 Of those contacted 40% have agreed to do so but 40% have  
 21 declined and 20% have not responded. In these latter  
 22 instances NERTC will undertake counselling."  
 23 There's a reference to Professor Cash following  
 24 that matter up with Trust General Managers.  
 25 Were any steps taken, to your knowledge, by SHHD

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1 good progress is being made."  
 2 Is that summary consistent with your recollection  
 3 of how matters were proceeded with by this point in time  
 4 this is May 1995?  
 5 A. Yes, so still relatively early in the process. So, yes,  
 6 this would be my recollection. Not unexpectedly,  
 7 problems encountered. But I think you can see from the  
 8 numbers that progress was indeed being made.  
 9 Q. I think if we pick it up in a document from the same  
 10 month, but it provides a little more detail, it's  
 11 SBTS0000463\_005. This is a "Meeting of the SNBTS  
 12 Medical and Scientific Committee, 17 May 1995", attended  
 13 by you, and the look-back discussion starts on page 5.  
 14 We can see, bottom half of the page, under the  
 15 first paragraph, again it refers to problematic  
 16 implementation and difficulties with documents. Then it  
 17 says this:  
 18 "[For example] in the [North East] region, letters  
 19 had gone from SHHD to GPs but not hospital MOs which  
 20 resulted in numerous phone calls to the RTC."  
 21 Do you know what that issue referred to?  
 22 A. Obviously a mistake was made but I can't remember any  
 23 more detail than what's recorded here.  
 24 Q. But it records that, nevertheless, good progress being  
 25 made and then, over the page, I'm not going to read any

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1 of this out, there's, in some respects, a slightly more  
2 detailed account of the progress, which complements what  
3 was set out in the document we looked at previously.

4 If we then pick matters up in 1996, so the  
5 following year, DHSC0004469\_013, this is a report from  
6 Dr Metters, so the Deputy Chief Medical Officer in  
7 England, to the Parliamentary Under-Secretary of State  
8 for Health in England, dated 5 February 1996. It's an  
9 interim report on the look-back exercise. If we go to  
10 the bottom of the second page, and we look at  
11 paragraphs 10 and 11. So under the heading "Reasons for  
12 slow progress", paragraph 10:

13 "Members of the MSBT considered why the exercise  
14 was taking longer than originally envisaged. They  
15 identified two particular bottlenecks, one was tracing  
16 medical records for recipients identified in the  
17 hospital blood banks and, secondly, a shortage of  
18 counsellors available to see patients prior to and post  
19 testing.

20 "The MSBT accepted that if both of these areas of  
21 difficulty were overcome, it was likely that the  
22 hepatology services for specialist assessment and, where  
23 appropriate, commencement of treatment would probably  
24 not be able to cope."

25 Now, that's picking matters up from an MSBT  
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1 envisage that maybe the Service wouldn't, at that point,  
2 have been geared up to delivering what was a newish  
3 treatment to a wider cohort of patients.  
4 Q. If we move matters forward to 1998, then, and look at  
5 PRSE0003277, we can see that Professor Franklin, who was  
6 by this time the National Medical and Scientific  
7 Director of SNBTS, wrote to you on 28 April 1998 and  
8 said this in the first paragraph:

9 "At a recent meeting of the SNBTS Medical and  
10 Scientific Committee, we once again reviewed the status  
11 of the HCV lookback exercise. Over the past months,  
12 progress with this has been virtually static. As you  
13 will see on the attached summary sheet prepared by  
14 Jack Gillon, we still have a number of patients whom we  
15 have been unable to trace and conclude that without  
16 additional resources from SOHD, doing so is not going to  
17 be possible."

18 Then there's a reference to then a particular  
19 issue in relation to RIBA indeterminates.

20 And then the third paragraph says:

21 "It is therefore the view of the SNBTS MSC that  
22 the current HCV lookback should be considered to be  
23 closed unless, of course, SOHD feel that it should  
24 resource one final effort to conclude every possible  
25 case."

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1 meeting, which obviously was a UK-wide meeting but, in  
2 relation to the position in Scotland, what's your  
3 recollection, if any, of the extent to which those two  
4 bottlenecks identified in paragraph 10 were problematic  
5 in Scotland at this time?

6 A. I think they were probably similar difficulties  
7 identified in Scotland, particularly around the shortage  
8 of counsellors. But, I mean, I don't have any specific  
9 recollection of discussions, and clearly this was  
10 a meeting with MSBT and I guess these bottlenecks were  
11 identified across the whole of the UK.

12 Q. Then in relation to the point in paragraph 11, the  
13 potential difficulty for hepatology services, both in  
14 terms of assessment and commencement of treatment,  
15 what's your recollection of the position in Scotland in  
16 that regard?

17 A. Well, there would have been anxiety about the numbers  
18 emerging from the look-back exercise who might be  
19 eligible for treatment, and worries about the hepatology  
20 services being overwhelmed. My recollection is that in  
21 the event that didn't happen, but, I mean, obviously  
22 there were significant numbers even in Scotland emerging  
23 from the look-back exercise at this point. So if they  
24 were going to be, not all of them, but a number of them,  
25 referred on to secondary care for assessment, you can

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1 Did the Scottish Health Department feel able to  
2 resource that "one final effort" referred to by  
3 Professor Franklin, as far as you can recall?

4 A. I don't remember additional resources being made  
5 available, but I do know that SNBTS were strongly  
6 encouraged, before a policy decision was made here, to  
7 have a final effort at the -- tracing these recipients.  
8 But I don't know -- well, I do know that no additional  
9 resource was found from within Government. Whether  
10 additional resource was found within SNBTS, I suspect  
11 the answer to that would be yes, because they did go  
12 ahead with a final push.

13 Q. And we can see -- we don't need to put the next document  
14 up on screen, but just for the record -- you raised this  
15 matter at an MSBT meeting on 4 June 1998. The reference  
16 for the transcript is DHSC0004026\_033.

17 Then you wrote back to Professor Franklin after  
18 that MSBT meeting.

19 If we could have this on screen, please, Lawrence.  
20 PRSE0004337.

21 10 June, you wrote to Professor Franklin in these  
22 terms:

23 "As you know this was on the agenda at the meeting  
24 of MSBT on 4 June, and the specific issue of whether  
25 SNBTS should draw a line under the lookback exercise was

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1 discussed. There was general agreement that all  
2 reasonable measures have been taken to trace components  
3 and recipients in Scotland, and that the tracing  
4 exercise could therefore stop. However, it was also  
5 agreed that the lookback exercise could not be  
6 considered formally closed until reasons for  
7 non-traceability of components or recipients had been  
8 logged on the lookback register. There is still a great  
9 deal of work to be done throughout the UK in this area,  
10 and Angela Robinson did make the point that it is labour  
11 intensive. Nonetheless, Ministers will need to be  
12 satisfied that the reasons for non-follow-up of  
13 components in recipients are very clearly documented and  
14 justifiable. I would therefore ask that SNBTS continue  
15 their efforts to provide this information to the  
16 register, as the lookback exercise cannot be considered  
17 complete until this has been accomplished."

18 So what further work did that anticipate needed to  
19 be undertaken by SNBTS?

20 A. I think it was really just a documentation of who'd been  
21 traced through the look-back to make sure that all those  
22 details were recorded and that the reasons for being  
23 unable to trace components or recipients had been logged  
24 on the -- what was at that point a developing UK  
25 look-back register and that, actually, has provided the

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1 read the first two paragraphs. The last paragraph says  
2 this:  
3 "Some GPs will undoubtedly be involved in helping  
4 to trace patients, and in some cases organising anti-HCV  
5 testing, and providing initial counselling. However,  
6 given that the total number of traceable anti-HCV  
7 positive recipients is expected to be 300 for the whole  
8 of Scotland, the burden for individual practices is  
9 unlikely to be great. My Departmental colleagues with  
10 responsibility for primary care have had no queries  
11 whatsoever on this issue. I personally have had only  
12 one or two telephone enquiries regarding the general  
13 principles of the look-back and none relating to the  
14 question of additional funding for GPs for taking part  
15 in the look-back exercise."

16 Just pausing there, do you know what the basis was  
17 for the estimate of 300 traceable anti-HCV positive  
18 recipients for the whole of Scotland?

19 A. Probably not a very accurate recollection, but I imagine  
20 that it was an exercise involving all of the Regional  
21 Transfusion Centres, probably based on the numbers that  
22 Jack Gillon's pilot had identified in South East  
23 Scotland.

24 Q. Then commenting on this letter in your witness  
25 statement -- so if we go back to WITN5736003, page 22,

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1 basis for long-term follow-up of recipients identified  
2 by the look-back exercise. It's a very valuable  
3 database, if you like. So we were all very keen that  
4 the data recorded on the register was as complete as  
5 possible.

6 Q. Did the data recorded on the look-back register  
7 include -- and it sounds from your answer a moment ago  
8 as though it would -- patient-identifying information?  
9 In other words, it had the details of patients and  
10 personal data relating to them?

11 A. Yes, yes.

12 Q. Was that something which patients of -- obviously not  
13 people who had not been traced, but patients who had  
14 been chased, was there consent sought to the inclusion  
15 of that information on the look-back register?

16 A. I don't know. I imagine it was, but, you know, I wasn't  
17 involved in that level of detail, as to whether --  
18 I mean, I'm sure that those who were speaking to  
19 recipients of components would have made them aware that  
20 there was a UK database being developed, but whether  
21 they got explicit consent, I don't know.

22 Q. Then can I ask you to look -- I'm just going back in  
23 time to 1995 now, in relation to the look-back -- at  
24 SBTS0003833\_421. This a letter from you, dated  
25 10 May 1995, to an Edinburgh GP. I don't propose to

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1 it's the penultimate paragraph, A41, so you refer to the  
2 letter that we just looked at and explain you don't have  
3 access to his original letter. And then you, I think,  
4 summarise couple of the points that you made in the  
5 letter. Then you say this, in the last sentence of this  
6 paragraph of your statement:

7 "Against this background, it was not felt  
8 necessary to provide additional information and/or  
9 training on HCV to GPs."

10 Professor Keel, one of the themes of a lot of the  
11 evidence this Inquiry has heard is about the lack of  
12 knowledge on the part of general practitioners about  
13 hepatitis C, its symptoms, and the potential link  
14 between blood or blood products and development of  
15 hepatitis C. Was any work undertaken in the 1990s by  
16 the Scottish Home and Health Department to try to glean  
17 what the level of understanding was amongst GPs in  
18 Scotland about hepatitis C?

19 A. None that I recollect but that doesn't mean there  
20 weren't any efforts. For example, the primary care  
21 division which looked after GP business may have done  
22 something in this area but I don't know.

23 Q. We can take that down. Thank you.

24 Do you recollect now how the look-back in Scotland  
25 was funded? Was it funded out of existing budgets by

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1 SNBTS and the relevant health boards or was any  
2 additional funding made available by SHHD?  
3 A. My recollection is the former.  
4 Q. Then it was obviously recognised that this look-back  
5 would not identify every patient positive with  
6 hepatitis C. Was any epidemiological modelling or other  
7 work undertaken at the time in order to try to estimate  
8 the numbers of patients who might conceivably be being  
9 missed?  
10 A. I remember SNBTS involving SCIEH, the Scottish Centre  
11 for Infection and Environmental Health, and specifically  
12 got Professor David Bloomberg, who was an expert on  
13 blood-borne virus epidemiology, I think SNBTS  
14 commissioned some work from him in this area. And  
15 I think -- DH definitely did, from a different  
16 individual.  
17 Q. I'm going to move now, Professor Keel, to a separate  
18 topic, and that's the question of the provision of  
19 financial support or assistance, compensation, however  
20 one wants to term it, although those are obviously  
21 different concepts, for those infected with hepatitis C  
22 from blood or blood products.  
23 Now, before we look at any specific documents, is  
24 this the position: that when you came into post in 1992,  
25 there existed within the Scottish Home and Health

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1 establish and the (clinical) judgments required would  
2 also make it costly and complex to administer.  
3 "In the circumstances, I feel I am therefore  
4 obliged to seek the views of our Ministers before we  
5 respond substantively. In particular, I am sure that  
6 Lord Fraser, our Minister for Health and Home Affairs,  
7 would wish to consider these proposals carefully given  
8 his earlier involvement when he was formerly Lord  
9 Advocate, with the HIV settlement scheme.  
10 "We will try to obtain the views of Ministers as  
11 quickly as possible. I hope the inevitable delay does  
12 not cause too much difficulty in dealing with a subject  
13 which I am aware is creating pressure on all UK Health  
14 Departments. I will, of course, inform you of our  
15 Ministers views as soon as these are known."  
16 So this letter suggests that there had been some  
17 initial discussions within the Department, including the  
18 Department's medical and legal advisers. Is it likely,  
19 given the subject matter of this, that that would have  
20 included you?  
21 A. Probably.  
22 Q. The reference in the paragraph beginning "I have now had  
23 the opportunity" to the consensus being that the  
24 no-compensation position was becoming "increasingly  
25 untenable", what can you recall about that consensus and

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1 Department an existing policy or line to take that  
2 financial support would not be made available to those  
3 infected with hepatitis C?  
4 A. Yes.  
5 Q. I'm going to pick the picture up, then, in 1995. If we  
6 look, first of all, at SCGV0000165\_1646.  
7 Now this is a letter dated 25 May 1995. It's  
8 addressed to Roger Scofield in the NHS Executive at the  
9 Department of Health, and it's from Ian Snedden (and we  
10 can see from the first paragraph that he has replaced  
11 George Tucker) and Mr Snedden is responding to a letter  
12 from Roger Scofield about proposals to institute  
13 a payment scheme for those infected with hepatitis C  
14 through blood and blood products, and the letter says as  
15 follows:  
16 "I have now had the opportunity to discuss the  
17 proposals with the Department's medical and legal  
18 advisers, and we are of the view that the scheme as it  
19 is proposed would give rides to a number of complex  
20 legal and medical questions. I can advise you that the  
21 consensus which emerged from these initial  
22 considerations was that whilst the 'no compensation'  
23 position was becoming increasingly untenable, the  
24 proposals to link payments to social needs and the  
25 degree of harm suffered would be very difficult to

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1 the reasons why it was thought to be increasingly  
2 untenable?  
3 A. Well, the consensus, I believe, arose from the view  
4 that, notwithstanding the HIV assistance scheme that had  
5 already been in place for a number of years, that making  
6 an exception to provide assistance, financial  
7 assistance, to sufferers of HCV acquired through  
8 transfusion would be inequitable to other patient groups  
9 already out there who might feel that they'd an equal  
10 claim to such assistance. However, the untenability  
11 I think arises from the fact that there was an  
12 increasing degree of lobbying from organisations such as  
13 The Haemophilia Society to make such payments available.  
14 Q. Now, we can see Mr Snedden was going to seek the views  
15 of ministers before responding substantively. And if we  
16 turn to SCGV0000165\_035, we can see the minute or at  
17 least a draft of the minute that was provided by  
18 Mr Snedden to the Minister of State. It's dated  
19 June 1995, and we can see that the recipients to whom  
20 it's copied include, towards the bottom of that list,  
21 you, Professor Keel.  
22 If we just look at paragraph 1, first of all:  
23 "This minute explains that Ministers at the  
24 Department of Health have asked officials to prepare  
25 proposals for a scheme to compensate those infected with

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1 the Hepatitis C virus (HCV) through blood or blood  
2 products but without any presumption that such a scheme  
3 would be desirable or inevitable. The Scottish, Welsh  
4 and Northern Ireland Offices have all been asked to  
5 comment on the proposals and I am seeking the Minister's  
6 agreement to respond in terms of ..."

7 Then there's reference to a draft letter.

8 If we go over the page, there's a section headed  
9 "Background". If we just look at the bottom of the  
10 page, there are some amendments because this is a draft.  
11 Is that your handwriting, Professor Keel?

12 A. It is.

13 Q. So you would undoubtedly have seen this draft and you're  
14 commenting on it there in relation to the -- some of the  
15 medical background.

16 If we go to the next page, we can see reference,  
17 at the bottom of the page, to "Media and Political  
18 Interest", and the reference there to the Panorama  
19 programme and The Haemophilia Society campaign. And  
20 then the last three sentences -- sorry, the last three  
21 lines say:

22 "We have had a number of Green Folders and letters  
23 for official reply on the matter over the past 9 months  
24 and we have dealt with 2 PQs tabled by Dr Norman Godman  
25 for written reply on 16 June ..."

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1 those reasons Professor, but if we can go over to the  
2 top of the next page, I just want to ask your view,  
3 first of all, about what's said at (d). It refers to:

4 "Negligence in the health care field not  
5 considered to be fundamentally different from negligence  
6 in any other walk of life, where claims for compensation  
7 are resolved through the courts ..."

8 Then this:

9 "... the present system arguably has a deterrent  
10 effect on malpractice and no-fault compensation could  
11 conceivably make doctors less careful."

12 As a doctor yourself and medical adviser to the  
13 SHHD, was that a view which you shared?

14 A. Well, insofar as I agreed it was a theoretical risk but,  
15 I mean, I didn't really feel that the introduction of  
16 a no-fault compensation scheme would lead to my  
17 colleagues casting all care to the winds and being  
18 cavalier in their practice. But it definitely was  
19 a theoretical argument.

20 Q. Then below paragraph (e), it says this:

21 "The main argument against compensation is that  
22 the treatment offered was the best available in the  
23 light of medical knowledge at the time."

24 Then there's reference to the issue about the  
25 introduction of the test for hepatitis C and it being

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1 What's the reference, if you know, Professor Keel,  
2 to the "Green Folders and letters for official reply"?

3 A. Um, gosh, I'm racking my brains. I'm not absolutely  
4 clear. I think Green Folders were maybe correspondence  
5 from members of the Parliament, but I'm not absolutely  
6 sure.

7 Q. In any event, it's recording, is this fair, increasing  
8 public and political interest in this issue?

9 A. Yes, indeed.

10 Q. If we go over the page, there's reference under the  
11 heading "Legal Action" to a test case in Scotland. As  
12 far as you can recall, did you have any involvement in  
13 advising in relation to that case?

14 A. Not that I recall.

15 Q. Then paragraph 10 refers to legal action against Baxter,  
16 a private pharmaceutical company. Do you have any  
17 knowledge about those claims?

18 A. Only what's written here, I'm afraid.

19 Q. We've then got the heading "No-Fault Compensation", and  
20 it's said and underlined:

21 "... establishing a no-fault compensation scheme  
22 would be contrary to the position which the Government  
23 has taken to date. The Government has opposed no-fault  
24 compensation for 5 reasons."

25 Now, I'm not going to take you through each of

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1 introduced earlier in other countries. Again, is that  
2 your handwriting on the right-hand side, Professor Keel?

3 A. Yes.

4 Q. So I think you say:

5 "Worth detailing relative dates of introduction of  
6 HCV testing in other countries -- or would this only  
7 complicate the issue further!"

8 A. That's exactly right. Yes.

9 Q. Can I then just pick up that sentence about the  
10 argument, the main argument being that the treatment  
11 offered was the best available in the light of medical  
12 knowledge at the time. Now, that reflects a line to  
13 take that this Inquiry has seen in documentation  
14 emanating from the Department of Health in the 1990s,  
15 the Department of Health in England. Was it your view,  
16 as the medical advisor with responsibility for this  
17 issue in Scotland, that the treatment had been the best  
18 available in the light of medical knowledge at the time  
19 and, if so, what was that based on?

20 A. Yes, it was my view. And I think the internal report  
21 that SHHD carried out in, I think, about 2000 into the  
22 efforts made by the Blood Transfusion Services in the  
23 UK, both the Protein Fractionation Centre and the  
24 Bio Products Lab, south of the border, in introducing,  
25 or discovering how to treat plasma products so that you

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1 inactivated certain viruses, I think that demonstrates  
2 the absolute complexity of this field.

3 So the coagulation factors that were being given  
4 to, let's say, haemophilia patients prior to the  
5 introduction of testing were state-of-the-art at the  
6 time. It wasn't until, unfortunately, 1987 that SNBTS  
7 began to produce a product called Z8, which was HCV safe  
8 and in sufficient quantities to supply all of the needs  
9 in Scotland. However, that didn't mean that they were  
10 not putting their very best efforts in, as were BPL  
11 south of the border, to developing viral products that  
12 were virus safe, be it from HIV or hepatitis C.

13 So yes, I do strongly believe that had -- at the  
14 time the products being used, although in, you know, in  
15 looking forward -- or looking back, obviously they  
16 contained viruses, and nonetheless they were the best  
17 available treatment at the time and, indeed, they had  
18 revolutionised the treatment of haemophilia.

19 In the 1960s, for example, the mean age of death  
20 of a haemophiliac individual was 37. By the 1980s,  
21 haemophiliacs had a nearly normal lifespan because of  
22 the introduction of Factor VIII and IX products, which  
23 saved them from dying of bleeding, saved them from  
24 disabling complications of bleeds, particularly into  
25 joints. So yes, I strongly support that sentence.

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1 light of medical knowledge at the time. And what I'm  
2 going to explore with you, Professor Keel, it's quite  
3 a long question from me, but I'm going to set out some  
4 scenarios and then invite your comments as a matter of  
5 generality.

6 In 1984, for the sake of argument, it might be  
7 said that the best available treatment for  
8 a haemophiliac, whatever the level of severity of their  
9 haemophilia, might not be a concentrate infected with  
10 hepatitis C and quite possibly with HIV, but might be  
11 cryoprecipitate or might be no treatment at all but  
12 bedrest and management; or in 1986, the best available  
13 treatment say for a haemophiliac with mild haemophilia  
14 might not be a factor concentrate at all, might be DDAVP  
15 or might be 8Y rather than the Scottish product.

16 Do you have any observations on that, professor?

17 **A.** Well, prior to the availability of factor concentrates,  
18 and prior to the availability of cryo, bedrest following  
19 bleeds was the only thing that was on offer. Now, we  
20 know, from that, that that meant young men, in the main,  
21 children, boys, spending long periods of time mainly in  
22 hospital or at home resting with the associated impact  
23 on the rest of their lives, particularly education. And  
24 we also know that, from a medical point of view, that  
25 didn't give good outcomes, because so many of those

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1 **MS RICHARDS:** Sir, I note the time. There are various  
2 matters I want to pick up with Professor Keel, both in  
3 relation to her last answer and the rest of this  
4 document but I'm conscious that the fire alarm is going  
5 to go off where Professor Keel is in a couple of  
6 minutes, so if we bring forward the afternoon break,  
7 I can pick those questions up afterwards.

8 **SIR BRIAN LANGSTAFF:** Yes, we will take a break now and come  
9 back at 3.25. So 3.25.

(2.57 pm)

(A short break)

(3.24 pm)

13 **MS RICHARDS:** Professor Keel, is it right, then, to  
14 understand from the evidence you were giving us before  
15 the break, in relation to life expectancy and improved  
16 life expectancy for haemophiliacs, is it your  
17 understanding that that was based upon the availability  
18 of factor concentrates rather than the availability of  
19 cryoprecipitate?

20 **A.** Well, yes, factor concentrates, yes. They transformed  
21 the management of the condition.

22 **Q.** I want to explore with you this idea of best available  
23 treatment, if I may, and suggest that there might be  
24 difficulties in generalising, as the briefing did, that  
25 the treatment offered was the best available in the

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1 young boys later developed severe osteoarthritis because  
2 of repeated bleeds into joints, and a number of them  
3 would have died too of fatal haemorrhage, often  
4 intracranial haemorrhage, before the availability of  
5 factor concentrates.

6 Moving on to your scenario in 1986, yes, DDAVP was  
7 available and indeed was recognised as being the  
8 preferable treatment for mild haemophiliacs but for  
9 severe haemophiliac patients it wasn't powerful enough.

10 And the availability of 8Y, which incidentally  
11 only in hindsight was proved to be safe from  
12 non-A, non-B -- the method that BPL applied was only  
13 recognised, I think, in 1988, with the passage of time,  
14 not to have communicated HCV. But anyway, the main  
15 limiting factor here was the fact that BPL could not  
16 supply -- or only with great difficulty, could supply  
17 the needs of England for that product.

18 So there was limited capacity, even if Scottish  
19 Haemophilia Directors had wanted to, to acquire 8Y in  
20 Scotland.

21 **Q.** Would you accept, however, reflecting on the kind of  
22 issues that I referred to in my question to you, that  
23 generalising -- by making an assertion as the main  
24 argument against compensation that the treatment offered  
25 was the best available in the light of medical knowledge

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1 at the time, is an over-generalisation?

2 A. Yes, but for the majority of the patients that is a true

3 statement. But there were exceptions that we touched on

4 just now, particularly the mild haemophilia patients who

5 would have benefitted from DDAVP rather than being

6 exposed to concentrates.

7 Q. What about the position of the haemophiliac in, say,

8 1984, where there may be a choice between a concentrate

9 infected, almost inevitably, with hepatitis C, quite

10 possibly infected with HIV: would you agree that the

11 best available treatment might well not be that

12 concentrate transmitting potentially fatal viruses, but

13 might be, for example, cryoprecipitate?

14 A. Yes, well, I have to say, again, hindsight is a fine

15 thing.

16 If we had known in 1984 what we now know about the

17 impact of non-A, non-B hepatitis, then maybe the choice

18 would have been to choose cryoprecipitate, but we didn't

19 know that then. In October 1985, the SNBTS Factor VIII

20 product was HIV safe. In 1984, there was only just the

21 beginnings of the emergence of the possibility that that

22 virus could be transmitted by blood products.

23 So we were in the middle of our state of

24 scientific flux, if you like. The virus had only been

25 discovered in 1984, or identified in 1984. By the

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1 position is in relation to compensation -- was

2 consideration given to the question of whether patients

3 had been treated with informed consent, whether they'd

4 been offered proper choices?

5 A. I don't remember that being our focus of discussion.

6 Just going back to the scenarios you described in

7 the mid-1980s, because by the 1990s we were already on

8 much firmer ground regarding the risks of transmission

9 of these viruses by factor concentrates. We weren't in

10 that position in the mid-1980s -- I repeat, HIV only

11 identified in 1984, hep C only identified in 1989 -- so

12 of course clinicians had a duty to describe to patients

13 the risks of whatever treatment they were being offered,

14 and I guess the option of not having any treatment.

15 But it would have been a difficult situation for

16 clinicians in the mid-1980s, given what I've already

17 said about these viruses only emerging at that point.

18 And the other point relating to non-A, non-B is, as we

19 discussed much earlier, the perception that this was

20 a relatively benign disease process, whatever organism

21 was causing it, and they hadn't identified that at that

22 point.

23 So there was -- what I'm trying to say is that it

24 would have been very difficult for clinicians to say,

25 "These are the definitive risks in this factor

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1 following year, SNBTS had a test in place, which meant

2 that the virus was practically abolished from being

3 transmitted by transfusion.

4 So to go back to your case of somebody with

5 a serious bleed -- I assume is what you're talking

6 about -- and whether that should be managed, in 1984, by

7 cryo rather than factor concentrate, I think there would

8 have been a clinical dilemma and, for example, in the

9 case of an intracranial bleed, with a serious risk of

10 death or severe brain damage, I think in many cases,

11 factor concentrates would have been the best option.

12 So it's a very complex clinical scenario.

13 Q. Would you accept that where there are clinical dilemmas,

14 where there are pros and cons of treatment, different

15 forms of treatment, no treatment, what lies at the heart

16 of the administration of treatment must include the

17 informed consent of the patient?

18 A. Yes, absolutely.

19 Q. And that must encompass a clinician spelling out to

20 a patient the risks both of having the treatment and, of

21 course, also the risks of not having the treatment?

22 A. Yes.

23 Q. To what extent in the 1990s when the Scottish Home and

24 Health Department was formulating or maintaining its

25 various policy positions -- here, obviously, the policy

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1 concentrate that I'm offering you compared to you not

2 having it", because the evidence was only emerging

3 around these viruses at that time.

4 Q. Does it follow from that, Professor Keel, that in

5 relation to the risks of non-A, non-B hepatitis, your

6 thinking in the 1990s, when you were advising the

7 Government on these issues from a medical perspective,

8 that that risk didn't have to be spelt out by clinicians

9 to patients?

10 A. In the 1990s?

11 Q. Looking at it in the 1990s when -- so I'm asking you to

12 think about what your advice was in the 1990s. Was it

13 your stance that in the course of the 1980s, clinicians

14 did not have to advise their patients in Scotland about

15 the risks of non-A, non-B hepatitis because of what

16 you've described as it being thought to be a relatively

17 benign condition?

18 A. No, I'm not saying that. What I am saying is that it

19 would have been very difficult to describe to patients

20 what risks they were running, because the perception was

21 that the virus non-A, non-B -- as yet undefined --

22 caused elevation of liver enzymes in virtually all of

23 the recipients of these products. But the implications

24 of that were by no means clear at all. It seemed

25 that -- and I saw these patients in the clinic with

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1 elevated enzymes. They didn't have symptoms of liver  
2 disease. They weren't complaining of liver disease  
3 symptoms. What they were complaining of was an  
4 arthritic elbow or knee.

5 So as I've said before, the general perception in  
6 the early, certainly to the mid-1980s, was that this was  
7 a relatively benign disease that only caused elevation  
8 of liver enzymes, and the other sequelae unfortunately  
9 only emerged over a longer period of time, by which  
10 time, of course, clinicians were informing patients  
11 anyway. When the virus was identified, all haemophilic  
12 patients were tested for it and they would have been  
13 informed of their results.

14 Q. Professor Keel, just to say I'm going to pick up on that  
15 issue and, indeed, what you've said earlier about the  
16 issue relating to the Scottish heat-treated product  
17 tomorrow, because the evidence you've given is not  
18 necessarily reflected in the evidence the Inquiry has  
19 heard on those issues.

20 Can I just go back to the briefing we were looking  
21 at, SCGV0000165\_035, page 5.

22 So we were looking at that sentence below  
23 subparagraph (e) about the main argument against  
24 compensation being the treatment offered was the best  
25 available in the light of medical knowledge at the time,

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1 Better Blood Transfusion Programme under way.

2 I absolutely agree that this sentence that is up  
3 here does not relate to the use of blood transfusion  
4 per se. I was reading it in the context of treatment  
5 for haemophilia. I'm not sure whether the previous  
6 paragraphs indicate that I'm correct but that was how  
7 I was interpreting it. But I absolutely agree with you  
8 that over-transfusion, unnecessary use of blood, was not  
9 the best available treatment for those requiring or not  
10 requiring transfusion at the time.

11 Q. The reason I would suggest, Professor Keel, that this  
12 assertion is looking at both blood products, which is  
13 referred to in the previous subparagraph, and  
14 transfusion, is of course what the paragraph then goes  
15 on to say:

16 "Whilst this is true, a weakness is that other  
17 countries did introduce the test for HCV earlier than in  
18 the UK and in Belgium ..."

19 And that I think must be a reference to the  
20 introduction of screening in the Blood Transfusion  
21 Service in 1991.

22 A. Yes.

23 Q. Again, just to explore with you the issue about  
24 treatment in the form of blood transfusion being the  
25 best available, and leaving aside the potential weakness

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1 and I've just been exploring with you some scenarios in  
2 relation to blood products and treatment with blood  
3 products.

4 Can I then perhaps test that main argument now in  
5 relation to the position of those who received  
6 transfusions and, again, suggest that it might be  
7 difficult to generalise to the extent set out in this  
8 briefing.

9 Would you accept, first of all, that the  
10 unnecessary use of blood, so giving transfusions where  
11 they weren't necessarily required or giving too much by  
12 way of a transfusion, was a well-known problem? Later  
13 to be addressed by the Better Blood Transfusion  
14 Initiative and others, which I'll ask you about  
15 tomorrow.

16 A. Yes -- well, whether it was a well-known problem at the  
17 time, I'm not absolutely confident. But certainly  
18 during my career as a haematologist, data began to  
19 indicate enormous variation in practice, transfusion  
20 practice, between similar groups of clinicians.

21 For example, surgeons operating -- cardiac  
22 surgeons, some using transfusion as a matter of routine,  
23 some others not using any blood transfusion at all.

24 So that began to emerge during the 1990s, and in  
25 fact was a catalyst for me and many others to get the

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1 that was identified in this paragraph in terms of the  
2 period of time before HCV screening was introduced, it  
3 might also be said that, in the context of blood  
4 transfusion, the best available treatment for those who  
5 genuinely required a blood transfusion and for whom  
6 there was no alternative, might nonetheless be blood to  
7 which there had been an element of testing through the  
8 use of surrogate testing, before the availability of the  
9 HCV screening test?

10 A. Well, I alluded -- well, you alluded earlier to the  
11 non-introduction of ALT testing in the UK, although of  
12 course it was adopted by many other countries. The  
13 reasons for its non-adoption in the UK were the  
14 non-specificity of that test, which means that it would  
15 have -- if we'd introduced this to the donor screening  
16 panel of tests, there would have been many, many false  
17 positives, ie, people whose ALT level was raised for  
18 other reasons such as alcohol, use -- obesity, and there  
19 are a number of other conditions which can give rise to  
20 ALT rises, not least all the other viruses that can  
21 affect the liver.

22 So it was decided, in the main, given to the -- in  
23 the main, due to the number of false positives that  
24 would arise, that this would not be a good idea. It  
25 would not be a good screening test. For example, if

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1 a donor tests positive for a virus, any of the tests  
 2 that are routinely applied, obviously they're offered  
 3 counselling, what would you say to someone whose ALT was  
 4 elevated? That they may or may not have a viral  
 5 infection or maybe the ALT elevation is due to the fact  
 6 that they are drinking too much alcohol, or that they  
 7 are overweight? So on those grounds, it was decided  
 8 that it was not a good screening test.

9 Q. I'm going to leave that paragraph for now and just look  
 10 at the rest of the document with you, if I may,  
 11 professor.

12 A. Can I just --

13 Q. Yes?

14 A. May I just look at the previous paragraph?

15 Q. Of course. So could we have -- on screen you should see  
 16 the previous two subparagraphs, and then we can look at  
 17 the previous page.

18 A. Yes.

19 Q. So these were what was said to be the five reasons for  
 20 the Government opposing no-fault compensation, those are  
 21 the last two, on the page.

22 A. If we go to the paragraph that you've referred to that  
 23 says that this argument against compensation was the  
 24 best available in the light of medical knowledge, and  
 25 you said that this document refers to transfusion as

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1 recorded in Mr Snedden's draft briefing, paragraph 13:  
 2 "It does seem to us, however, that the HIV  
 3 settlement represents a powerful precedent. We do not  
 4 believe that it is reasonable that different policies  
 5 should apply in respect of 2 different but both serious  
 6 and potentially fatal viruses. In addition HCV carries  
 7 its own social stigma since it is often associated with  
 8 intravenous drug misuse. (One of the main demands of  
 9 the Haemophilia Society campaign is a public education  
 10 programme.) Furthermore the prognosis and risk of  
 11 transmission, for those (mainly haemophiliacs) infected  
 12 with both viruses is worse than for those affected with  
 13 HIV alone."

14 It appears to be, as recorded there, the settled  
 15 view within the Scottish Home and Health Department at  
 16 this point in time, which is '95, that there isn't  
 17 a good basis for distinguishing HIV from hepatitis C.  
 18 We don't see that, I think, reflected in the -- in some  
 19 of the later documentation, which we'll come on to.  
 20 What was your understanding at the time, of the  
 21 Department's position?

22 A. Well, again, I'm struggling to remember, because you're  
 23 right: this does vary from subsequent positions taken.  
 24 I can't remember really having any discussion with --  
 25 was it Ian Snedden who put this forward?

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1 well as factor concentrates, could I just refresh my  
 2 memory on that?

3 Q. Yes, of course. If we just go to the first page, the  
 4 heading is "Payments for those infected with hepatitis C  
 5 through blood transfusion/blood products".

6 A. Yes, okay.

7 Q. Then the first paragraph refers, in the third line, to  
 8 "through blood or blood products".

9 A. Yes.

10 Q. So it would appear to be addressing both.

11 A. So my reading of the subsequent paragraph was -- were  
 12 limited than it should have been. My interpretation was  
 13 more limited. So apologies for that.

14 Q. So if we go back to page 5, the bottom half of the page  
 15 now. The heading "HIV Settlement as a Precedent",  
 16 paragraph 12 says:

17 "The HIV settlement is being cited as  
 18 a precedent."

19 Then it refers to the Department of Health arguing  
 20 that there were special factors applying to that  
 21 situation, and then three factors are there set out.  
 22 The first of which is the fatal nature of HIV; the  
 23 second is, I think, a longhand for stigma; and then the  
 24 third is double disadvantage of haemophilia and HIV.

25 If we go over the page, this is the view being

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1 Q. Yes.

2 A. With him, about this paragraph. And, actually, I don't  
 3 really disagree -- I don't really agree wholly with it.  
 4 It seemed to me at the time, and now, that HIV, when the  
 5 existing scheme was set up, was a very much more serious  
 6 disease than HCV.

7 We all remember the advert, the campaigns, you  
 8 know, "Don't die of ignorance". It was a really  
 9 enormous -- perceived as an enormous public health  
 10 threat. I worked as a locum at St Mary's Hospital in  
 11 London, which was a place which looked after many  
 12 HIV/AIDS sufferers, and I used to, when required, do  
 13 bone marrow examinations on them. So I saw firsthand  
 14 the devastating effect that HIV had within a relatively  
 15 short period of time after acquiring the virus, to  
 16 developing AIDS and inevitable death at that point.  
 17 Because, of course, this was long before antiviral  
 18 treatments appeared.

19 So I don't really wholly agree with what Ian is  
 20 saying here. And I don't think the social stigma around  
 21 HCV was anything like as hyped as the problems that HIV  
 22 sufferers encountered. The only thing I would agree  
 23 with wholeheartedly is that, of course, if you get both  
 24 viruses, then you're going to do worse, you're going to  
 25 get much iller much quicker.

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1 So this is a slight puzzle to me, this paragraph.  
 2 Q. It may be a fair reading of this paragraph is not to say  
 3 that HIV and HCV are identical but to say the same  
 4 treatment is engaged and that they are both serious and  
 5 potentially fatal viruses. Would you accept that, as at  
 6 1995 -- leave aside for the moment the position in  
 7 relation to earlier years -- it's accurate to describe  
 8 HCV as a serious and potentially fatal virus?  
 9 A. Yes, I would.  
 10 Q. In terms of stigma, this doesn't, on its face, read as  
 11 though Mr Snedden is saying the social stigma associated  
 12 with hepatitis C is identical to the stigma associated  
 13 with HIV, but he's saying it does carry its own stigma,  
 14 for the reason he sets out. And would you agree that  
 15 hepatitis C was known to be stigmatising, in particular  
 16 because of the association with IVDU?  
 17 A. Yes, but I repeat not the same degree as HIV positive  
 18 individuals were stigmatised in the 1980s.  
 19 Q. If we then just continue more quickly through the rest  
 20 of this document, there's a summary of the Department of  
 21 Health proposals, I don't propose to read through that.  
 22 If we go to the next page there's a heading "Numbers and  
 23 Costs", and it talks about, it gives an estimate of  
 24 possible numbers and possible costs. If we go over the  
 25 page, there's reference to CJD and human growth hormone

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1 to make such a scheme unworkable. Legal and medical  
 2 opinion suggests that there is no realistic option but  
 3 to compensate all those infected through contaminated  
 4 blood products on equal terms, the only compromise  
 5 possible being on the amount of the settlement and this  
 6 is the line we are taking in responding to the  
 7 Department of Health."  
 8 Now, we'll see how the Department of Health then  
 9 deals with the issue shortly, but that being the view  
 10 set out by Mr Snedden, "increasingly difficult to hold  
 11 the line", "no realistic option but to compensate all  
 12 those infected through contaminated blood products on  
 13 equal terms", that being the advice in June 1995, what's  
 14 your understanding as to why it was not for another  
 15 eight years that the Scottish Government decided that  
 16 there should be some form of financial assistance to  
 17 those infected with hepatitis C?  
 18 A. I suspect, at least in part, for the reasons that I have  
 19 just outlined, that HIV was seen as a uniquely awful  
 20 disease, which merited a precedent being set. But, in  
 21 other cases, although of course there are -- of course  
 22 there are similarities, great similarities, between HIV  
 23 and HCV, but there was a desire to maintain the HIV  
 24 assistance, financial assistance as a unique precedent  
 25 and not to set or to enshrine other cases, such as HCV,

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1 patients. Then there's a heading "Treasury", and  
 2 a reference to the position or anticipated position of  
 3 the Treasury to any financial assistance.  
 4 Then if we go to the next page, if we just pick it  
 5 up under the heading "Conclusion", Mr Snedden says this  
 6 at paragraph 22:  
 7 "Mounting pressure in the political arena and the  
 8 pending legal actions make it increasingly difficult to  
 9 hold the line for no compensation."  
 10 Then there's reference to the  
 11 Haemophilia Society's campaign, and then picking it up  
 12 in the sixth line:  
 13 "Continued adverse publicity about blood safety,  
 14 risks damaging confidence in the system. There is also  
 15 the question of whether the case for not offering  
 16 compensation is sufficiently robust to hold up,  
 17 particularly in view of the Baxter settlement and the  
 18 precedent set by payments made to those already infected  
 19 with HIV."  
 20 Then it continues:  
 21 "We have considered the administrative, legal and  
 22 medical implications of the proposed compromise of  
 23 paying compensation to those infected with HCV on the  
 24 basis of need and/or the harm they have suffered but the  
 25 difficulties likely to be encountered ... above appear

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1 with the same status. Because it was well known that  
 2 there were other -- and I've already alluded to this --  
 3 other groups of patients out there suffering from  
 4 entirely different conditions, who might feel that they  
 5 had a right to compensation or financial assistance in  
 6 the same way as would be offered to HCV sufferers.  
 7 Q. Can you give us some examples of the other groups about  
 8 whom you or your colleagues were particularly concerned,  
 9 who might point to the provision of assistance to those  
 10 infected through blood or blood products and suggest  
 11 that they were therefore entitled to similar support?  
 12 A. Well, there was certainly a couple that come to mind.  
 13 There was a group, I think it was called RAGE,  
 14 Radiotherapy Action Group -- I can't remember what the  
 15 "E" stood for -- but they were a group that formed to  
 16 highlight the problems that women with breast cancer had  
 17 encountered following radiotherapy, and they were  
 18 seeking compensation.  
 19 Another was a product called Myodil, which was  
 20 a contrast medium for visualising the spine. It was  
 21 injected into the spinal cord and caused inflammation.  
 22 So that was another group that were looking for  
 23 compensation and there would have been others out there,  
 24 I can't remember. So the view that HCV should not be  
 25 added to the precedent set by HIV was founded on that

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1 context.

2 Q. Do you know whether either of those groups that you

3 referred to were using the HIV settlement as the

4 argument as to why they should be compensated?

5 A. I don't know. I don't know.

6 Q. Just to complete the picture in relation to the 1995

7 decision making, SCGV0000166\_054.

8 This is a letter from the Department of Health,

9 England. It's from a Mr Guinness to Mr Snedden,

10 13 October 1995. We can see from the handwriting at the

11 top that it says "Dr Keel for information", so it would

12 have been, it looks like, copied to you. And we can see

13 Mr Guinness says in the first paragraph:

14 "It is important that we keep in regular touch

15 over this issue to ensure a consistent presentation of

16 policy, which as you say is ultimately a matter for

17 collective consideration by Government.

18 "Your concerns over the operational difficulty of

19 any compensation scheme are well taken. As I understand

20 it part of Roger Scofield's intention in proposing

21 a problem was to expose the problems of appropriately

22 targeting resources in the face of a disease of such

23 uncertain history and variable effects. I do think that

24 this will prove useful groundwork in the event that

25 there is a change in policy."

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1 hepatitis C, that did not go anywhere in Scotland?

2 A. Yes.

3 Q. I'm going to pick matters up, then, in 1998 which

4 appears to be, at least from the available

5 documentation, the next occasion on which the matter was

6 expressly considered.

7 If we go, please, to SCGV0000167\_178.

8 This is a minute from Rachel Sunderland,

9 PS/Mr Galbraith, 29 July 1998, and it's addressed to

10 Mr Nichol, and then it's copied to a number of

11 individuals. It's clearly copied at ministerial level

12 and it's copied to you, although you're down as

13 "Mr Keel" rather than "Dr Keel" on that list.

14 It says:

15 "Mr Galbraith has seen your minute of 28 July

16 informing him that Mr Dobson was due to announce

17 yesterday that the Department of Health will not be

18 offering compensation to individuals infected with ...

19 (HCV) through NHS treatment. As discussed with you by

20 telephone Mr Galbraith is content with the

21 recommendation to adopt a similar position in Scotland

22 and with the proposed lines to take subject to the

23 deletion of the fourth bullet."

24 We'll see what that refers to in a moment.

25 "The Minister has noted the 'if pressed' line and

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1 Then there's reference to the schemes in the

2 Republic of Ireland.

3 And then it says:

4 "As you will be aware my Secretary of State has

5 made it clear that there is currently no prospect of

6 such a change in his mind. The expense and associated

7 opportunity cost of any settlement are significant

8 factors but the main plank of resistance remains

9 opposition to the principle of a no-fault compensation

10 scheme. In evidence to the Health Committee Public

11 Expenditure Enquiry on 19 July the Secretary of

12 State ..."

13 Pausing there, that is a reference to

14 Stephen Dorrell, as I understand it, the then Secretary

15 of State for Health in England:

16 "... acknowledged that there was an illogicality

17 in the payment to HIV infected patients, given that

18 principle. However he did not see this as sufficient

19 reason to err from it."

20 So I think it's right that, following the exchange

21 of documents that we've looked at, and then there are

22 others that I'm not going to spend time looking at, but

23 in 1995, although consideration was given in the way in

24 which we've explored to the possibility of introducing

25 some form of financial support for those infected with

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1 would be grateful if this could be held back, however if

2 it was to be issued then the Minister would be grateful

3 if the phrase 'public revulsion' could be deleted."

4 And again we'll see what that refers to.

5 Now "Mr Dobson" is Frank Dobson, by this time

6 Secretary of State for Health in the UK Government, and

7 Mr Galbraith was who?

8 A. He was the Health Secretary at that point in Scotland.

9 He was, as it so happens, a doctor. He was a

10 neurosurgeon.

11 Q. So it's July 1998, so we're still pre-devolution, so he

12 was a Health Minister in the Scottish Home and Health

13 Department; is that right?

14 A. Yes.

15 Then the document that is being referred to in

16 this minute is at SCGV0000167\_181.

17 And we can see this is from Andy Nichol, Health

18 Care Policy Division, to Mr Galbraith's Private Office.

19 Again, copied to you (you're correctly referred to as Dr

20 rather than Mr Keel on this occasion) and then we can

21 see that the purpose of the briefing, in paragraph 1,

22 is:

23 "To advise Mr Galbraith that Mr Dobson will today

24 be announcing that the Department of Health will not be

25 offering compensation to individuals infected with

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1 Hepatitis C ... through NHS treatment, and to recommend  
2 that a similar position be adopted in Scotland."

3 Then if we go towards the bottom of the page, we  
4 see reference, under the heading "Background", to  
5 The Haemophilia Society's campaign. I'm not going to  
6 read through that.

7 If we go over the page, we can see paragraph 5  
8 describes the previous administration having rejected  
9 claims for a compensation scheme, and then various  
10 grounds are set out, and the first refers, again, to  
11 that line to take of best available treatment.

12 If we go to the next page, we can see the heading  
13 "Scottish considerations" just over halfway down the  
14 page, and paragraph 9 reads:

15 "There are 122 known cases of HCV-positive  
16 Scottish parents who have been infected through blood  
17 transfusions or blood products. It is likely that  
18 today's announcement will lead to a number of actions  
19 for compensation being raised against the Government and  
20 in Scotland there are currently 10-12 pending court  
21 actions. If Mr Galbraith agrees to adopt a similar  
22 position to the Secretary of State for Health, we can  
23 expect the remainder of the 122 Scottish cases to  
24 request Legal Aid to pursue claims for damages."

25 Then the recommendation in paragraph 10:  
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1 the Government to take on a complex issue. It reads as  
2 Scotland effectively falling into line behind the  
3 decision of Mr Dobson in England.

4 Are you able to tell us whether, from your  
5 perspective, there was indeed a long period of  
6 consideration resulting in a very hard decision for the  
7 Government to take?

8 A. Well, I think the chronology here indicates that there  
9 was quite a long period, because the previous document  
10 you've put up, the DH letter, I think was 1995, and this  
11 submission dates from 1998, is that right?

12 Q. That's right, although it's not currently clear to me  
13 what, if anything, in terms of active contemplation of  
14 this issue was taking place in the intervening period.

15 A. Then I'm afraid I can't enlighten you on that. I mean,  
16 a lot of this kind of discussion around possible  
17 compensation schemes would have been led very much by  
18 policy colleagues and legal advisers, rather than the  
19 medical side of the house. I mean, obviously my view  
20 was taken on the medical comments included in the  
21 submissions but the direction of policy was very much  
22 driven by policy colleagues.

23 Q. Then we can see there that the fourth bullet point is  
24 crossed out, and that is presumably a reflection of the  
25 minute from Mr Galbraith's office, which had said:

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1 "This issue has always been viewed as a UK-wide  
2 matter which requires the four territorial Death  
3 Departments to adopt a consistent line. Mr Dobson's  
4 announcement therefore effectively binds Scotland Wales  
5 and Northern Ireland to following the same line.  
6 Unfortunately Department of Health officials were unable  
7 to give us prior warning of this announcement (we were  
8 first advised yesterday afternoon). However, we see no  
9 reason to deviate from the decision reached by the  
10 Secretary of State for Health and would recommend that  
11 Mr Galbraith agree to adopt a similar position in  
12 Scotland."

13 And we know from that minute that we looked at  
14 that Mr Galbraith did indeed accept that recommendation.

15 Then if we go over the page, the "Line to Take":  
16 "11. In the likely event of media enquiries  
17 I would suggest the following line to take ..."

18 The first refers to "great sympathy" and "personal  
19 tragedy".

20 The second is this:

21 "This has been a very hard decision for the  
22 Government to take on a complex issue which is why it  
23 has taken so long to come to a view."

24 Now, just pausing there, this briefing doesn't  
25 necessarily read as reflecting a very hard decision for  
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1 "This is agreed subject to deletion of the fourth  
2 bullet point."

3 Now, that fourth bullet point is this:

4 "We accept that there is a low level of public  
5 understanding of Hepatitis C and are therefore committed  
6 to looking into how we might improve information and  
7 education in this area."

8 First of all, would you say it was broadly correct  
9 in Scotland in 1998 that there was a low level of public  
10 understanding of hepatitis C?

11 A. I honestly can't say. I suspect, given that the virus  
12 had been only identified less than 10 years previously,  
13 there probably was a relatively low understanding. But  
14 I can't be sure of that.

15 Q. Does it concern you, looking at this now, and bearing in  
16 mind that, obviously, your input was as medical advisor,  
17 that the suggested commitment to looking into how  
18 information and education in this area might be  
19 improved, has been crossed through as a result of the  
20 Minister's decision?

21 A. Well, I don't think that that means that there were --  
22 all moves to improve education and information were  
23 abandoned. I mean, for example, Health Protection  
24 Scotland, an agency of Scottish Health Service, were  
25 very involved on the public health -- in the area of

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1 public health in producing materials around hepatitis C.  
 2 So I don't think the Minister scoring this line out  
 3 didn't mean that he didn't want any efforts to improve  
 4 information and education.  
 5 **Q.** If we just go a little further down the page, I don't  
 6 have a question to ask you about it but we can see there  
 7 "If pressed", the words "or public revulsion" crossed  
 8 out", and I refer to that just to make sense of what was  
 9 said in the accompanying minute. If we just go back to  
 10 the previous page, back to paragraph 10, the bottom of  
 11 the page, the assertion there that it has always been  
 12 viewed as a UK-wide matter that the four territorial  
 13 Health Departments are required to adopt a consistent  
 14 line and that Frank Dobson's announcement effectively  
 15 binds Scotland, Wales and Northern Ireland.  
 16 Do you have any understanding as to why that was  
 17 believed to be the case? Why couldn't Scotland, or  
 18 indeed Wales or Northern Ireland, go it alone, and  
 19 introduce a financial support scheme, if they wished to?  
 20 **A.** Well, I think in law they could have but the point,  
 21 though, I think material point, would have been that,  
 22 had Scotland decided to go ahead with the scheme, and  
 23 England had decided against it, then public perception  
 24 would have been very confused. There would have been  
 25 inequity in supporting patients south of the border, and

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1 "... that the patients concerned received the best  
 2 treatment available at the time, given the state of  
 3 knowledge about HCV and the lack of a reliable screening  
 4 test."  
 5 You told counsel that you -- I think by the time  
 6 that this was written, you accepted that it was known  
 7 that hepatitis C was a serious disease, with potential  
 8 long-term serious consequences, which could be fatal.  
 9 Now, if one were to add to that the potential for  
 10 somebody who is a carrier of that disease and isn't  
 11 detected because of a lack of an appropriate test, let's  
 12 say, that would add to the reservoir of those who had  
 13 infection in the community, that would be a matter of  
 14 interest, I suppose, to Government, the Public Health  
 15 wing, because it would want to prevent that pool  
 16 developing and leading to further problems, would it  
 17 not?  
 18 **A.** Yes.  
 19 **SIR BRIAN LANGSTAFF:** Now if you -- let us suppose -- this  
 20 is purely hypothetical -- given the state of knowledge  
 21 about HCV -- plainly that's referring to 1998. If you  
 22 or somebody in your position had been, as CMO or Deputy  
 23 CMO in Scotland, let's suppose, been advising or in  
 24 a position to advise ministers in 1980, 18 years before,  
 25 just picking a date, that indeed hepatitis was

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1 in other parts of the UK. So it was seen as desirable  
 2 to move forward on a UK-wide basis, but I don't think  
 3 England could have dictated to Scotland not to go ahead  
 4 with such a scheme.  
 5 However, what Scotland would have had to do was to  
 6 find the funding for such a scheme from its block grant.  
 7 **Q.** That's a theme we'll no doubt pick up tomorrow when we  
 8 look at what happened in 2002, 2003.  
 9 Sir, I'm going to move now to the issue of the  
 10 Scottish Executive's Inquiry, internal inquiry in '99  
 11 and 2000, and can I suggest that we pick that up in the  
 12 morning rather than me starting it now?  
 13 **SIR BRIAN LANGSTAFF:** Yes.  
 14 Just before we stop for the evening, I wonder if  
 15 you could help me with something. Can we just go back  
 16 to the previous page on this document that is currently  
 17 on the screen., and it's paragraph 5 there, the -- it's  
 18 saying what the previous administration had done, it  
 19 had:  
 20 "... rejected claims for a compensation scheme on  
 21 the grounds ..."  
 22 And I'm just interested in the formulation of what  
 23 is said at the beginning, in the light of some of the  
 24 evidence that you have been asked about this afternoon,  
 25 and it's:

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1 potentially fatal, it was a severe disease or serious  
 2 disease with potential serious long-term consequences,  
 3 and it added to the reservoir of infection in the  
 4 community, do you think that what then followed after  
 5 that would have been what could be described as the best  
 6 treatment that should have been given? Or would it have  
 7 altered, do you think, the treatment available, and  
 8 would you have advised ministers that they should do  
 9 something about it? Or might wish to do something about  
 10 it?  
 11 It's a hypothetical question but I'd be  
 12 interested in your view.  
 13 **A.** So what you're asking me is if in 1980 -- what would --  
 14 **SIR BRIAN LANGSTAFF:** I'm exploring the question of how  
 15 relevant the state of knowledge about HCV is to what is  
 16 being done. Because that's the connection made here --  
 17 **A.** Yes.  
 18 **SIR BRIAN LANGSTAFF:** -- and I'm picking 1980 as a date, and  
 19 suppose that had been known at the time.  
 20 **A.** If it was known then that hepatitis C was indeed  
 21 a serious infection, which could lead to death in some  
 22 circumstances, yes, of course that would have changed  
 23 the advice given, and I dare say the political  
 24 perception of the need to do something.  
 25 **SIR BRIAN LANGSTAFF:** Well, thank you very much. I thought

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1 that would be your answer but I needed to ask you to  
2 find out, because you're in that position of giving  
3 advice or being in the position to advice Government, or  
4 were, and it's the sense of what would have merited  
5 politicians being told at that time. But thank you very  
6 much for that.  
7 We'll take a break now until tomorrow morning at  
8 10.00. The same rules, of course, apply about  
9 discussing your evidence, Professor Keel, but I wish you  
10 a good evening, and look forward to seeing you again  
11 tomorrow morning at 10.00. Thank you very much.  
12 **THE WITNESS:** Thank you, thanks.  
13 **(4.18 pm)**  
14 **(The hearing adjourned until 10.00 am the following day)**  
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1	I N D E X	
2	PROFESSOR AILEEN KEEL (sworn) .....	2
3	Questioned by MS RICHARDS .....	2

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(40) 9 April 1992 - agree

<b>A</b>	115/17 117/8 119/11 119/14 124/22 124/24 125/11 126/9 126/23 128/20 132/7 135/3 135/11 144/8 144/22 <b>allow</b> [1] 97/16 <b>allowing</b> [2] 70/24 90/11 <b>alluded</b> [3] 128/10 128/10 136/2 <b>alluding</b> [1] 42/14 <b>almost</b> [1] 121/9 <b>alone</b> [4] 83/17 89/25 131/13 145/18 <b>along</b> [2] 11/14 16/25 <b>alongside</b> [1] 51/1 <b>already</b> [19] 12/3 15/6 21/25 37/11 46/5 63/22 75/18 79/10 84/10 88/21 90/15 98/5 99/19 112/5 112/9 123/7 123/16 134/18 136/2 <b>also</b> [24] 9/11 11/17 11/17 14/8 34/24 38/11 41/4 48/5 57/1 62/16 74/21 75/2 80/22 88/18 92/24 94/18 95/18 95/19 105/4 111/2 119/24 122/21 128/3 134/14 <b>ALT</b> [6] 53/20 128/11 128/17 128/20 129/3 129/5 <b>altered</b> [1] 148/7 <b>alternative</b> [2] 81/6 128/6 <b>although</b> [13] 8/5 53/9 63/21 72/7 81/16 89/24 109/20 117/14 128/11 135/21 138/23 139/12 143/12 <b>always</b> [16] 4/23 19/9 26/19 27/13 30/14 30/14 32/18 35/22 39/3 43/1 61/10 64/6 75/13 83/24 142/1 145/11 <b>am</b> [16] 1/2 1/18 2/7 23/23 39/25 40/2 80/15 81/4 88/16 89/7 111/3 111/5 111/13	113/5 124/18 149/14 <b>ambition</b> [1] 5/17 <b>amendments</b> [1] 113/10 <b>amongst</b> [6] 8/24 49/17 51/13 74/15 85/8 108/17 <b>amount</b> [3] 97/19 98/8 135/5 <b>an agency</b> [1] 144/24 <b>an announcement</b> [1] 89/7 <b>an applicant</b> [1] 58/5 <b>an assertion</b> [1] 120/23 <b>an assistant</b> [1] 18/10 <b>an Edinburgh</b> [1] 106/25 <b>an enormous</b> [3] 72/23 97/1 132/9 <b>an equivalent</b> [1] 21/17 <b>an estimate</b> [1] 133/23 <b>an exercise</b> [2] 81/6 107/20 <b>an eye</b> [1] 67/11 <b>an HCV</b> [1] 97/6 <b>an honorary</b> [2] 2/13 4/11 <b>an imperative</b> [1] 87/15 <b>an important</b> [1] 71/10 <b>an individual</b> [1] 69/15 <b>an inevitable</b> [1] 56/21 <b>an Inspired</b> [1] 89/8 <b>an intracranial</b> [1] 122/9 <b>an issue</b> [1] 97/7 <b>an MSBT</b> [1] 101/25 <b>an observer</b> [3] 6/15 40/5 44/1 <b>an overlap</b> [2] 17/10 21/7 <b>an overview</b> [1] 2/7 <b>an SMO</b> [1] 22/5 <b>an SNBTS</b> [1] 72/1 <b>Andrew</b> [5] 26/22 26/25 27/1 27/2 27/11	<b>Andrew Fraser</b> [2] 26/25 27/11 <b>Andrew's</b> [3] 72/14 72/19 73/25 <b>Andy</b> [1] 140/17 <b>Andy Nichol</b> [1] 140/17 <b>Angela</b> [1] 105/10 <b>Annex</b> [3] 49/3 49/5 49/13 <b>Annex A</b> [2] 49/3 49/13 <b>Annex B</b> [1] 49/5 <b>announce</b> [1] 139/16 <b>announcement</b> [7] 89/7 90/8 93/6 141/18 142/4 142/7 145/14 <b>announcing</b> [3] 82/24 93/3 140/24 <b>annual</b> [5] 38/12 38/13 38/18 38/24 39/4 <b>annually</b> [1] 39/2 <b>another</b> [15] 8/2 15/15 19/11 27/23 35/6 36/15 38/6 49/20 55/3 65/23 67/24 84/7 135/14 136/19 136/22 <b>answer</b> [13] 8/15 19/21 37/5 60/6 60/23 60/24 66/22 78/15 84/19 104/11 106/7 118/3 149/1 <b>answering</b> [1] 82/2 <b>anti</b> [6] 60/22 70/4 96/14 107/4 107/6 107/17 <b>anti-coagulants</b> [1] 96/14 <b>anti-HCV</b> [5] 60/22 70/4 107/4 107/6 107/17 <b>anticipate</b> [1] 105/18 <b>anticipated</b> [2] 48/19 134/2 <b>antiviral</b> [1] 132/17 <b>anxiety</b> [3] 79/15 80/5 102/17 <b>any</b> [109] 7/3 9/15 9/20 10/1 10/15 12/19 13/6 13/7 13/17 13/17 13/22 14/25 19/3 21/1	21/10 22/3 22/24 25/8 26/16 26/17 27/19 32/1 32/5 32/6 32/9 32/22 34/22 36/8 37/9 37/9 37/20 38/4 39/20 42/5 42/9 43/3 43/5 43/8 43/11 43/21 44/17 45/7 46/7 46/11 47/1 47/5 47/6 47/7 48/15 53/10 58/5 59/1 59/8 59/16 59/24 68/25 70/15 71/6 72/13 78/10 79/5 79/15 79/23 81/15 81/19 81/19 82/9 83/16 85/21 85/21 85/22 86/15 87/2 87/6 90/11 91/1 91/10 93/25 94/5 95/14 95/25 96/20 97/3 98/25 99/9 100/22 100/25 102/3 102/8 108/15 108/20 109/1 109/6 109/23 113/2 114/7 114/12 114/16 115/6 119/16 123/14 126/23 129/1 131/24 134/3 137/19 138/7 145/3 145/16 <b>anybody</b> [4] 12/19 67/19 92/6 92/21 <b>anyone</b> [2] 39/19 39/20 <b>anything</b> [9] 13/12 23/2 35/17 38/5 39/22 42/15 67/6 132/21 143/13 <b>anyway</b> [7] 18/12 20/15 20/16 40/21 54/17 120/14 125/11 <b>anywhere</b> [1] 139/1 <b>AOCB</b> [2] 69/25 71/13 <b>apart</b> [5] 15/14 15/15 24/17 77/21 86/16 <b>apologies</b> [4] 4/2 36/22 74/14 130/13 <b>apparent</b> [2] 99/1 99/23 <b>Apparently</b> [1] 97/21 <b>appear</b> [2] 130/10 134/25 <b>appeared</b> [2] 75/2
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(41) agree... - appeared

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(42) appeared... - back

<b>B</b>	96/11 98/7 99/2 104/11 113/10 117/21 119/25 120/1 123/7 124/2 124/15 124/20 125/17 131/22 132/17 133/16 136/1 143/9 147/11 147/15 148/16 149/2 <b>becoming</b> [2] 110/23 111/24 <b>bedrest</b> [2] 119/12 119/18 <b>been</b> [118] 7/8 10/6 13/10 13/19 17/17 21/8 23/5 25/10 25/13 25/16 28/3 28/13 32/18 33/2 35/14 36/12 37/10 37/13 37/15 37/22 38/12 39/8 41/22 42/12 42/24 44/1 44/1 45/8 46/19 48/9 52/13 56/21 56/22 56/24 57/22 58/2 58/10 58/18 61/11 62/6 62/16 62/19 64/16 67/8 71/18 71/23 73/23 74/2 74/19 74/23 75/10 75/22 78/6 78/9 89/24 90/14 91/2 91/24 92/16 92/22 94/15 95/6 95/9 96/8 96/17 97/16 97/18 98/16 99/8 99/14 99/22 102/17 103/2 103/12 103/15 105/2 105/7 105/17 105/20 105/23 106/13 106/14 111/16 112/5 113/4 116/17 121/18 121/24 122/8 122/11 123/3 123/4 123/15 123/24 124/19 125/12 126/1 128/7 128/16 130/12 136/23 137/12 141/16 142/1 142/21 143/17 144/12 144/19 145/11 145/21 145/24 145/24 146/24 147/22 147/23 148/5 148/6 148/19 <b>before</b> [33] 1/10 2/24	10/6 10/9 14/15 33/1 42/8 44/5 51/20 52/22 62/17 65/5 68/13 70/14 72/13 75/6 76/11 81/10 84/8 84/17 85/2 104/6 109/23 111/4 112/15 118/14 120/4 125/5 128/2 128/8 132/17 146/14 147/24 <b>began</b> [7] 3/1 11/17 14/10 33/7 117/7 126/18 126/24 <b>beginning</b> [8] 4/25 14/21 19/12 27/7 49/22 98/6 111/22 146/23 <b>beginnings</b> [1] 121/21 <b>begun</b> [1] 22/7 <b>behalf</b> [1] 76/8 <b>behind</b> [1] 143/2 <b>being</b> [69] 12/3 13/13 13/21 16/11 16/13 20/22 20/24 20/25 21/1 30/9 31/18 31/23 32/8 32/16 42/21 43/8 43/9 43/23 44/1 44/25 47/3 50/3 50/23 51/13 51/20 52/21 63/4 63/5 64/12 71/8 80/5 84/18 85/24 91/14 93/11 97/5 100/1 100/8 100/24 102/20 104/4 105/22 106/20 109/8 111/23 115/17 115/25 116/10 117/3 117/14 120/7 121/5 122/2 123/5 123/13 124/16 125/24 127/24 130/17 130/25 135/5 135/9 135/13 135/20 140/15 141/19 148/16 149/3 149/5 <b>Belgium</b> [1] 127/18 <b>believe</b> [5] 54/15 85/13 112/3 117/13 131/4 <b>believed</b> [2] 77/15 145/17 <b>bells</b> [1] 48/15 <b>below</b> [2] 115/20	125/22 <b>beneficial</b> [1] 79/9 <b>benefit</b> [3] 16/14 79/16 91/10 <b>benefits</b> [2] 50/25 88/22 <b>benefitted</b> [1] 121/5 <b>benign</b> [8] 47/18 47/23 52/2 52/14 52/21 123/20 124/17 125/7 <b>Bennett</b> [1] 7/9 <b>best</b> [26] 13/2 14/7 41/14 86/19 90/23 92/5 115/22 116/11 116/17 117/10 117/16 118/22 118/25 119/7 119/12 120/25 121/11 122/11 125/24 127/9 127/25 128/4 129/24 141/11 147/1 148/5 <b>better</b> [6] 5/15 5/18 6/9 55/9 126/13 127/1 <b>between</b> [24] 2/18 3/5 3/10 3/21 4/3 4/6 7/14 21/11 25/20 27/16 28/16 31/5 32/6 33/24 57/3 58/7 66/1 75/2 90/7 96/19 108/14 121/8 126/20 135/22 <b>beyond</b> [2] 1/22 36/6 <b>big</b> [3] 22/13 82/24 90/7 <b>binds</b> [2] 142/4 145/15 <b>Bio</b> [1] 116/24 <b>Bio Products Lab</b> [1] 116/24 <b>bit</b> [3] 17/22 28/14 87/21 <b>bits</b> [3] 63/22 66/14 84/5 <b>bleed</b> [2] 122/5 122/9 <b>bleeding</b> [7] 7/24 8/17 11/18 11/22 12/16 96/16 117/23 <b>bleeds</b> [3] 117/24 119/19 120/2 <b>block</b> [1] 146/6 <b>blood</b> [122] 4/25 6/18 6/19 11/11 13/11 13/11 14/20 14/20	17/9 18/3 18/3 18/4 18/4 18/20 18/20 18/20 20/19 20/19 20/23 20/24 23/21 24/11 24/17 25/3 28/4 32/15 32/15 32/16 34/17 34/22 35/18 35/21 37/12 41/2 41/23 41/23 42/4 42/7 45/1 45/25 45/25 46/13 46/13 46/23 47/3 47/3 50/3 50/4 50/9 50/9 50/10 50/12 50/20 50/22 53/3 53/3 54/6 54/19 54/25 56/4 59/12 63/8 63/9 65/17 65/17 71/1 72/4 74/9 74/25 76/3 79/7 88/20 89/10 89/12 90/25 91/8 91/9 93/12 94/17 95/13 95/13 95/18 96/1 96/12 98/7 101/17 108/14 108/14 109/13 109/22 109/22 110/14 110/14 113/1 113/1 116/22 121/22 126/2 126/2 126/10 126/13 126/23 127/1 127/3 127/8 127/12 127/20 127/24 128/3 128/5 128/6 130/5 130/5 130/8 130/8 134/13 135/4 135/12 136/10 136/10 141/16 141/17 <b>blood-borne</b> [1] 109/13 <b>Bloomberg</b> [1] 109/12 <b>board</b> [1] 98/3 <b>boards</b> [4] 29/12 29/16 29/25 109/1 <b>Bob</b> [1] 43/15 <b>Bob Perry</b> [1] 43/15 <b>bodies</b> [1] 27/19 <b>body</b> [1] 51/23 <b>bone</b> [3] 11/8 11/11 132/13 <b>border</b> [7] 19/25 32/11 33/13 69/12 116/24 117/11 145/25 <b>borne</b> [2] 90/10
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(43) back... - borne

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<b>F</b>	52/18 <b>Fund [2]</b> 3/4 7/17 <b>fundamentally [1]</b> 115/5 <b>funded [2]</b> 108/25 108/25 <b>funding [6]</b> 97/22 98/1 98/3 107/14 109/2 146/6 <b>further [21]</b> 2/21 24/14 29/3 29/24 57/22 58/4 59/24 71/25 73/19 74/13 78/19 79/15 81/20 93/9 93/12 93/18 95/6 105/18 116/7 145/5 147/16 <b>Furthermore [1]</b> 131/10	<b>generalise [1]</b> 126/7 <b>generalising [2]</b> 118/24 120/23 <b>generality [1]</b> 119/5 <b>generally [2]</b> 25/18 38/23 <b>generated [1]</b> 54/23 <b>genesis [1]</b> 37/6 <b>genito [1]</b> 57/21 <b>genito/urinary [1]</b> 57/21 <b>genuinely [1]</b> 128/5 <b>George [9]</b> 7/9 18/9 18/10 18/12 72/20 72/25 74/21 75/23 110/11 <b>George McDonald [1]</b> 7/9 <b>George Tucker [4]</b> 18/9 18/12 72/25 110/11 <b>George Tucker's [1]</b> 72/20 <b>get [15]</b> 5/23 10/24 18/15 19/5 22/24 31/15 68/23 68/24 84/5 85/16 90/13 99/9 126/25 132/23 132/25 <b>getting [2]</b> 12/12 30/19 <b>Gillon [11]</b> 33/9 62/16 63/24 66/5 68/8 69/23 70/7 71/19 71/23 80/7 103/14 <b>Gillon's [4]</b> 61/13 69/16 71/8 107/22 <b>give [12]</b> 7/2 16/17 19/6 39/21 41/14 88/18 90/25 110/19 119/25 128/19 136/7 142/7 <b>given [29]</b> 4/24 9/22 16/15 22/20 39/20 47/23 59/13 70/15 75/3 81/9 82/10 88/16 91/1 97/3 107/6 111/7 111/19 117/3 123/2 123/16 125/17 128/22 138/17 138/23 144/11 147/2 147/20 148/6 148/23 <b>gives [1]</b> 133/23	<b>giving [6]</b> 13/18 86/16 118/14 126/10 126/11 149/2 <b>glad [1]</b> 88/16 <b>Glasgow [18]</b> 2/19 2/24 3/5 3/9 7/9 7/11 8/19 10/20 10/25 11/19 11/25 12/6 12/22 46/25 48/3 62/11 62/12 62/14 <b>glean [1]</b> 108/16 <b>gleaned [5]</b> 8/16 8/16 14/16 40/17 55/21 <b>gleaning [1]</b> 39/6 <b>go [65]</b> 21/24 22/25 31/11 33/18 41/20 49/8 49/12 49/19 56/5 57/9 57/9 58/16 60/5 60/17 64/23 68/3 72/11 72/11 72/24 73/3 74/1 74/13 74/16 76/9 76/15 77/5 77/9 78/1 83/11 84/7 85/7 85/10 88/16 91/4 93/9 97/10 101/9 104/11 107/25 113/8 113/16 114/10 115/1 118/5 122/4 125/20 129/22 130/3 130/14 130/25 133/22 133/24 134/4 139/1 139/7 141/3 141/7 141/12 142/15 145/5 145/9 145/18 145/22 146/3 146/15 <b>Godman [1]</b> 113/24 <b>goes [2]</b> 57/21 127/14 <b>going [53]</b> 1/8 2/7 6/5 15/24 19/20 19/22 19/23 20/15 24/2 32/10 48/19 49/14 55/25 57/6 59/23 60/2 60/12 69/14 70/8 72/5 76/12 77/7 83/7 83/16 84/15 86/24 87/11 89/25 90/5 93/7 96/22 98/9 99/3 100/25 102/24 103/16 106/22 109/17 110/5 112/14 114/25 118/4 119/2 119/3 123/6 125/14 129/9 132/24 132/24 138/22 139/3 141/5	146/9 <b>gone [1]</b> 100/19 <b>good [24]</b> 1/3 1/4 1/7 4/23 6/10 12/8 18/25 28/18 32/24 34/5 42/2 43/3 62/18 63/14 63/17 74/3 100/1 100/24 119/25 128/24 128/25 129/8 131/17 149/10 <b>Gordon [1]</b> 12/11 <b>gosh [1]</b> 114/3 <b>got [11]</b> 14/11 29/20 34/6 49/21 69/6 82/21 83/5 83/5 106/21 109/12 114/19 <b>government [30]</b> 3/19 4/8 13/25 16/12 19/10 27/22 33/1 34/23 37/8 37/10 39/5 44/8 60/25 71/16 75/22 75/23 104/9 114/22 114/23 124/7 129/20 135/15 137/17 140/6 141/19 142/22 143/1 143/7 147/14 149/3 <b>Government's [2]</b> 86/18 86/25 <b>governmental [1]</b> 14/2 <b>GP [3]</b> 94/4 106/25 108/21 <b>GPs [12]</b> 93/15 93/17 97/6 98/19 99/2 99/6 99/9 100/19 107/3 107/14 108/9 108/17 <b>grant [1]</b> 146/6 <b>granted [1]</b> 97/25 <b>grateful [2]</b> 140/1 140/2 <b>great [10]</b> 5/21 27/16 27/16 35/20 63/19 105/8 107/9 120/16 135/22 142/18 <b>greater [3]</b> 1/21 98/10 98/13 <b>green [4]</b> 83/23 113/22 114/2 114/4 <b>ground [1]</b> 123/8 <b>grounds [3]</b> 129/7 141/10 146/21 <b>groundwork [1]</b>
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(51) from... - groundwork



<b>G</b>	107/22 110/16 111/16 111/22 112/4 113/22 116/17 117/13 117/17 117/21 120/19 121/16 121/24 122/1 123/3 123/12 128/7 132/14 136/5 136/16 143/25 144/12 145/22 145/23 146/5 146/18 146/19 147/12 147/22 148/19 <b>had very</b> [1] 36/7 <b>hadn't</b> [4] 21/8 53/19 78/9 123/21 <b>haematological</b> [4] 11/3 11/6 12/2 12/20 <b>haematologist</b> [2] 4/12 126/18 <b>haematologists</b> [9] 7/7 11/21 12/3 14/25 48/2 97/19 98/13 98/19 99/2 <b>haematology</b> [18] 2/13 3/1 3/10 4/14 5/2 7/6 7/19 7/20 10/3 10/22 10/24 11/23 12/10 12/23 44/14 44/21 45/21 47/25 <b>haemophilia</b> [33] 7/25 8/13 8/24 9/3 10/10 11/18 11/20 12/4 12/9 12/13 36/3 36/14 37/14 38/1 38/7 38/14 38/19 39/2 39/5 48/25 112/13 113/19 117/4 117/18 119/9 119/13 120/19 121/4 127/5 130/24 131/9 134/11 141/5 <b>haemophilia A</b> [1] 7/25 <b>Haemophilia Society</b> [2] 112/13 113/19 <b>Haemophilia</b> <b>Society's</b> [1] 134/11 <b>haemophiliac</b> [7] 94/19 117/20 119/8 119/13 120/9 121/7 125/11 <b>haemophiliacs</b> [10] 36/11 50/3 50/24 57/2 75/3 94/7 117/21 118/16 120/8 131/11	<b>haemorrhage</b> [2] 120/3 120/4 <b>half</b> [15] 3/16 23/16 35/4 36/18 45/18 47/15 49/8 60/20 73/4 76/9 93/10 94/1 98/7 100/14 130/14 <b>halfway</b> [3] 60/7 79/4 141/13 <b>hammered</b> [1] 35/23 <b>hand</b> [6] 4/21 25/21 50/22 60/24 86/13 116/2 <b>handwriting</b> [3] 113/11 116/2 137/10 <b>happen</b> [4] 77/17 90/1 95/1 102/21 <b>happened</b> [7] 11/25 33/15 72/21 74/5 92/8 97/24 146/8 <b>happens</b> [1] 140/9 <b>hard</b> [3] 142/21 142/25 143/6 <b>harder</b> [1] 34/4 <b>harm</b> [2] 110/25 134/24 <b>harmonisation</b> [1] 88/24 <b>Harold</b> [2] 72/2 72/18 <b>Harold Gunson</b> [2] 72/2 72/18 <b>has</b> [40] 1/18 17/12 32/18 41/21 42/25 48/7 48/9 56/19 56/21 56/22 58/2 63/7 67/8 68/21 69/6 80/22 85/14 90/10 94/15 95/25 97/18 99/22 103/12 105/17 105/25 108/11 110/10 114/23 114/23 115/9 116/13 125/18 138/4 139/15 139/25 142/1 142/21 142/23 144/19 145/11 <b>have</b> [180] <b>haven't</b> [1] 48/21 <b>having</b> [26] 5/8 9/2 9/15 9/18 16/14 21/25 34/24 43/14 48/13 54/8 55/2 60/12 67/3 68/8 69/1 77/15 86/21 92/16 95/8 98/16	122/20 122/21 123/14 124/2 131/24 141/8 <b>Hazy</b> [1] 37/24 <b>HCDO</b> [1] 36/10 <b>HCV</b> [60] 32/24 33/3 46/1 49/18 50/12 51/14 54/12 60/22 61/17 69/25 70/4 70/13 71/3 71/21 73/2 73/14 74/3 74/18 74/22 75/3 75/9 76/10 80/16 85/13 91/13 93/12 95/18 96/3 96/3 97/6 97/13 103/11 103/22 107/4 107/6 107/17 108/9 112/7 113/1 116/6 117/7 120/14 127/17 128/2 128/9 131/6 132/6 132/21 133/3 133/8 134/23 135/23 135/25 136/6 136/24 139/19 141/15 147/3 147/21 148/15 <b>HCV-infected</b> [1] 74/3 <b>HCV-positive</b> [1] 141/15 <b>he</b> [46] 9/7 9/11 9/13 10/8 10/16 10/17 10/17 26/22 27/2 27/5 41/1 41/10 41/20 42/16 42/20 43/18 46/6 62/16 62/17 62/17 64/2 66/7 72/17 75/15 77/20 77/20 81/18 82/3 82/3 82/19 83/22 85/19 85/23 86/2 88/14 94/14 94/24 110/10 111/8 133/14 138/18 140/8 140/9 140/9 140/11 145/3 <b>he'd</b> [2] 48/13 87/15 <b>he's</b> [1] 133/13 <b>head</b> [4] 25/2 56/13 56/14 72/3 <b>headed</b> [3] 17/21 26/11 113/8 <b>heading</b> [15] 36/21 49/16 49/21 69/24 79/1 101/11 114/11 114/19 130/4 130/15	133/22 134/1 134/5 141/4 141/12 <b>headline</b> [1] 21/6 <b>health</b> [128] 3/20 4/18 5/23 6/7 15/1 15/2 15/15 15/21 16/3 17/11 17/19 17/20 21/12 22/10 22/10 23/4 23/4 23/9 23/13 24/8 24/9 24/15 25/11 25/18 25/20 26/1 26/8 26/17 26/20 27/2 27/3 27/11 27/15 27/20 27/22 28/2 28/7 28/9 28/17 28/20 29/12 29/16 29/24 30/4 30/11 30/24 31/5 31/6 31/8 31/24 32/7 32/14 32/17 32/23 32/23 33/16 33/25 34/1 34/5 34/7 37/2 38/15 38/20 38/21 38/25 40/14 41/7 50/7 51/17 55/16 56/11 57/8 58/8 59/6 64/20 67/12 67/18 69/2 69/3 73/10 75/12 78/22 78/25 79/21 82/11 86/6 86/23 87/4 92/19 101/8 104/1 108/16 109/1 109/11 109/25 110/9 111/6 111/13 112/24 115/4 116/14 116/15 122/24 130/19 131/15 132/9 133/21 135/7 135/8 137/8 138/10 138/15 139/17 140/6 140/8 140/12 140/12 140/17 140/24 141/22 142/6 142/10 144/23 144/24 144/25 145/1 145/13 147/14 <b>Health Service</b> [2] 56/11 67/18 <b>Healthcare</b> [1] 5/10 <b>hear</b> [2] 1/5 2/5 <b>heard</b> [8] 34/12 38/16 40/7 54/7 68/8 72/16 108/11 125/19 <b>hearing</b> [1] 149/14 <b>heart</b> [1] 122/15 <b>heat</b> [3] 50/10 53/24
<b>H</b>	<b>had</b> [114] 3/13 5/20 10/6 10/8 11/25 14/4 15/11 16/25 18/1 20/16 21/21 22/7 25/9 25/10 25/15 26/16 26/19 27/11 28/24 32/9 32/14 33/2 34/11 36/7 36/11 37/10 37/13 37/14 39/8 44/1 46/7 47/19 47/21 52/2 57/20 57/22 58/10 62/3 62/16 62/17 62/19 66/5 67/6 70/18 70/20 71/18 71/23 72/4 72/21 72/23 73/23 74/19 74/23 75/10 75/24 77/23 78/6 82/16 82/17 83/22 86/7 87/14 89/24 90/14 90/25 91/2 91/3 91/13 91/24 92/15 92/22 94/7 95/18 96/15 96/23 99/19 100/19 105/7 105/23 106/9 106/13 106/13 107/10 107/11			

(52) groundwork... - heat



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(58) mainly - mindset

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(59) mini - Nicky Munro



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(70) think... - treatment

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46/2 46/5 47/10 47/14 47/22 55/17 56/1 56/2 58/17 59/10 60/4 60/5 60/6 60/13 60/15 60/18 60/23 63/15 65/4 66/18 68/1 68/6 69/1 71/5 71/7 76/15 77/10 78/8 86/9 86/12 90/18 90/19 90/23 91/4 91/18 93/18 95/3 98/25 100/2 102/2

(73) which... - your

<b>Y</b> <b>your... [26]</b> 102/15 106/7 107/24 108/6 113/11 115/2 116/2 116/15 118/16 119/4 120/6 122/4 124/5 124/12 124/13 131/20 135/14 136/8 137/18 139/15 143/4 144/16 147/22 148/12 149/1 149/9 <b>yours [1]</b> 1/11 <b>yourself [5]</b> 65/12 67/3 69/22 74/15 115/12 <b>YouTube [1]</b> 2/1				
<b>Z</b> <b>Z8 [1]</b> 117/7 <b>zoom [2]</b> 23/16 73/4				