

Wednesday, 11 May 2022

(10.00 am)

ANDRZEJ STEFAN MIROSLAW REJMAN (continued)

Questioned by MS RICHARDS (continued)

SIR BRIAN LANGSTAFF: Yes?

MS RICHARDS: Dr Rejman, before we leave the topic of the

HIV Haemophilia Litigation, I wanted to ask you about

a memo, a minute you wrote in February 1991.

Could we have DHSC0004766_068, please, Paul.

So we can see it's a minute from you to

Mr Powell in the DH's solicitor's office. You refer

to a brief conversation with Dr Peter Kernoff at the

Royal Free Hospital, who had received a couple of

writs in relation to hepatitis infection, and you

observe in paragraph 2 that those are individuals who

are HIV negative and so wouldn't be covered by any

general settlement of the HIV Litigation.

Then you say this in paragraph 3:

"I believe that any that are HIV positive would have to agree not to raise hepatitis in any [future] litigation, but this obviously does not exclude those not in the scheme."

As I know you'll appreciate from the evidence that you've provided in writing to the Inquiry, it's what's set out in paragraph 3 of that minute that

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No, actually, that's the wrong page, sorry. Can you go to page 4.

We pick it up in paragraph 15, and there's reference to that minute of the 22 February that we've just looked at, and then there's a reference to the oral evidence of Mr Evans, Jason Evans, and the suggestion that you were the architect of what would later come to be known as the "waiver". This is what you say and this is what I want to explore with you, Dr Rejman. You say:

"I disagree with this allegation. My minute was not the genesis of the general undertaking; I was conveying a concept to DH officials that had already materialised from discussions between the legal representatives of the Plaintiffs and the Defendants in the HIV litigation."

Sorry, I've just noticed that the version we have on screen has the paragraph redacted at the bottom of the page and we ideally need the unredacted paragraph. I can read it out in any event, don't worry.

You then go on to say that:

"The idea of a general undertaking by the Plaintiffs to discontinue claims against the Defendants was raised and discussed long before my

3

I particularly want to ask you about. That's

an expression of your view or belief that, as part of

the settlement, those involved in the settlement who

were HIV positive would have to agree not to sue for

being infected with hepatitis. Is that the right way

to understand paragraph 3?

A. That is correct, yes.

Q. We know that there was, in the final settlement

agreement and then in the documentation that at the

Macfarlane Trust required to see, effectively

an undertaking, waiver, however it's been differently

described --

A. Yes.

Q. -- at various stages, which effectively prevented

those who were HIV positive from also bringing claims

in relation to hepatitis.

A. Yes.

Q. So that was the end result?

A. That's correct.

Q. Now, you've responded to a suggestion that that

document suggests that you were the architect of that

proposal in your second witness statement.

A. Yes.

Q. I just want to look at that, if I may, with you.

WITN4486025, please, Paul. If we could go to page 11.

2

minute of 22 February 1991."

You then refer, in the following subparagraphs of your statement, to various documents that were made available to you for the purposes of the statement.

A. Yes.

Q. You say you don't know -- or, sorry, you wouldn't at

the time have had access to communications between the

Department of Health solicitors or the TSol --

A. Yes.

Q. -- and what was being said, for example on

a counsel-to-counsel basis. You wouldn't have known

that; is that correct?

A. I wouldn't have known the precise detail but

looking -- obviously, I cannot recall the precise

circumstances but, looking at the papers that have

been provided to me and reading what I said in that

minute to Mr Powell saying, "I believe", which

suggests not "I think it would be a good idea if we

did this". It is the understanding that -- my

understanding that that has been decided, and all that

I'm doing is I'm reminding Mr Powell -- I can't

remember who else was actually copy recipients of

that. I think it must have been Mr Canavan and

somebody else.

Q. Mr Canavan, Mr Dobson and Dr Pickles.

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1 A. That's right. So, in a sense, I suspect that, even
 2 though the minute is addressed to Mr Powell, and
 3 you'll find this with a lot of the minutes, the person
 4 you're addressing may well know what you're actually
 5 saying in the minute but it's the copy recipients that
 6 are the ones that are not aware and, in a sense, you
 7 write to the recipient so that if the recipient feels
 8 that what you have said is incorrect, he can or she
 9 can then write back and say, "Sorry, Dr Rejman, I
 10 think really this is what we have agreed" or "This is
 11 what has been agreed". It's not "what we have
 12 agreed", it is "what has been agreed" or "what is
 13 under discussion".

14 Q. Just before we look under the remaining subparagraphs
 15 that are on this page of your statement and the next,
 16 as I understand it from your statement, there are two
 17 general points that you make then by reference to
 18 a more detailed exposition in your statement.

19 A. Yes.

20 Q. The first was that there had been discussions prior to
 21 22 February about second interval claims and words to
 22 that effect.

23 A. Yes.

24 Q. We'll look at those examples in a moment. But that
 25 was the first point you make. The second point you

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1 times hepatitis appeared, it was, you know, all the
 2 way through it. In a sense, you could have taken out
 3 the HIV Haemophilia Litigation bit completely and just
 4 made it about hepatitis.

5 Q. Except what would have been crucially missing if you'd
 6 done that was a claim by Plaintiffs for damages for
 7 having been infected with hepatitis.

8 A. Yes.

9 Q. That was never part of the HIV Haemophilia Litigation,
 10 was it?

11 A. No, because, basically, the litigation was called
 12 HIV Haemophilia Litigation and, I suspect, judging
 13 by -- okay, by that stage, this was 1988 to 1991,
 14 people were aware that hepatitis C did have
 15 significant effects but I suspect, particularly if one
 16 looks at the public perception, and I think what one
 17 cannot remove from the whole of the HIV Haemophilia
 18 Litigation is the fact that there were MPs that were
 19 pushing about this, newspapers were forever commenting
 20 about it. Some more, some less.

21 So -- and there was a public perception from
 22 everybody, "Look, these people have got this terrible
 23 disease which is going to kill a lot of them in a very
 24 short space of time, and this is why this litigation
 25 is so important".

7

1 make was that hepatitis was something which was
 2 an issue being explored in the litigation.

3 A. Yes, very much so.

4 Q. Can I just deal with that second point, first of
 5 all --

6 A. Yes.

7 Q. -- to see whether we can agree on the way in which
 8 hepatitis featured in the HIV Haemophilia Litigation.
 9 There were references in the HIV Haemophilia
 10 Litigation to what the Department should have known
 11 about hepatitis, is that right, and the risks of
 12 transmission of hepatitis?

13 A. Yes.

14 Q. Because they formed part of the springboard for the
 15 argument, for example, that the Government should have
 16 done something to establish self-sufficiency at
 17 an earlier stage?

18 A. Yes.

19 Q. So hepatitis was being relied on in that kind of way;
 20 is that right?

21 A. Yes, but also -- yes, but it was more of a general
 22 concept and, in essence, the litigation mentioned
 23 hepatitis -- it was through, through, through.
 24 I would say -- I don't know, I didn't count the pages,
 25 but if you counted through the pages, the number of

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1 If one had done the litigation purely on
 2 hepatitis C or non-A, non-B -- well, it was
 3 hepatitis C by then, sorry -- on hepatitis C, then
 4 would they have had the public interest? Probably no.
 5 Would there have been the pressure -- as much pressure
 6 from individuals? Probably no.

7 And I suspect that that is the reason why HIV
 8 had to be the main point of the litigation, and
 9 hepatitis C, although it figured so prominently
 10 throughout the litigation -- and obviously, with the
 11 best will in the world, the Sunday Times is not going
 12 to give you a copy of the MSC, and a lot of the people
 13 were obviously chasing headlines, and what is the
 14 thing that the public are interested in?

15 So I think, to be honest, there was so much
 16 hepatitis C in the litigation it couldn't be, sort of,
 17 removed from it.

18 Q. Let's leave aside, if we may, what might be regarded
 19 as a degree of speculation on your part as to the
 20 motivations of others involved in bringing the
 21 litigation --

22 A. I'm not suggesting that was motivation; I'm just
 23 suggesting that, in reality, you know, anybody on any
 24 of the solicitors acting for the haemophiliacs would
 25 have just said, "Well, look, this is a no-brainer.

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1 This is obviously what we need to do".

2 **Q.** I think we can agree that, as a matter of fact, these

3 were claims for having been infected with HIV and HIV

4 alone. Those were the actual claims in the

5 litigation.

6 **A.** Those were the claims at the time.

7 **Q.** Yes.

8 **A.** Now, I think one of the problems was, as I mentioned

9 earlier, there was an original MSC, an amended MSC,

10 a re-amended MSC and a further re-amended MSC. So one

11 doesn't know what would have happen between the last

12 re-amended MSC and the time it went to court, whether

13 they would have actually thought, "Well, we may have

14 a case for hepatitis, let's throw that into the ring",

15 so to speak. But, in a sense, it was in the ring.

16 **Q.** If we then go back to the statement on the screen and

17 go back to the first of the general points which you

18 make, which was you say there had been discussions or

19 documents earlier than your minute of

20 22 February 1991 --

21 **A.** Yes.

22 **Q.** -- which talked about settling all claims or

23 relinquishing claims, and so on. You've given here

24 the examples that had been -- you've identified from

25 the documentation made available to you from your

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1 **A.** Yes.

2 **Q.** Then a number -- a subset of the Plaintiffs had

3 additional individual medical negligence claims?

4 **A.** That is correct.

5 **Q.** Saying, "Well, I should never have been" -- this is

6 just a hypothetical example -- "I should never have

7 been given in 1985 as a child a Factor VIII

8 concentrate" --

9 **A.** Yes.

10 **Q.** -- "or a commercial concentrate"?

11 **A.** And I think there was one case where an individual was

12 given unheat-treated Factor VIII after August 1985

13 after the -- well, I'm not sure it was the edict but,

14 basically, the instructions from the Department of

15 Health that nobody else was supposed to be given

16 unheat-treated Factor VIII.

17 **Q.** I think we see those individual claims sometimes

18 referred to in the documents as the medical negligence

19 claims; is that right?

20 **A.** Yes. Thank you.

21 **Q.** If we just look here, there's a letter from

22 Pannone Napier, the solicitors for the Plaintiffs,

23 referred to in paragraph (a) of your statement, which

24 makes reference to, if there is going to be

25 a compromise:

11

1 legal advisers.

2 We can see the first is a letter which talks

3 about compromise being based on:

4 "... full and final settlement of all claims by

5 the Plaintiffs against the Defendants."

6 **A.** Sorry, could I just butt in there?

7 **Q.** Yes.

8 **A.** I think throughout this there is going to be this

9 reference about the special treatment of people with

10 clinical management concerns, because that goes

11 through all out of it. Because I think that is

12 an important aspect of this, that there were two parts

13 to this. There was the main body of what the

14 solicitors on behalf of the haemophiliacs were

15 claiming but also there was the subgroup of the

16 clinical management, which had to be separated out

17 later on.

18 **Q.** Is this right: that there were claims common to all

19 Plaintiffs --

20 **A.** Yes.

21 **Q.** -- based upon the broader, bigger allegations --

22 **A.** Yes.

23 **Q.** -- in the main statement of claim, which raised

24 a whole range of issues including self-sufficiency and

25 other issues?

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1 "... based on the full and final settlement of all

2 claims by the Plaintiffs against the Defendants."

3 Then the reference to clinical management. So

4 we'll leave that, if I may, to one side because

5 I think that's a separate issue.

6 **A.** Yes, thank you.

7 **Q.** Now, that doesn't refer to hepatitis, of course, in

8 terms, does it?

9 **A.** No, but it refers to everything. You see this is --

10 I mean to say, as I say, I didn't see it at the time,

11 but reading it now, and it would appear to be

12 a blanket covering everything.

13 **SIR BRIAN LANGSTAFF:** Covering everything what? Every

14 claim?

15 **A.** Well, basically of all claims. Now, the argument

16 obviously is: does that mean all claims in the future

17 of everything? But one reading of that is that there

18 will not be any claims in the future about any of this

19 from the Plaintiffs.

20 **SIR BRIAN LANGSTAFF:** How does one define "of this"?

21 **A.** Sorry?

22 **SIR BRIAN LANGSTAFF:** "Any of this", you say. How do you

23 define "any of this"?

24 **A.** Well, any of the matters -- well, if we go further on,

25 in fact, there was in one of the drafts of the trust

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1 deed, I think I made a comment that, in fact, it was
2 too wide because it would cover everything remotely to
3 do with the use of Factor VIII, et cetera. Now,
4 reading this it suggests that, basically, there would
5 not be any claims against DH or others in respect of
6 the treatment of haemophiliacs.

7 **SIR BRIAN LANGSTAFF:** Right. It may be that another
8 interpretation is all claims, that is all the claims
9 which have been made in this litigation by the
10 Plaintiffs against the Defendants, might it not?

11 **A.** It might be but I think the thing is, on that basis,
12 you would need to read through the whole of the MSC
13 and see whether anywhere there, there is criticism --
14 well, there was criticism of hepatitis non-A, non-B.

15 **SIR BRIAN LANGSTAFF:** I think there may be a difference
16 between your reading -- I appreciate you're not
17 a lawyer -- and those of us who have been lawyers for
18 years.

19 **A.** Yes, of course.

20 **SIR BRIAN LANGSTAFF:** Where a claim is what you're
21 claiming about which is generally -- in the injury
22 context, is generally the injury or disease you have
23 suffered, full stop. The reason for the claim is that
24 you say that there has been a breach of a duty owed to
25 you by the person you're claiming the money or the

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1 the Department of Health, then that also is covered by
2 the claim.

3 So I suspect that people reading through the claim
4 carefully might well say, "Well, look, this actually
5 refers not only to HIV but also it does refer to
6 hepatitis C, so therefore that part they cannot sue
7 on". Then it all gets into a real mess.

8 **SIR BRIAN LANGSTAFF:** So your reading of it was that the
9 expression "all claims" really meant all complaints?

10 **A.** Yes. Now, I hasten to add, this is my reading today
11 of a document I didn't see at the time.

12 **SIR BRIAN LANGSTAFF:** Well, yes. It's the time you're
13 being asked about of course, but anyway, Ms Richards.

14 **MS RICHARDS:** Yes. So -- anyway the chair has explored
15 with you the issue that I would have explored with you
16 in relation to that subparagraph.

17 In the next paragraph it's redacted on the
18 screen, I'm just going to read it out. Just so that
19 there is no mystery, the reason it's redacted is
20 because you refer in that subparagraph to advice given
21 by the plaintiff's counsel in the litigation and there
22 was an issue as to whether that was still legally
23 privileged or had lost confidentiality and can be
24 referred to. The chair has resolved that issue by
25 saying it can be referred to but the document on the

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1 compensation or whatever it may be, from. So the
2 claim is what you have actually suffered. The reason
3 for the claim or the basis for the claim is then set
4 out, generally speaking, in the start of a document,
5 and in this context it's a claim for everything that
6 went on leading to the fact that individuals claiming
7 that it was in breach of duty that they suffered HIV
8 infection. I don't think the claim was for hepatitis
9 infection.

10 **A.** Yes, but you could -- I mean to say, as a non-lawyer,
11 one could --

12 **SIR BRIAN LANGSTAFF:** I appreciate you're a non-lawyer and
13 you're going to tell me how you saw it.

14 **A.** As a non-lawyer, and reading this, claims not only --
15 to my understanding, the claims are the whole body of
16 the statement of claim. Now if in the statement of
17 claim you say that had there been self-sufficiency --
18 that there was not self-sufficiency and that the
19 Department is at fault because of that, and if that is
20 part of the claim, which it was, then -- now obviously
21 that didn't really relate to hepatitis C, but, you
22 know, one could actually interpret that any part of
23 the MSC in -- whether it be on process of how things
24 were done and everything else like that, any bit of
25 that where there is an allegation about failures by

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1 screen is out of date in that regard.

2 We don't need to look at the document itself.
3 I can read out what's said in this short paragraph and
4 I think, in case you need to look at it, you've got
5 a hard copy of your statement.

6 **A.** Yes.

7 **Q.** You say:

8 "At paragraph 9 of the advice from the Plaintiffs'
9 counsel on the settlement of the HIV Litigation dated
10 12 December 1990, the Plaintiffs' counsel provides an
11 outline of the proposed settlement negotiated with
12 the Defendants for the Plaintiffs' consideration
13 stating that [and then this is the relevant phrase] in
14 return for a cessation to the litigation against all
15 the Defendants, the DH would make payment into the
16 Macfarlane Trust."

17 That's the phrase you point to, "in return for
18 a cessation to the litigation against all the
19 Defendants"?

20 **A.** Yes.

21 **Q.** First of all, you obviously didn't see that document
22 at the time.

23 **A.** Yes.

24 **Q.** And you have seen it for the purposes of providing
25 your statement for the first time, is that right?

16

1 A. Yes.

2 Q. Secondly, would you accept a "cessation to the
3 litigation" is perhaps not, on its most natural
4 reading, the same as saying "You won't bring any
5 future claims for hepatitis or for a different
6 infection"?

7 A. Well, as I explained to the chairman, it is a case of
8 interpretation, and I do not know. I mean to say that
9 would be up to the lawyers to discuss at the relevant
10 time. But reading it as a non-lawyer, my
11 understanding would be that it meant everything
12 that is included in the litigation will not be
13 litigated against in the future. And one would have
14 to go through it with a fine-tooth comb to see exactly
15 which parts of the MSC would actually be part of
16 a litigation for hepatitis C.

17 Q. Then I think -- if we go over the page, I think it's
18 essentially the same point that arises in relation to
19 the further three documents you referred to. So you
20 refer to an article in the BMJ -- this is
21 subparagraph (c) at the top of the page -- which
22 refers to -- uses the term "settle their legal
23 claims".

24 Paragraph (d), you refer to a minute from
25 Mr Canavan, January 1991, which refers to signing away

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1 supposed to be quite confidential information is
2 actually in the public domain."

3 Q. And --

4 A. Because it also gave details of the payments,
5 I believe, doesn't it?

6 Q. I'm afraid I'd have to check because that's
7 not -- (overspeaking) --

8 A. You'd have to check the actual thing.

9 Q. -- be the issue that I wanted to explore, but we'll
10 just have a quick look. Yes, it does refer to details
11 of some of the payments.

12 A. You see, all of this, all of these things were
13 supposed to be at this stage confidential, yet somehow
14 or other they had leaked, or somebody had leaked them
15 intentionally.

16 Q. In any event, that's not --

17 A. Sorry.

18 Q. -- I think, relevant to the point we're exploring,
19 Dr Rejman.

20 A. No, no. Yes.

21 Q. In relation to the document at (d), that is a document
22 that was copied to you at the time.

23 A. Yes.

24 Q. In relation to (e), is that a document that you would
25 have seen at the time?

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1 litigation rights.

2 Then at (e) you refer to an early draft of the
3 proposed terms of settlement, or proposed detailed
4 terms of settlement, which referred to
5 "[discontinuing] ... actions", and then "[undertaking]
6 not to bring fresh proceedings".

7 Is it right to understand that you didn't see
8 (c) at the time, the article in the BMJ --

9 A. Sorry, (c)? Ah yes, that was my copy.

10 Q. Okay. But at the time was that something you'd have
11 paid any particular attention to?

12 A. Yes, because if you look at that article, if you look
13 at it, it's got my writing on it, "Please copy to",
14 and I can't remember who I copied it to, so it was my
15 copy of the BMJ. I read it, I looked at it, and
16 I copied it. I can't remember who I copied it to.
17 Would have been Mr Canavan, Dr Pickles, and I don't
18 know, Dr Metters, probably. I don't know who I copied
19 it to. But presumably I copied it to them because
20 obviously Mr Canavan won't have been reading the BMJ,
21 I suspect Dr Pickles and Dr Metters would have been,
22 but anyway they may or may not have focused on it.
23 But obviously from my point of view, because it was an
24 important aspect, I photocopied it to them and said,
25 "Look, this is just so that you know that what is

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1 A. No, I think -- as I think I've tried to explain in my
2 statement, when it came to discussions between
3 the respective counsels, that obviously I -- I might
4 hear little snippets, or if Mr Fenwick felt that it
5 was necessary for me to know something, he would tell
6 me. I might hear a little bit more from Mr Powell,
7 who obviously I had much closer day-to-day contact
8 with, but -- the precise details I would not be aware
9 of but I would be aware of the generalities. And as
10 Mr Canavan sent that minute, which was actually more
11 than a month before my minute about Dr Kernoff's
12 patients suing the Trust, I would be aware this is
13 going on in the background. I wouldn't know every --
14 all the precise details.

15 Q. Now those are the documents you've referred to in your
16 statement that predate your minute of
17 22 February 1991.

18 A. Yes, that's right.

19 Q. Is it right to understand then that, as far as you are
20 aware -- and of course you haven't seen everything,
21 you've relied upon the material provided to you --

22 A. Yes.

23 Q. -- either by the Inquiry or, for these purposes,
24 provided to you by the Government Legal Department --

25 A. Yes.

20

1 Q. -- is it right to understand that your minute of
2 22 February is the first specific reference to
3 relinquishing any claim for hepatitis?

4 A. I really do not know, to be honest. I mean to say,
5 the fact -- obviously, hepatitis was the subject of my
6 minute. So that's why I referred to hepatitis. And
7 I say there "I believe", which means not that I think
8 this would be a good idea to do this, it means that
9 I understand from my discussions with others that this
10 is likely to be what they will have to say. So
11 I think that is probably the sum total of my minute.

12 Q. If we just go back to your minute for a moment,
13 DHSC0004766_068 -- DHSC0004766_068.

14 It's right, I think, to understand the context
15 of your minute was you'd had flagged up to you by
16 Dr Kernoff that there had been, against the Royal
17 Free, some specific writs now in relation to
18 hepatitis.

19 A. That is correct.

20 Q. Is it right to understand then you -- were you keen to
21 ensure that the Department did not find itself in the
22 same position?

23 A. I think -- well, reading that minute again, and I've
24 read it a number of times, my understanding is I am
25 here passing on information. I've had a chat with

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1 anybody else he wanted to copy, to say, "Dr Rejman has
2 got this wrong".

3 Q. Do you recall being party to any discussions within DH
4 at this time about the introduction into the terms of
5 settlement of an express reference to relinquishing
6 not just any HIV claims but hepatitis claims?

7 A. Well, I think that appeared in the trust deed at
8 various times because -- I was not involved in that,
9 because I think there was a minute from me about an --
10 the earliest version, this would have been
11 22 March 1991, or something like that, where
12 I actually say that I think that the way it is phrased
13 is too all encompassing. It encompasses anything to
14 do with treatment, which I thought was probably not
15 correct. So I'm on record as having said that.

16 And then -- you see, I think the thing is, like
17 with everything else, there was some things I was
18 copied into, some things I was not. And, in a sense,
19 when you're sending minutes to people, you know, okay,
20 we have had some minutes where the number of copy
21 recipients had been 30, you know: three zero. Now,
22 whether all of those 30 really needed that minute or
23 not is a matter of conjecture but it may be that
24 people are covering their back to make sure that
25 everybody who needs to know does know, which I think

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1 Peter Kernoff on the phone, and he's told me, look,
2 he's had a couple of writs about hepatitis infection
3 in haemophiliacs. And I specifically say there that
4 these are people who are HIV negative. So a different
5 group from the one that we're talking about at the
6 moment.

7 And I said, therefore, that is the reason why they
8 are taking out the litigation: because they would not
9 be beneficiary -- they would not benefit by the
10 payment scheme. That is why they are taking out the
11 litigation.

12 And, as a side issue, I say, you know, by the
13 way, you know, I understand that people who have got
14 the payments won't be able to do this. You know,
15 that's just a throw -- well, a throwaway remark,
16 basically, because that does not add to what the
17 minute -- the important bit of the minute, in a sense,
18 is paragraph 1, paragraph 2 and paragraph 3 where he
19 says that he does not believe DH is a named Defendant.
20 So those are the three paragraphs that are important.

21 Paragraph 3, in a sense, is me just saying "Oh,
22 well, we all know that", or, you know, I'm saying
23 I believe, so, you know. And, presumably, if my
24 interpretation were incorrect, Mr Powell would have
25 sent me a minute copied to those individuals plus

22

1 is sometimes the reason for copy recipients.

2 But, usually, what I think most of us would do
3 is, if we're writing a minute -- and if we take this
4 minute, for example, I'm writing this minute because
5 I've had a chat on the phone with Peter Kernoff who is
6 a nice chap, you know, we got on very well. Had
7 a chat, informal chat, he's telling me about this. He
8 hasn't written a letter or anything, this is
9 an informal chat over the phone.

10 Now, obviously, none of the others would have
11 been aware of that chat. Now, I could have mentioned
12 it to them *en passant* or I could have phoned them and
13 told them about this but if one writes a minute there
14 are two things. First of all, it is there and I've
15 actually had to think carefully what -- well,
16 carefully -- at least I've thought about what I'm
17 going to be writing. Also, it gives me the
18 opportunity to copy in people I think ought to know
19 and, in this particular situation, I was -- Mr Powell
20 was the important person. He needed to know about the
21 writs.

22 Mr Canavan, probably. Mr Dobson? Well,
23 courtesy. Dr Pickles, courtesy. David Burrage, who
24 John Canavan presumably copied it to, because he
25 needed to know because he was Mr Canavan's junior and,

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1 as such, had to know what's going on. So I think, you
 2 know, you can make too much out of these things but
 3 I think when minutes were being sent about the draft
 4 settlement --
 5 Well, the draft settlement, I think, none of
 6 that came to -- not very much of that came to me.
 7 I think the draft trust deed, I got that. But if you
 8 look at them, you know, the copy recipients were
 9 different. Sometimes I was included, sometimes
 10 I wasn't. Sometimes I might be asked for an opinion,
 11 I might not be. Everybody might be asked for in
 12 opinion. And if you get a minute and you're put down
 13 as a copy recipient you then have to decide well, (a)
 14 is there something important I can contribute?
 15 Therefore, I will write back, and copy everybody else.
 16 I'll copy the person that's sent the minute, and all
 17 the copy recipients. Or you look at it and say,
 18 "Well, I've not really got anything to say, so I'll
 19 file it", and that is it.
 20 Q. I appreciate you can't necessarily speak to what other
 21 discussions may or may not have been happening on this
 22 topic elsewhere in the Department or between counsel
 23 or so on --
 24 A. Yes, yes.
 25 Q. -- but would it be right to take at least from this

25

1 with HIV; is that right?
 2 A. Yes.
 3 Q. Then if we go to the top of the next page,
 4 paragraph 18, you refer there to a minute and I'm
 5 going to take it from your statement rather than go to
 6 the underlying documents, Dr Rejman, just because
 7 you've set out the relevant passages, but we can look
 8 at any underlying ones if you want. You're absolutely
 9 right, you talk there about limiting the
 10 undertaking --
 11 A. Yes.
 12 Q. -- but you're not talking, are you, about limiting it
 13 to HIV. You're talking about limiting it to HIV or
 14 other viral infections?
 15 A. Yes, because, in essence, the litigation was about HIV
 16 or other viral infections because, if you remember, in
 17 the litigation, they referred to -- I can't
 18 remember -- other exotic viruses. The word they used
 19 in the litigation, they do actually say that we should
 20 have been protecting not only for HIV but other
 21 "exotic viruses".
 22 Q. So your view, as expressed in the minute you referred
 23 to in paragraph 18, was that the undertaking shouldn't
 24 be so wide as to prevent any kind of claim but it
 25 should be wide enough to cover both HIV and other

27

1 minute that it was your view, hence you're expressing
 2 it in paragraph 3, that the settlement should include
 3 a relinquishing of any future claim to hepatitis?
 4 A. No, this is my understanding that that is what is
 5 being discussed. It's not my view about what should
 6 be, because I don't say there that they should be.
 7 I'm saying there "I understand that this is what
 8 people have told me" or, you know, "in conversation
 9 I've gathered this".
 10 Q. Can you recall -- and I appreciate, again, obviously,
 11 in terms of recalling conversations it's a long time
 12 ago, but all the material that you've referred to in
 13 your statement up to this date doesn't expressly
 14 mention hepatitis. Can you recall any discussions
 15 about the particular issue that you flagged here in
 16 paragraph 3?
 17 A. I have not -- well, of the papers that I've been
 18 given, and that is what it boils down to, I have not
 19 come across any mention of hepatitis, no.
 20 Q. Then just for the sake of completeness, if we just go
 21 back to your witness statement, WITN4486025, you make
 22 the point in paragraph 17, bottom of the page, that
 23 you were sent a minute on 22 March asking for comments
 24 on the latest iteration of the trust deed, and that
 25 contained an undertaking that was solely concerned

26

1 viral infections, which would include but not be
 2 limited to hepatitis; is that what you were suggesting
 3 in paragraph 18?
 4 A. I presume what my -- what I'm saying there is the
 5 undertaking, as you say, is so wide-ranging that
 6 anything remotely, you know, to do with treatment of
 7 haemophiliacs would be covered by this. You know, no
 8 matter how remote. Whether people sort of suffered
 9 because, you know, the bottle of concentrate fell on
 10 somebody's hand and they -- you know, suffered a minor
 11 injury. You know, things which are completely
 12 remotely not connected with this would be covered by
 13 the undertaking, because the undertaking was so broad
 14 that I felt that it should be limited to what was
 15 more -- what was the relevant context of the
 16 litigation.
 17 Q. Now, you've said more generally in your statement, I'm
 18 not -- I think we can take it down for present
 19 purposes, Paul, if we need to look back at any
 20 particular passage we will.
 21 But you've said that it was common clinical
 22 knowledge at this time, or indeed I think you say
 23 before this time, that most haemophiliacs treated with
 24 Factor VIII were affected with non-A, non-B hepatitis.
 25 A. Yes, that is correct.

28

1 **Q.** Would you accept that that which is common clinical
 2 knowledge -- and I think elsewhere you used the term
 3 "scientific community" in your statement -- doesn't
 4 mean that the individuals themselves are aware that
 5 they are infected with non-A, non-B hepatitis or
 6 hepatitis C?

7 **A.** Well, I did actually, at one stage in my statement,
 8 make the comment that the vast majority of
 9 haemophiliacs would have been aware of non-A, non-B
 10 because either they themselves have been jaundiced at
 11 some stage or they knew of people who had been. And
 12 the haemophilia community being quite a close
 13 community, and people knew each other well, not only
 14 because they were in the same families but, obviously,
 15 even within the same area. You know, people would
 16 chat, you know, if they were waiting in the clinic
 17 to -- if there was a follow-up clinic, for example,
 18 and they were chatting in the clinic or they were
 19 coming up for their supplies or whatever, they were
 20 forever meeting other fellow sufferers.

21 And so I think the idea that haemophilia patients
 22 or the majority of them were not aware of hepatitis in
 23 generality, I think, is probably not correct, and also
 24 the Haemophilia Society, I think, in their various
 25 Bulletins, refers to hepatitis.

29

1 it with fellow sufferers or not, that obviously: best
 2 guess.

3 **Q.** Did you -- sorry, not you, I'm not suggesting this was
 4 your role -- did the Department of Health, to your
 5 knowledge, take any steps to ascertain what the state
 6 of knowledge was of those who would be expected to
 7 sign the undertaking, either as to whether they
 8 themselves were infected with hepatitis C or as to
 9 what their understanding was about the seriousness or
 10 potential seriousness of hepatitis C?

11 **A.** I don't think the Department was involved in that
 12 sense. This was a discussion between the legal
 13 team -- well, between counsel and their legal teams
 14 for the haemophilia patients and for the Department.
 15 So I think the Department was never specifically asked
 16 this. I don't -- well, from the papers that I've been
 17 given, there is no indication that the Department ever
 18 went out to haemophilia patients saying to them "Are
 19 you aware about the risks of hep C? Do you know
 20 whether you've had ..." nothing like that would
 21 have --

22 And, in a sense, you see, that would be
 23 an intrusion, would it not, for the Department to be
 24 asking people that? Because, after all, this is
 25 clinical information which is supposed to be governed

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1 So the idea of people not being aware of
 2 hepatitis at all is one thing. Whether they were
 3 aware how much of the risk was to them individually,
 4 if they had not been jaundiced ever, that is another
 5 matter and I can't answer that.

6 **Q.** With the greatest of respect, Dr Rejman, your last
 7 answers, I think, must be a matter of speculation
 8 because you yourself had not, as you'd been at pains
 9 to point out, had any great involvement with the
 10 treatment of haemophiliacs?

11 **A.** No, that is spec -- well, yes, it is speculation, but
 12 one has to look at what is likely, and the likelihood
 13 is -- and I know, because we do know that
 14 a significant number of haemophilia patients did
 15 become jaundiced. That is beyond any doubt. So at
 16 least those people would have been aware because I'm
 17 pretty sure that any haemophilia patient that became
 18 yellow would have gone to their doctor, usually they'd
 19 have gone to their haemophilia doctor, rather than
 20 their GP, and said, "Look, I'm yellow, what is the
 21 problem? And, look, I'm passing dark urine, what is
 22 the problem?" And they would have been told.

23 The speculation, really, is how many people who
 24 themselves didn't have signs or symptoms of
 25 non-A, non-B were aware of it and, had they discussed

30

1 by confidentiality, and to actually write to people
 2 and to say to them individually, "Look, are you aware
 3 ..."

4 And, in a sense, you see, the Department has no
 5 right to even know who the patients are with
 6 haemophilia. That is not within their purview, is it?
 7 Because who has haemophilia has nothing to do with the
 8 Department at all. The Department is aware that there
 9 are patients who have haemophilia and the people who
 10 know about who has haemophilia are the haemophilia
 11 treaters and, obviously, the GPs of the patients, but
 12 the Department couldn't, for example -- you know, if
 13 they were going to send a letter, they'd have to send
 14 it to the whole population of the country and not just
 15 to the haemophilia patients.

16 **Q.** Dr Rejman, I'm going to move away from that topic now
 17 because, obviously, there's still quite a lot we still
 18 need to cover.

19 **A.** Yes.

20 **Q.** But just before we leave the HIV Litigation
 21 completely, there is one further document I want to
 22 ask you about. It's DHSC0006480_080.

23 This is August 1991, and you are writing to
 24 Mr Canavan, copied to Mr Powell and to someone else
 25 within the solicitor's office, setting out some

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1 observations about the medical negligence cases
 2 topping up. Now, in relation to -- can you just
 3 explain to what us what the "topping up" refers to?
 4 A. Well, my understanding and, as I say, this is a long
 5 time ago but, having read the various papers, my
 6 understanding is that the medical negligence cases
 7 were -- well, they were all against the District
 8 Health Authorities or Regional Health Authorities and,
 9 in some cases, against specific doctors. And, from my
 10 understanding of the papers that I've seen, although
 11 the majority of the costs for paying for medical
 12 negligence cases was to actually come from the budgets
 13 of the DHAs and the RHAs, I understand that the
 14 Department did contribute, and I don't know what
 15 proportion they contributed but they did make
 16 a contribution, which is why the Department was at all
 17 involved, otherwise they would not have been involved.
 18 Q. That answers what was going to be my next question as
 19 to the Department's involvement. As to your own, are
 20 you able to assist us in understanding why, in
 21 particular, you were commenting on these claims? Some
 22 of the comments you make might be said to be medical
 23 in nature. But others, if we go, for example over the
 24 page, the second paragraph on the page, you refer to
 25 discrepancies in relation to a wife's supposed

33

1 papers but a brief summary of the case to Mr Powell.
 2 Now, Mr Powell not being a medic, and also not being
 3 an administrator but being purely a solicitor, would
 4 have sent it on, presumably -- I don't know whether he
 5 sent it to me first or whether he sent it to
 6 Mr Canavan and Mr Canavan sent it to me, but I would
 7 have been the first person to look at the individual
 8 claim. And, as you can see, these ones here, they're
 9 code numbers. There isn't a name, right?
 10 Now, if they had a code number, the chances are,
 11 I had their individual statement of claim. And that
 12 individual statement of claim would have said things
 13 like -- well, I went through it the other day -- about
 14 age, sex, married -- oh, sorry, I didn't mention that,
 15 married/unmarried/in a stable relationship. That,
 16 again, would have been within the individual statement
 17 of claim.
 18 So I had the individual statement of claim so,
 19 therefore, I had some information about these
 20 individual cases. So there was that information
 21 that I had, and there was the information that we had
 22 from the Health Authority.
 23 Now presumably they would have submitted the
 24 actual claim from the claimant, which actually gives
 25 details about, you know, why they're making the claim,

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1 earnings in a fish and chip shop.
 2 What was it you were intending to bring to the
 3 assessment?
 4 A. Well, obviously, I cannot remember exactly what
 5 happened, but reading this, I assume that what would
 6 have happened would have been that the Health
 7 Authority, if there was a particular medical
 8 negligence claim where they felt that the Department
 9 might be prepared to top up, they would have sent the
 10 details to Ron Powell.
 11 Now, obviously, the name -- well, I know that
 12 sometimes they did actually use the names but,
 13 ideally, they shouldn't have used the names. They
 14 should, in fact -- you see the problem, ultimately, is
 15 that some of these cases were cases that were in the
 16 litigation, and so had code numbers, and so,
 17 therefore, one could preserve confidentiality that
 18 way. And I think I do refer sometimes to people -- to
 19 code numbers.
 20 Sometimes because they haven't been in the
 21 litigation, therefore we had their actual names, which
 22 again was not ideal, and probably, in retrospect, one
 23 should have tried to avoid that.
 24 Anyways, be that as it may. I presume that the
 25 Health Authority would have sent -- well, not all the

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1 and a lot of this in fact is about subsidiary
 2 payments, et cetera. And so what I was doing here is
 3 they're using me not just as a medic but basically,
 4 you know, there's a lot of work to be done here, and
 5 if you've got somebody who's actually going to be
 6 reading through this thoroughly, he might as well sort
 7 of comment about any aspects of the claim.
 8 Because I was a medic, "Do not say" -- "You're
 9 a medic, you can't say anything about this".
 10 The understanding was, I would read through the claim,
 11 I'd go through it and I'd give my general view --
 12 I'd give my medical view about the medical aspects and
 13 then if there were other things that came to my mind
 14 as a non-medic but just as a general member of the
 15 public almost, I could say, "Well, look, you know,
 16 this doesn't hang -- you know, this doesn't sort of
 17 make sense". Then I would put that in my comment to
 18 Mr Canavan.
 19 Mr Canavan would then presumably not comment
 20 upon my medical comments, but he would look at my
 21 non-medical comments and say, "Well, no, you see,
 22 I think Dr Rejman's view is" -- well, he's the person,
 23 it's not me, he would be the person taking the lead in
 24 non-medical matters, and he would say, well, having
 25 read what I said, he doesn't agree, and then he would

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1 actually say to Ron Powell, "Look, you know, you've
2 seen Dr Rejman's minute. I've looked at it, and
3 basically I think Dr Rejman has got this wrong on the
4 non-medical side". And that would be the way.

5 So it was really a case of, you know, everybody
6 throwing in their two penny worth, so to speak.

7 **Q.** We can take that down, thank you, Paul.

8 Did you see it as the Department's role, whether
9 or not by extension that then became your role, to try
10 to cut down the claims as much as possible to ensure
11 that the Department paid out as little as it could?

12 **A.** I think there is a difference between saying we're
13 trying to do this to do it as cheaply as possible, and
14 saying we want to do this fairly. And I think the
15 Department's role was to make sure that it was fair
16 both to the claimant and also to the public purse.
17 And I think it was a case of what was fair that was
18 important. It wasn't just saying, "Oh, well, can we
19 actually cut this down and save some money?" It
20 wasn't that. It was a case of looking at it in the
21 broader context. Is this a reasonable thing to ask
22 for, or is it something that really we think, well --
23 well, you know, a lot of solicitors obviously will, as
24 usual, put in for the maximum they think they can get,
25 knowing that when the crunch comes and when the final

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1 a much more significant role in this, my role and
2 others would be to look at it and to say: well, does
3 this look a reasonable claim?

4 And I think on most of -- these cases that are
5 here are a minority. Because the number of -- I don't
6 know how many people were actually paid in the end.
7 It was over 1,200, wasn't it? Something like that.
8 Was it 1,200 people paid? Something like that. So
9 1,200 people roughly were paid. And the number of
10 these cases that came to me, I'm not sure -- if you
11 tot them all up, would there have been 20 of them?
12 I don't know. But a small number. The vast majority
13 were paid no problem -- oh, sorry, we're talking
14 medical -- sorry, medical negligence there were about
15 80 or 100. Anyway, below 100 medical negligence
16 changes. And the thing with the medical negligence
17 cases were that the medical side of the medical
18 negligence cases were looked at by Professor Hardisty,
19 who at that stage was professor of haematology at
20 Great Ormond Street Hospital, and he would look at it
21 from the medical point of view on behalf of the Health
22 Authorities.

23 I would look at it on the medical point of view
24 from DH side, also bearing in mind that I might have
25 additional information from the individual's statement

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1 decision comes, they will not get everything that they
2 ask for. That is negotiation. And I think this is
3 part of negotiation.

4 **Q.** Can I move, then, to the --

5 **SIR BRIAN LANGSTAFF:** May I ask, does it follow that in
6 your comments as to the detail of the claims, you
7 never suggested that the figure claimed was too low?

8 **A.** I think -- well, as a non-solicitor -- you know,
9 I have to say this is all the time -- my assumption is
10 that the solicitor, if they're worthy of their
11 profession and they're doing their job properly, the
12 idea that they would miss out on something which was
13 significant I think would never have crossed my mind.

14 **SIR BRIAN LANGSTAFF:** So you started with the idea that
15 the claim was at the highest it could reasonably be
16 put? Or maybe even higher?

17 **A.** I think the assumption we made was that the solicitor
18 was trying to get the most they could for their
19 client. Which is their job, at the end of the day.
20 And therefore, they would actually put in everything
21 that they thought could possibly be claimed for. And
22 I think the Department's role, and I add my role only
23 partly because obviously the administrators and the
24 solicitors within the Department and everybody else
25 would obviously have -- in a lot of respects, have

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1 of claim which Professor Hardisty wouldn't have had.
2 So he did -- wasn't -- he didn't have as much
3 information as I had, so therefore his advice might
4 not give the whole picture. So I was asked to look at
5 it with the advantage of the individual's statement of
6 claim information. And most of the time I suspect we
7 agreed with Professor Hardisty's views anyway because,
8 you know, he was an eminent haematologist, very good,
9 did the job thoroughly. Although I seem to recall in
10 some of the papers that we did actually say that, you
11 know, he had not been given as much information as he
12 should have been, even from our reading, that we
13 thought the Health Authorities should have provided
14 more information.

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

16 **A.** Thank you.

17 **MS RICHARDS:** Dr Rejman, I want to move to the
18 establishment of the HIV payment scheme for those
19 infected through transfusional tissue.

20 **A.** Yes.

21 **Q.** I think, perhaps, we can look only at couple of
22 documents for these purposes, DHSC0003532_015. Now,
23 we can see this is a briefing for Number 10 from
24 Mr Canavan copied to you and others, and addressed to
25 Mr Dobson and to the Parliamentary branch. If we go

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1 over the page, we'll see the context of the briefing
 2 is the detailed terms of the settlement of the HIV
 3 Haemophilia Litigation.
 4 **A.** Yes.
 5 **Q.** So that's being drawn to the attention of the Prime
 6 Minister. If we go to the next page, we will see
 7 there is then a background note, which refers to the
 8 settlement negotiations. We're not proposing to go
 9 through that.
 10 If we go to page 5, we can see then this is
 11 a briefing in relation to "HIV Infected Blood
 12 Transfusion Recipients". The first paragraph says:
 13 "... Government does not accept the case for
 14 no fault compensation ... recognised that special
 15 circumstances applied [to haemophiliacs]."
 16 There's reference there to the double disadvantage
 17 of the haemophilia and then HIV, and also to the fact
 18 that it can mean -- because haemophilia is hereditary,
 19 it can mean more than one member of the family
 20 affected.
 21 Then the statement in the last two paragraphs:
 22 "A similar combination of factors would not
 23 generally apply to blood transfusion cases.
 24 "In principle blood transfusion cases are no
 25 different from other people who suffered medical

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1 that was raised by a number of the haemophilia doctors
 2 and other doctors at various times, that they wanted
 3 a no-fault compensation because they thought this
 4 would solve all the problems.
 5 And I think at the time when they decided to make
 6 the payments to the haemophilia sufferers, they
 7 decided that because of the -- well, unique
 8 circumstances that they were dealing with, this was
 9 a reason to make the payments.
 10 And at that time, the pressure from the public,
 11 the press, the MPs, haemophiliacs and everybody else,
 12 was that this was a special case that merited
 13 a special treatment.
 14 **Q.** Now, that line to take, as set out in the document we
 15 just looked at, which was May 1991, it's maintained in
 16 another document that you've seen in August 1991. I'm
 17 not going to take you to it.
 18 **A.** Yes.
 19 **Q.** But, for the transcript, it's NHBT0000062_102. But we
 20 can see that the Government's position then changed,
 21 and I just want to ask you about that.
 22 If we go to DHSC0020274, this is a minute from
 23 Mr Scofield.
 24 **A.** Yes.
 25 **Q.** Sorry, can you just assist us with what Mr Scofield's

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1 accidents or the unintended side effects of
 2 treatment."
 3 So is it right to understand that, at the point
 4 in time at which the Haemophilia Litigation was
 5 settled, the Department's line in relation to those
 6 infected with HIV through transfusional tissue was no
 7 financial assistance?
 8 **A.** That is my -- well, recollection is probably too
 9 strong a word, but I mean to say, reading the papers,
 10 I think that is probably correct.
 11 **Q.** Then there's a little more detail given over the page.
 12 So we can see the bottom of the page, paragraph 6
 13 refers again to the double disadvantage in relation to
 14 those who have haemophilia. But we go to the next
 15 page, top of the next page, the concerns, it would
 16 appear, in 7 and 8 are if we concede the position in
 17 relation to those infected through transfusion, we
 18 can't really ring-fence it to prevent a slide into
 19 a broader scheme of no-fault compensation.
 20 Was that your understanding of the Department's
 21 thinking at the time?
 22 **A.** Reading this, I mean to say, I think it seems quite
 23 clear that, in essence, I think the Government, as had
 24 previous governments, was opposed to
 25 no-fault compensation, even though this was something

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1 role was or what HC(A)4 was?
 2 **A.** Sorry?
 3 **Q.** Do you know what HC(A)4 was?
 4 **A.** As I've mentioned before, branches changed their names
 5 nonstop and Roger Scofield was the assistant secretary
 6 who was in charge of the administrative branch that
 7 dealt with blood transfusion. Because if you look
 8 lower down there you see Mr Canavan, HC(A)4B, and my
 9 understanding is that HC(A)4 is the overarching
 10 branch, and then Mr Canavan, which is the bit dealing
 11 with the blood, has the "B" suffix.
 12 **Q.** We can see it's addressed to the Secretary of State.
 13 **A.** Yes.
 14 **Q.** Then we can see from the first paragraph it says that:
 15 "... the Prime Minister will make a statement in
 16 the House during Question Time tomorrow ... stating
 17 that financial assistance will be offered to blood
 18 transfusion victims infected with HIV.
 19 Now, do you have either any independent
 20 recollection or any understanding, having been
 21 reminded from the papers, as to why and how the
 22 governments position changed?
 23 **A.** I think any such decisions, whether it was the
 24 payments to the haemophilia sufferers or these
 25 payments, ultimately, are made at a much higher level.

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1 So quite often people at my level get told "This has
2 been decided and just get on with making it happen".
3 And I think I, you know -- and I mean to say, this
4 isn't like what I suggested with the haemophilia
5 payment there was a change of government. There was
6 something that might have influenced the decision.

7 Here -- well, I don't know you see, there was
8 a general election that was in the offing. I don't
9 know whether this was the time when you had these
10 five-yearly general -- no, I don't think -- no, this
11 was before. So I'm not sure. But the general
12 election did actually happen a couple of months after
13 this, or less. So whether that had any impact on it,
14 I do not know.

15 **Q.** If we pick it up in paragraph 3, towards the bottom of
16 the page, what is said by Mr Scofield here is:
17 "... the line we have taken hitherto that the
18 distinction between recipients of Factor 8 for
19 haemophiliacs and whole blood through transfusion is
20 proving a difficult position to defend and there is
21 little public understanding or sympathy for the
22 Department's position."

23 You're not able to then to add anything from
24 your own understanding as to how that shaped the
25 Department's thinking?

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1 I think it's politics, at the end of the day.
2 **Q.** Can I then come to the mechanics of the scheme because
3 you were involved in relation to that.

4 **A.** I was involved. Very much so.

5 **Q.** The decision was taken that the Department would
6 decide who was eligible for the scheme, and I think
7 you'll probably have picked up from some of the
8 documents that you've seen for the purposes of your
9 statement, there was a concern expressed as to whether
10 there was a tension there or a conflict of interest.
11 Are you able to assist us in understanding why it was
12 decided that the Department would determine
13 eligibility?

14 **A.** Well, I think I said in my statement that basically
15 the number of patients that were likely to come up
16 with this would be a small number. I don't know what
17 the final number was in the end, was it about 80 or
18 something like that? I can't remember the exact
19 numbers but it was a relatively small number.

20 The idea of setting up a completely separate
21 unit outside the Department, which would basically
22 mean, I don't know, two, three people, plus the costs
23 of office space, their salaries, their costs of travel
24 and everything else -- you know, there are costs
25 involved. And at the end of the day the other problem

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1 **A.** Well, no. I mean to say, my guess -- and I think at
2 the time, you know, most of the people at my level
3 would have just accepted, "Well, somebody has made the
4 decision, let's just get on with it, because it's got
5 to be done" type of thing. And I think here, what
6 particularly prompted this -- you see, I think one of
7 the things with a lot of what was going on in the
8 political sphere was it depended upon which
9 particular MPs were pushing a particular line and how
10 much influence those MPs had primarily with Number 10
11 but possibly also with the Secretary of State or other
12 ministers within the Department.

13 So if you had a particular MP who was -- and you
14 had adjournment debates and whatever, and there was
15 a particular MP who was pushing for it, particularly
16 if he was somebody from your party as opposed to
17 the -- see, if it was somebody from the opposition you
18 could actually sort of say, "Ah, well, you know,
19 they're just doing this for party political reasons",
20 whereas if it's somebody from within your own party,
21 and particularly if there's a body of other MPs from
22 within your party that say, "Look, we think that this
23 is something we should do, and if we do it and if we
24 do it well, with good grace, the public will
25 appreciate it and they will thank us for it" -- so

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1 also is if you have a unit that is set up which has
2 only a small amount of work that is being done, then
3 the people there might complain at a later stage -- at
4 some stage, "Look, we're wasting our time", and they
5 may not even give it the time that is necessary,
6 because they say, "Oh well, I'll do something else".
7 And particularly if it's done on a sort of *ad hoc*
8 basis.

9 So I think the -- reading the various minutes,
10 my understanding is that a decision was made: look,
11 the numbers are small, it's something that the
12 Department can cope with without too much difficulty,
13 and so we will do it in-house.

14 And I know that there was this note of a meeting
15 where the AIDS Unit representatives said they were
16 worried about us making decisions, and I think, as
17 I explained, the thing was that there was this panel
18 that would make the final decision. So if
19 an applicant put in an application to the Department
20 and it was turned down, then that applicant could then
21 go to the panel and the panel would be the final
22 arbiter of whether they were paid or not.

23 **Q.** So is it right to understand the scheme worked this
24 way: the application would come to the Department,
25 whilst you were there, you considered that

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1 application?

2 A. Well, in essence the application was sent to me

3 because I was named on the CMO letter.

4 Q. You were.

5 A. So the application would have come to me, and

6 I presume I would have then sent it to my admin

7 colleagues, who would just check all the bits and

8 pieces of facts, whether this is correct and

9 everything else, and then I would -- then we would

10 have to get some information, because the application

11 itself, I think the application form, I think we

12 actually did include it -- you included it in some of

13 the papers from the Inquiry -- had very little detail.

14 It had a name, consultant, and also -- I'm not sure,

15 actually, if it had a date, did it? I can't remember.

16 I would have to have a look at the actual application

17 form. But it had very little detail. So, obviously,

18 to get the detail, one would need to get information

19 from the hospital notes, and I think initially, in the

20 draft of how it was supposed to happen, I think the

21 idea was that the hospital would send over photocopies

22 or whatever, but I think in reality what happened was

23 that -- sorry, just to go back a moment.

24 CDSC had a number of patients who they believe

25 had actually contracted HIV as a result of

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1 notes, they should actually have the number of the

2 blood transfusion. So, therefore, we could actually

3 go to the Transfusion Centre, although, normally, one

4 would have expected that the claimant, or the person

5 claiming on behalf of the claimant, would have

6 actually contacted the Transfusion Centre, so they may

7 already have actually checked that out.

8 So it was a case of getting all the facts

9 together as best we could and then, having got all

10 these facts together, then, if they all sounded as

11 though, yes, it's likely that the person got it from

12 a blood transfusion, there's no other factors that are

13 relevant, then there was a meeting -- and I think I've

14 referred in my statement to this -- there would be

15 a meeting between the solicitor -- and I can't

16 remember if it was Mrs Edwards at that time, and then,

17 an administrator and myself, I would present the case,

18 so to speak. I'd say, "Look, I've looked through

19 this, this is what I found, this is what I've found,

20 this is what I've found", and usually we'd say "Yes,

21 that sounds fine", and we'd send a summary to the

22 assistant secretary, who would look at it, and he

23 would sign on behalf of the Secretary of State to say

24 payment should be made.

25 Q. Do you have any sense of how many -- what kind of

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1 blood transfusion, and they therefore had some

2 information. So if an application mentioned that CDSC

3 were aware of this, then obviously we didn't need to

4 do anything at all about it. And if, on the other

5 hand, there wasn't that information, and therefore we

6 were starting with no information, we then had to get

7 hold of the hospital notes or see them. And I seem to

8 recall in the early stages I would actually travel to

9 the hospital, look at the hospital notes, see whether

10 in the hospital notes it said that they had actually

11 had a transfusion -- because obviously this was one of

12 the things that was important, to make sure that they

13 had had a blood transfusion -- although usually,

14 because they were supposed to be signed off by medic,

15 then hopefully that would have been correct, but

16 I gather that there were some applications that were

17 not countersigned by medical professionals.

18 And I would then actually look through the

19 notes, check what had happened, the date of the

20 transfusion, see whether there was any other obvious

21 reason why they may have got HIV from another source,

22 and then I would have to make any other further

23 enquiries, such as going back to the blood transfusion

24 centre and saying, "Look, this individual had blood

25 donation", and usually we would -- in the hospital

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1 proportion of cases were rejected or not accepted at

2 that stage and, therefore, went off to the panel?

3 A. I think it was a small number because I think in most

4 cases it was pretty obvious, and there was no reason

5 to -- not to pay. Because, at the end of the day,

6 I mean to say, one really had -- you know, what were

7 the reasons not to pay? Well, the primary reason not

8 to pay was that they had not had a blood transfusion

9 or the blood transfusion was at a time when we already

10 had screening for HIV. So they were post-October '85.

11 Q. There was no cut-off date in the scheme, was there?

12 So there was no date by which the person had to

13 establish that the treatment had taken place?

14 A. Well, I don't know, I'd have to read through the

15 actual words of the scheme. I think there was a bit

16 of a cut-off, in the sense that it said that if you

17 are aware that you have got HIV, then, you know,

18 within a year or so, you should really make

19 an application or, at least, make some sort of start

20 towards the application.

21 Q. Then, in relation to the panel, if a case went to the

22 panel, it was chaired by an independent QC?

23 A. Yes.

24 Q. They could hold an oral hearing, as it were, if they

25 wanted, at which the applicant attended?

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1 **A. (Witness nodded)**
 2 **Q.** There was the ability for the applicants to have
 3 a legal representative there?
 4 **A.** Yes.
 5 **Q.** Is this right: there was no limitation or fetter on
 6 the kind of evidence that could be considered by the
 7 panel?
 8 **A.** Well, the panel -- if an application was turned down,
 9 I think in one of the cases that, actually, you
 10 highlighted, I would actually send all the information
 11 I had to the panel. So, therefore, they had as much
 12 information as I had. So everything that I had was
 13 photocopied and sent to the panel, so they had
 14 everything.
 15 They would then, having looked at the
 16 information that I had provided, decide whether they
 17 needed more information. Because, if they didn't need
 18 any more information, obviously there's no point in
 19 contacting the applicant.
 20 If, on the other hand, there was insufficient
 21 information for them to make a judgment, then they
 22 would ask -- well, I suspect a lot of the time it was
 23 done in writing, rather than calling the applicant to
 24 make a face-to-face meeting because I think that's
 25 always a little bit less pleasant, because ultimately

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1 taken, either at this time or subsequently, to try to
 2 publicise the scheme? Was there any kind of press
 3 campaign or anything of that kind to try to ensure
 4 that as many people as possible who might be eligible
 5 knew about it?
 6 **A.** I think there was a press notice, wasn't there, that
 7 was issued, I seem to recall. I'd have to look in my
 8 files there at what else I said in my statement.
 9 I think there was a press notice, and I'm not sure
 10 whether -- which -- oh, that would be in 3. I don't
 11 know, you can probably find it easier than me.
 12 **Q.** Not necessarily.
 13 **A.** There would have been a question from you specifically
 14 about publicity.
 15 **Q.** Yes, I can check that Dr Rejman, perhaps rather than
 16 take up time.
 17 I'm thinking more after the initial announcement
 18 with the CMO letter, and it may well have been
 19 accompanied by a press notice, and I can check that,
 20 do you recall whether there was anything else done or
 21 was the sense that the cases were coming forward?
 22 **A.** Well, my -- I don't recollect exactly but, reading
 23 through the various papers, my understanding is that
 24 the other people that would have been contacted would
 25 have been CDSC, obviously, and also the Regional

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1 these patients, some of them were quite elderly, were
 2 ill for other reasons, or might have been ill because
 3 of the HIV even. So I think that the panel would
 4 probably have avoided asking them to come to the panel
 5 if at all possible.
 6 **Q.** Just so you understand, Dr Rejman, and this is for
 7 your information rather than for a response, the
 8 reason I ask those questions is to draw out those
 9 features which might be said to be different from the
 10 features of the scheme that was established a number
 11 of years later after you left --
 12 **A.** Yes.
 13 **Q.** -- the Skipton Fund, the scheme in relation to
 14 hepatitis C.
 15 **A.** Yes.
 16 **Q.** So that's the reason for trying to understand the way
 17 in which it worked.
 18 Just then, I think, finally, in relation to
 19 the -- this scheme, if we look at OXUH0001251_004,
 20 this is the CMO letter from Dr Calman in April 1992
 21 which drew attention to all doctors -- well, all
 22 hospital consultants and all general practitioners,
 23 I should say, that this scheme was now up and running
 24 so that they could identify patients.
 25 As far as you can recall, were any other steps

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1 Transfusion Centre Directors. And, on top of this,
 2 I suspect that there would have been communication
 3 with them and saying to them, "Look, CMO sent out this
 4 letter but, you know, you really have to take this
 5 seriously. This actually is your job to do".
 6 So, obviously, CDSC, having their list of
 7 patients who were probable recipients of HIV infected
 8 blood, then obviously they would have been contacted
 9 to make absolutely sure that all of their individuals
 10 had been contacted, or their -- or people, if they had
 11 died, then their personal representatives, et cetera.
 12 And I think the Regional Transfusion Centres directors
 13 were aware, and I think, as we discussed the other
 14 day, one of the advantages of this being a Chief
 15 Medical Officer letter is that it guaranteed that
 16 every medical practitioner in the country, in all four
 17 countries of the United Kingdom -- well, no, sorry
 18 this is England.
 19 **Q.** Yes.
 20 **A.** So it's obviously England, this particular one, but
 21 each of the other countries had their own separate CMO
 22 letter. That each doctor was aware of the scheme and
 23 we put down there, you know, "Ask, you know, if
 24 there's any suggestion that your patient has got HIV
 25 from this", and I suspect that probably a lot of the

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1 HIV clinics themselves would have looked thorough
 2 their records and said to themselves, "Well, this
 3 person doesn't sound as though he or she has got HIV
 4 from any other known factor, it might have been blood
 5 transfusion". So they themselves might have
 6 approached the patient and said, "Did you ever have
 7 a blood transfusion?"

8 **Q.** The reference in your statement, I don't think I need
 9 to ask you to go to it, but just so, again, it's
 10 clear, you deal with it in section 107 of your witness
 11 statement pages 159-160, and you flagged up, for
 12 example, an instance in which you wrote to a clinician
 13 asking for details of the scheme to be brought to the
 14 attention of the personal representative --

15 **A.** Yes, because I think I'd been informed about that
 16 through another source and, therefore, I felt that
 17 the -- it was Dr -- Professor Adrian Newland, whom
 18 I knew personally, so I wrote to him and I said, "Look
 19 I understand this patient may well have got
 20 an infection from blood transfusion, could you fill in
 21 an application form for the patient, so that we can
 22 assess this and actually pay the patient if it's
 23 appropriate?"

24 **MS RICHARDS:** Sir, I note the time, and I'm going to move
 25 to a fresh topic, the ACVSB, after the break, so if we

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1 and the other for it".

2 **Q.** In terms of its functioning or its terms of reference,
 3 if we could have, please, Paul, PRSE0001189. This is
 4 a paper for the first ACVSB meeting and we can see the
 5 "Terms of Reference" set out at the top of the page:
 6 "To advise the Health Departments of the UK on
 7 measures to ensure the virological safety of blood,
 8 whilst maintaining adequate supplies of appropriate
 9 quality for both immediate use and for plasma
 10 processing."

11 Then there's a reference there to the remit
 12 being UK-wide -- sorry, can we zoom in again on that
 13 top half of the page, Paul.

14 "Our concern is matters of major policy, not the
 15 detailed implementation of policy."

16 Was it, as far as you understood it, part of the
 17 role of the ACVSB to consider questions of financial
 18 resources, how things might or might not be paid for?

19 **A.** It was not a major concern. I think the thing is
 20 finances -- everything in the NHS has costs, and so
 21 finances are going to be considered in anything to do
 22 with the NHS, and I think the -- my understanding of
 23 the role of the Advisory Committee was that it was
 24 a group of independent experts, that means people not
 25 tied to the Department, who were there to provide

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1 could take our morning break now, please.

2 **SIR BRIAN LANGSTAFF:** Yes, well, let's do that and come
 3 back at 11.50. 11.50.

4 **A.** Thank you.

5 (11.20 am)

6 (A short break)

7 (11.50 am)

8 **SIR BRIAN LANGSTAFF:** Yes.

9 **MS RICHARDS:** Dr Rejman, I want to move next to the role
 10 of the Advisory Committee on the Virological Safety of
 11 Blood --

12 **A.** Thank you.

13 **Q.** -- and then to explore with you the decision making as
 14 regards the introduction of hepatitis C screening.

15 **A.** Yes.

16 **Q.** Now, do you know why there was no national committee
 17 on the virological safety of blood prior to 1989?
 18 I know you weren't there prior to 1989? Did you glean
 19 any reasoning when you joined the Department?

20 **A.** No, I think when I came I was basically told "This is
 21 a committee that's been set up, you're going to be the
 22 medical secretary", and literally -- well, a month and
 23 three days or four days after I started, it happened.
 24 So I was basically told, "It's there, this what its
 25 function is, and you're going to have to do this, that

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1 advice to ministers, and ministers could either accept
 2 that advice or could reject it.

3 There was no obligation on ministers to accept the
 4 advice. I think, in reality, they accepted it every
 5 time, on the basis that these are experts and if
 6 they're experts who don't have any particular reason
 7 for pushing a particular view, such as commercial
 8 reasons or whatever -- although, having said that, I'm
 9 not sure whether the Committee ever did ask people
 10 about commercial interests but I think people assume
 11 that they didn't have any specific commercial
 12 interests.

13 And, basically, the Committee was there, the
 14 great and the good.

15 **Q.** The Chair was, of course, from within the Department,
 16 it was the Deputy Chief Medical Officer, Dr Harris
 17 first and then Dr Metters?

18 **A.** That's right, Dr Harris and Dr Metters, yes.

19 **Q.** There would then be observers from the Department,
 20 observers from the Scottish Home and Health
 21 Department, Welsh Office and the Northern Irish
 22 Department of Health --

23 **A.** Yes.

24 **Q.** -- and then the Secretariat?

25 **A.** Yes.

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1 **Q.** One of the observations that has been made by another
2 witness to the Inquiry in terms of the membership of
3 the Advisory Committee was that it may have had
4 insufficient public health expertise and too much
5 focus on virology. Do you recall whether that was
6 something that was ever considered or discussed, as to
7 whether the membership should be broadened?

8 **A.** I can never -- well, I can't recall, and from the
9 papers I can't see any evidence at any of the meetings
10 that somebody has said that they feel that the
11 membership of the Advisory Committee is either
12 insufficient or inappropriate, and I think the
13 Committee was set up before I was there. I had no
14 hand in deciding who was going to be on it. If one
15 looks at the membership, some of the people on it were
16 obvious, ie Harold Gunson as head of the Transfusion
17 Service in England and Wales and also a representative
18 of the Scottish Blood Transfusion Service, who was
19 Ruthven Mitchell initially. And obviously the
20 fractionators, Richard Lane in England and Robert
21 Perry for Scotland. So they were the obvious people.

22 Now, obviously it's a virological safety, so
23 therefore you must have virologists on it. You can't
24 operate without virologists. The other people, well,
25 I think there was a general haematologist and I think,

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1 **A.** I think I've referred to this in my statement.
2 I think there are several reasons for the
3 confidentiality. One reason was that the Committee
4 would make recommendations and those recommendations
5 would go to the Department, to ministers. And if
6 ministers were to choose not to accept those
7 recommendations or were to come back and say, "Look,
8 we've seen your recommendation, but could you change
9 this or change that or whatever", that sort of
10 information probably should not be in the public
11 domain because, after all, it's probably something
12 that will be covered by PII in other circumstances.

13 And the idea of a blow-by-blow account in the
14 press of what goes on in the Committee I don't think
15 was in anybody's -- was not in the interests either of
16 the Department or basically anybody that was going to
17 be affected by any of the recommendations of the
18 ACVSB.

19 So I think that was one reason. Another reason
20 is that, as we all know, different medics, different
21 scientists, have different views. And if a particular
22 scientist or medic who was on the Committee gave his
23 view, he felt that that view was for the information
24 of the Committee that needed it. He didn't want to
25 have to go and defend that view against people who

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1 at some stage, I was asked to nominate someone --
2 I think I may even have been asked twice to nominate
3 somebody. The first person I nominated was
4 Dr Geoffrey Summerfield from Middlesbrough, but I
5 think, his work was such that he found it difficult to
6 come to the Committee because, obviously, it's quite
7 a journey from Middlesbrough and I don't know the
8 railway connections, but it may just have been the
9 connections were very difficult for him.

10 But he actually had to absent himself from
11 a number of meetings and in the end he resigned
12 because he realised that he wasn't able to contribute
13 and then we had a replacement for him, and, again,
14 I think I was asked about that.

15 But, apart from those two nominations, I don't
16 think I was ever asked about nominations.

17 **Q.** We see from minutes a refrain from the minutes, from
18 time to time, is a reminder about the confidentiality
19 of the meetings.

20 **A.** Yes.

21 **Q.** Again, we've heard from Dr Perry who said that that
22 was something that was very rigorously emphasised in
23 particular by Dr Metters to members. Do you recall
24 from the time why it was thought that confidentiality
25 was so critical?

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1 might disagree with him or her. So I think there was
2 that point.

3 The other point which also obviously flows
4 through all of this is commercial confidentiality. If
5 the Committee were talking -- I mean to say we talked
6 about screening kits. Now, initially, for hep C,
7 there was just one, then there was a second one and
8 then later on there were more and more and more. And
9 if the Committee were to come up and say, "We think
10 the screening kit from such-and-such a company is the
11 best", again, would that be against commercial
12 interests? Would that be -- could a company say that
13 they had not had a fair hearing? In which case, we
14 then end up with all the stuff being discussed at the
15 ACVSB, all the subsidiary papers, who said what to
16 whom and who had influence. You know, it could be
17 a --

18 **Q.** Would you accept commercial confidentiality is
19 a consideration that could be addressed by redaction
20 of appropriate parts of the minutes? Not a reason to
21 prevent the broader public health debate from being
22 made public.

23 **A.** But you see the question with redaction, as you know,
24 is what you redact, because I've seen papers where
25 bits have been redacted where never in a month of

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1 Sundays could I justify that redaction because it is
 2 just so completely unnecessary, and other times you
 3 look at it and you say, "Well, actually, perhaps that
 4 particular bit could have been redacted". So I think
 5 the concept of redaction, while it's fine in theory,
 6 it's the practicalities that are the problem.

7 **Q.** It might be said that a consequence of confidentiality
 8 is that it insulated both the Committee and the
 9 Department from criticism. Was that part of the
 10 thinking at the time, as far as you can recall?

11 **A.** I don't think so because I think -- you have to look
 12 at the confidentiality. I do not believe that every
 13 single thing that was said at ACVSB was confidential
 14 to the Committee. And we've got minutes from
 15 Scotland, for example, where it was quite obvious that
 16 Ruthven Mitchell had discussed things that had been
 17 discussed at the ACVSB with Professor John Cash, for
 18 example. So, therefore, confidentiality had been
 19 breached in a sense, but I think with
 20 confidentiality -- I don't think anybody in the
 21 Department, or Dr Metters for his part, would have
 22 said to people, "No, you cannot say anything about
 23 what we've said to anybody", because after all one of
 24 the points of the Committee was to try to get as much
 25 of information as we could.

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1 and you can't just drag it on and on for hours on end.
 2 And from my other committee work, I can well see the
 3 reason for that. Because if a committee just drags
 4 on, people will walk out because they've got other
 5 things to do, or topics get rushed to try to fit. So
 6 I think Dr Metters wanted really to have a good idea
 7 as to what is likely to happen during the Committee.

8 And I think, if you look through some of the
 9 papers that I produced, the covering papers, you will
 10 see there that the Committee has actually asked
 11 questions, you know: what does the Committee think
 12 about this? In a sense, focusing the mind of the
 13 Committee so -- and because these papers were sent out
 14 to the Committee members two weeks in advance, most of
 15 them, or hopefully most of them, would have read the
 16 papers would have read my covering notes, and would
 17 have seen from that, look, what the Committee needs to
 18 decide is this or that.

19 **Q.** And for the purposes of the pre-meeting meeting or the
 20 briefing meeting that you and Mr Canavan and I think
 21 also, during her time there, Dr Pickles, would have
 22 with the chair, there would be a written briefing
 23 produced for the chair?

24 **A.** Well, looking through the papers, it looks as though
 25 there was usually a written thing. Whether it was

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1 Now, obviously a lot of information was from
 2 scientific articles, et cetera, but if, for example,
 3 one of the members of the Committee heard something or
 4 said something, well, there's nothing to stop him, you
 5 know, on an informal basis, going back to his place of
 6 work and saying to a colleague, particularly somebody
 7 who might even know more than that individual about
 8 something, and say, "Well, look, we were chatting
 9 about this, what do you think?"

10 And, you know, again, a breach of
 11 confidentiality in the strictest sense, but not one
 12 that anybody would lose sleep over.

13 **Q.** In terms of the mechanics for the arrangements of the
 14 meetings, part of your role, and I think the role of
 15 the administrative secretary, Mr Canavan, as well, was
 16 to gather the relevant materials, circulate them, and
 17 so on.

18 **A. (Witness nodded)**

19 **Q.** Is it the case that you also had a -- or usually had
 20 a pre-meeting meeting with the chair?

21 **A.** Yes. Usually we'd have a pre-meeting meeting, and
 22 I think it was -- I can't remember whether with
 23 Dr Harris but definitely with Dr Metters, I think he
 24 was aware that with all of these committees you have
 25 fixed period of time that the committee can run on,

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1 every single time, I suspect it would depend upon how
 2 busy people were, because obviously with the
 3 HIV Haemophilia Litigation it might well be on a given
 4 occasion that it was not possible to prepare a written
 5 briefing, and it might be that we met up with
 6 Dr Metters or whoever and talked it through, but
 7 coming with our own notes.

8 **Q.** Can I just ask you to look at one example. It's
 9 DHSC0003583_043. Is there another page to that? Is
 10 there a second page? Great.

11 So, yes, the first page just gives us the date.
 12 It's for the meeting, but we can see from the top of
 13 this it's for the ACVSB meeting on 22 May 1989. This
 14 is the chairman's brief. I think this is your
 15 handwriting on it?

16 **A.** Yes.

17 **Q.** Then if we go up to the second page, we can see the
 18 heading "Non-A, Non-B" at the bottom of the page.
 19 Paragraph 14, the suggestion there to the chair is
 20 that a number of individuals including yourself should
 21 be asked to speak to their respective papers.

22 Then would it be right to understand Dr Metters is
 23 being given a steer:
 24 "Following the general discussions you will wish
 25 to focus the Committee's attention on the

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recommendations in paragraph 5 of ACVSB2/7 [which is one of the particular papers]. You may wish to point out that whilst CBLA has legitimate concerns about marketing its products, the Committee should consider the issues only in relation to protecting public health. The question is whether the Committee agrees there is no pressing need to introduce routine surrogate testing for Non A and Non B hepatitis for health reasons but that the position should be reconsidered when the results of the BTS study are available."

Now, first of all, would this briefing be put together by you or by Mr Canavan or it was a joint effort?

A. I think it would be a joint effort but I think Mr Canavan would be in the lead, so to speak.

So, for example, if you go back to the top of it, it talks about arrangements for lunch, et cetera, which obviously is not something that I'd be involved in. But if there were medical bits in it, then I would contribute, but ultimately, it is an administrative function.

Q. It could be said that the way in which this is described is really giving Dr Metters a steer as to the steer that should then be given to the Committee

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I need to ask them". I mean, that's the way it operated.

Q. Just on the question of what Dr Metters might have done on his own papers, we'll come to the question of what happened to some files in the course of the afternoon --

A. Mm.

Q. -- but is this your understanding: that Dr Metters' papers, personal papers, were disposed of and so those were not available to the Department?

A. That I --

Q. If you don't know --

A. That I found out from this. I didn't know that before.

Q. You've told us, or I think you said in your response to the Penrose Inquiry warning letter, you made the point that on the secretariat you didn't have a vote. Was the ACVSB a voting committee? It doesn't appear from the minutes and isn't, I think, the effect of the evidence the Inquiry has received so far?

A. No, I don't -- I cannot recall occasions when the chairman actually asked for a vote because, obviously, if you had a vote then you'd have to have all this argument about does the chairman have a-- if it's a split vote does the chairman have a vote? So

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in pursuit of an outcome that there's no pressing need to introduce routine surrogate testing?

A. Well, I think this -- I think the way it operated was -- you see we were in contact with Dr Metters -- well, with Dr Harris I didn't really have much contact but I really probably focus on Dr Metters. We had a lot of contact with him. I mean, it's not as though I was in his office every day but, if you look at the minutes that are amongst the papers, you know, there are a lot of minutes that I write which are either to Dr Metters or are copied to him, and how often I'd be -- I wouldn't be that often in his office. I don't know even how often we had telephone conversations. But, you know, but we were in quite constant contact.

So, for example, in this particular instance, the chances are that the topic had already been discussed earlier and here we are reminding the chairman that this is something we discussed before, and this is -- in some respects, this is a reminder to the chairman of what we've discussed, so that, I don't know, I cannot remember exactly, but I assume that the chairman would have taken this with his own annotations to the meeting. And then when he's going through the particular sections of the meeting, he'd look it up and say, "All right, this is something

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I don't think there was ever any suggestion of a vote in that sense but I think what I mean by not having a vote, I mean not having a say in how the Committee -- because, usually, you will see that the chairman sums up, and usually the chairman's summing-up, he would actually -- I'm trying --

Well, you see, obviously this is a long time ago and I may have confused this with other committees, but my understanding -- my recollection for the best that it is, is that Dr Metters would actually go round the table, and I think he was quite keen that people said something. So, for example, if we were discussing a particular topic and if somebody had said nothing at all about that topic, he might quite easily say to somebody "Dr So-and-So, have you a view?" or "Do you agree?" or whatever. So I think when he sums up, it's the summation of the general mood of that committee meeting.

And there hasn't been a vote because, in a sense, usually the majority of the people would agree a particular line. There was, I can't recall occasions when people had stood up and said, "I completely disagree with this, I think this is absolute rubbish, I think we should do something else."

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1 I think most -- obviously this was a committee,
2 people were polite to each other, and people I think
3 accepted that others might have a different view. If
4 they had a particular view, I think -- well, there
5 were one or two people, probably, that didn't possibly
6 push their view as hard as they might. There were
7 other people that were much more pushy with putting
8 forward their view, but that's all -- any committee,
9 that's the case. But I think, overall, there wasn't
10 any need for a vote because it was obvious which way
11 people were thinking.

12 Q. Can I ask you to look at an extract from the evidence
13 of Dr Perry to the Inquiry.

14 A. Yes.

15 Q. It is INQY1000184, please, Paul, page 35.

16 If we pick it up in the bottom half of the page,
17 left-hand side, line 4, so this is picking up
18 Dr Perry's evidence to the Penrose Inquiry, in which
19 he was asked about the contribution of the secretariat
20 to the meetings and whether they contributed to the
21 meetings and then his answer to the Penrose Inquiry,
22 Dr Perry says:

23 "Yes, there were -- certainly Dr Rejman and
24 Dr Pickles -- and I'm trying to recall if there were
25 others ..."

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1 Do you accept his description of the process as
2 an accurate one?
3 A. No.
4 Q. In what sense do you say that it's inaccurate?
5 A. Right, okay, shall we start off with "full part in the
6 discussions of the committee". No. Taking a full
7 part in the discussions of the Committee means that I
8 would have been asked, "Dr Rejman, what is your view
9 about this?" That never ever happened -- never.
10 I was there purely and simply as a facilitator. I was
11 there, as is mentioned -- I can't remember which
12 report is in the BSE Inquiry report, where they talk
13 about the function of a secretariat, and we were very
14 much aware of what our role was. Our role was to make
15 sure that the Committee worked. It functioned. And
16 our role was to get together the papers that we
17 thought were going to be helpful to the Committee to
18 make their judgments. It was not to make any decision
19 or to influence the decision in any shape or form.

20 Q. If we leave aside the phrase "full part in the
21 discussions of the committee", did you participate
22 actively in the discussions?

23 A. No. If you look in the minutes of the Committee's --
24 and I think I made the comment in -- I can't remember
25 if it was my first statement or wherever, if you look

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1 Then line 14:

2 "Yes, periodically they were called upon
3 specifically to report on a particular issue, but also
4 took a full part in the discussions of the committee."

5 Then the question that's put to him, lines 17 to
6 20, was that the secretariat:

7 "... weren't simply there to put together the
8 agenda and take a note; they participated actively in
9 the discussions?"

10 Dr Perry's answer:

11 "No, they had quite senior medical officers from
12 the [DH] that were part of the committee. They
13 weren't full members ... but then it wasn't a full
14 voting committee. It didn't used to vote on issues
15 and so on. There was a process that I never really
16 understood what the detail was, and we would have the
17 discussions at the meeting and then those discussions
18 would get taken away to the Department of Health for
19 further consideration and perhaps a revised position
20 might come back from the Department of Health for
21 consideration. So they were very much an integral
22 part of the process as far as I can recall."

23 Then he draws a distinction between that and the
24 role of the observers from Wales, Scotland and
25 Northern Ireland, more observers than participants.

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1 at some of the minutes of the Committee, you will see
2 that my name only appears in the whole of the
3 Committee minutes as being a member of the
4 secretariat, and my name does not appear anywhere else
5 in those minutes.

6 If you look carefully at the minutes you will
7 see that I present a paper, I am asked to update
8 people on what has happened. I take no part in the
9 discussion.

10 Q. Who prepared the minutes?

11 A. The minutes were prepared primarily by the HEO, not
12 Mr Canavan but his deputy, who was there at the
13 Committee. I would be shown the draft Committee
14 minutes because I tended to make my own personal notes
15 of what had been discussed at the Committee. So
16 therefore, I would look at my notes and see whether
17 they agreed with what -- well, David Burrage was the
18 one that obviously I'm most aware of, what he had
19 written, and then if there were any suggestions that I
20 could make apart from typos, obviously, then I would
21 make those suggestions. And then the minutes were
22 then circulated to the Committee members. And usually
23 at the subsequent Committee, people were asked, "Are
24 there any errors?" And occasionally there were errors
25 that were picked up.

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1 Q. Now the first meeting of the Committee was on
 2 4 April 1989. I am not going to go to those minutes.
 3 For the transcript, they are at NHBT0000041_003.
 4 For present purposes, I think it's sufficient to
 5 say it was said in the course of that meeting that
 6 hepatitis would be on the agenda for the next meeting.
 7 Is that right?
 8 A. Yes.
 9 Q. If we then go to the second meeting, it's -- actually
 10 I'm going to check the reference -- NHBT0000041_020,
 11 I think.
 12 Just so that we can get a sense of who was in
 13 attendance -- I'm not going to do this for every set
 14 of minutes, but we've got the chair, who at that point
 15 was still Dr Harris, so before Dr Metters took over,
 16 we've got the various members, we've got you and
 17 Mr Canavan present from the secretariat. In terms of
 18 the observers, we know, obviously, who Dr Pickles was,
 19 you've told us previously about Dr Rotblat. What was
 20 Dr Purves' role?
 21 A. Sorry? Well, Dr Rotblat was the SMO, I think
 22 I mentioned, in charge of -- well, I don't know what
 23 her other roles were but she was the one who was in
 24 charge of blood products at MCA, and Dr Purves was the
 25 pharmacist in MCA who again had responsibility for

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1 fractionation and products.
 2 Then, in terms of testing of in relation to
 3 non-A, non-B:
 4 "It was agreed [non-A, non-B] testing should not
 5 be introduced into the NBTS prior to the results of
 6 the UKBTS NANB trial; anti HBc testing was not without
 7 problems. The Chairman considered that PHLS may need
 8 to be involved in the follow-up."
 9 Is that a reference to surrogate testing there,
 10 as you understand it?
 11 A. That's surrogate testing, yes.
 12 Q. Then paragraph 21:
 13 "The Department would keep the issue of testing
 14 under review. The use of Chiron or surrogate testing
 15 would be influenced by Chiron data once released; MRC
 16 might be asked to consider. Members regarded the
 17 matter to be a priority."
 18 So the statement of it being a priority but
 19 essentially no decision being taken at this stage.
 20 A. No.
 21 Q. It's just something that will be kept under review?
 22 A. Yes. But having said that, I don't know whether they
 23 refer there to my -- because I prepared a paper, what
 24 is it, ACVSB2/7, which was a background to hepatitis
 25 and non-A, non-B.

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1 blood products.
 2 Q. Then the other three, Dr McIntyre, Dr Flett and
 3 Dr George, are representatives from Scotland, Wales
 4 and Northern Ireland?
 5 A. And Northern Ireland, yes.
 6 Q. Then I don't think we see any reference to there being
 7 someone else there from Mr Canavan's team taking
 8 notes, but --
 9 A. So presumably on that occasion Mr Canavan would have
 10 taken notes.
 11 Q. Can we then go to page 3, just so that we can pick up
 12 the chronology of decision making in relation to
 13 hepatitis.
 14 We've got there "Non A Non B" just above
 15 paragraph 16.
 16 If we just zoom in on 16 to 21, could we, Paul?
 17 Thank you.
 18 Then there's a reference in paragraph 17 to the
 19 Chiron test. There's a reference in paragraph 18 to
 20 a questionnaire.
 21 A. Sorry, I think in that paragraph 16, there, presumably
 22 he says there anti-HBc instead of anti-HBs.
 23 Q. Yes, that's picked up in a later set of minutes.
 24 There's a reference in paragraph 19 to the
 25 position of ALT testing in the context of

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1 Q. Yes, I'm not proposing to go to that.
 2 A. No, they're both -- just for the --
 3 Q. We don't have time to go through the papers.
 4 A. -- formality.
 5 Q. There is though, if we go to DHSC0002494_048,
 6 a summary of action points. So you'll see it says:
 7 "Advisory Committee on the Virologic Safety of
 8 Blood, meeting of 22nd May 1989."
 9 So that's the meeting we've just been --
 10 looked at.
 11 "Summary of action arising."
 12 Then there's a number of matters set out. If we
 13 go over the page, we can see it continues.
 14 Before I ask you about any of the details, do
 15 you know who produced this document? Was this you or
 16 Mr Canavan or, again, was it a joint effort?
 17 A. I think this would have been Mr Canavan or his deputy.
 18 Q. Then if we go to, on this page, paragraph 13, I just
 19 wonder whether you can help us understand this:
 20 "Consider separate requirements for ALT testing.
 21 Pure science or public health?"
 22 Now, that's not something that one can make
 23 sense of, or I haven't been able to make sense of,
 24 looking at the minutes. Are you able to assist us in
 25 understanding what that question is intended to

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1 reflect?

2 A. I honestly can't tell you, because basically

3 the discussion about ALT testing, particularly when it

4 came to BPL, was that they were interested in having

5 ALT testing because it would mean that their products

6 could be sold to those countries that required ALT

7 testing. So the public health aspect -- and we

8 discuss this later on in subsequent Committee

9 meetings -- so I cannot actually explain that because

10 the pure science of ALT is ...well, I mean to say, the

11 relevance of ALT is public health, in theory, or

12 commerce. I don't know where the "pure science" comes

13 into it.

14 Q. If we look at the paragraph 14:

15 "Consider reminding clinicians of need for

16 post-transfusion hepatitis reporting".

17 Again, it's not, I think, completely clear how

18 that emerges from the minutes, but I don't think that

19 particularly matters. Whose job would it have been to

20 action these action points?

21 A. I think, ultimately, the administrator, if they wanted

22 me to write to somebody like the Royal College of

23 Pathologists or College of Physicians or whatever to

24 ask them to remind their members about this. But

25 I don't know. I mean to say, I don't know where that

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1 ask and answer?

2 A. Well, I think everybody hoped that we would find

3 something that would completely clear post-transfusion

4 hepatitis, which obviously was something that had --

5 people were aware of for a number of years and,

6 ideally, you would eradicate it. That was the ideal.

7 And Council of Europe papers, obviously you have to

8 remember that the people on the Council of Europe

9 were, you know, a very large number of countries and

10 sometimes their English might not be ideal. They may

11 not be aware of the nuances of the words that were

12 used.

13 So it may be that what they really meant was

14 "reduction" rather than "eradication". I do not know.

15 But, in an ideal world, it would have been

16 eradication.

17 Q. Then if we go to -- actually, sorry can we have that

18 document back on screen, please, Paul and just go to

19 the next two paragraphs.

20 Paragraph 11, bottom of the page, again, is it

21 right to understand that's looking at the issue of

22 surrogate testing?

23 A. Yes.

24 Q. There is no decision, in particular, it just says it

25 doesn't reveal anything of specificity, and

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1 came from. Presumably -- see, I don't know whether

2 this is a sort of a wish list, as much as things that,

3 actually, we need to do, or this is something we need

4 to bear in mind for the future. I don't know.

5 Q. Was this routinely done, a summary of action points,

6 as far as you can recall?

7 A. I was surprised about this because I cannot recall

8 these sort of things happening regularly.

9 Q. So if we move on then, in any event, to the third

10 meeting of the ACVSB, 3 July '89, NHBT0000072_025. If

11 we pick it up at paragraph 3, that answers the point

12 about the typographical error in the minutes. If we

13 go over the page to page 2, bottom of the page,

14 paragraph 10. So there's reference to two of the

15 ACVSB papers which we have in the material that was

16 provided to you, Dr Rejman:

17 "A Council of Europe Paper ... had stated that

18 anti-HBc testing alone was not sufficient to eradicate

19 post-transfusion hepatitis, and members supported this

20 view."

21 Again, I don't know if you can assist in

22 relation to this but do you know why the question

23 apparently posed and answered was relating to

24 eradication, rather than reduction of post-transfusion

25 hepatitis, which might be a more relevant question to

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1 a reference to commercial stance of test

2 manufacturers. So, certainly, no decision to

3 recommend any form of surrogate testing; is that

4 right? Is that a correct reading of the minutes?

5 A. Yes, although I must say that, looking at that, I am

6 surprised about the figure of 25 per cent. I would

7 have thought it would have been lower but maybe that

8 was what it was.

9 Q. Then we see in relation to HCV screening, reference in

10 paragraph 12 to the Chiron test in first-time

11 recipients of Factor VIII, and a suggestion of study

12 of stored haemophilic sera.

13 Then at the top of the next page --

14 A. Although that is interesting, that comment about the

15 haemophiliacs having had their first treatment. That

16 shows problems with sensitivity because, obviously,

17 they should have been positive.

18 Q. Then if we go to the top of the next page, we see

19 Dr Mortimer reporting from a conference:

20 "... considered the findings represented

21 a persuasive case that the Chiron test results were

22 reliable."

23 Then the suggestion is then further information

24 will be gathered for consideration at the next

25 meeting.

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1 A. Yes, I mean to say, I made a comment about this.
 2 Unfortunately, minutes are a summary of what was said
 3 and what was done at a committee. It doesn't tell you
 4 what other people said but, presumably the fact that
 5 the chairman said, "We need to get a lot more data",
 6 suggests that the Committee as a whole were not persuaded
 7 that this test was the answer to everything. And this
 8 was very early on in the -- at the time of the first
 9 tests using Chiron.
 10 Q. If we go to, please, NHBT0000061_035, we can see --
 11 that meeting was 3 July 1989. This is a minute from
 12 you a month later, 3 August 1989.
 13 A. Yes.
 14 Q. "Dr Jones MEDISD", what division was that?
 15 A. He was -- I'm not --
 16 Q. If you don't know ...
 17 A. I get a bit confused because, you see, I was, at one
 18 stage in Med ISD and Dr Jones, if you look later on,
 19 there was a thing about that meeting in Rome and
 20 everything, and he was my -- he was the SPMO, who was
 21 Dr Pickles' senior. So I'm not sure whether this was
 22 at a time when they were changing names for branches
 23 and divisions.
 24 So I presumably Med ISD -- you know, that was my
 25 guess: is that he was Dr Pickles's line manager in the

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1 as to what -- why a decision had been taken, and it
 2 was -- we were, after all -- the UK, after all, was
 3 one country, in general terms. And so decisions made
 4 in one part of that -- well, I keep on getting
 5 confused between nation and country and everything,
 6 but decisions in one part of the UK might well impact
 7 on another part.
 8 I mean to say a classic example of that is
 9 North Wales who were supplied by blood from Liverpool,
 10 even though they were over the border. Because the
 11 transfusion centre for Wales was in South Wales, in
 12 Swansea, and that supplied southern Wales but not
 13 northern Wales because northern Wales, obviously, was
 14 much closer and more convenient transport-wise to
 15 Liverpool.
 16 So what would happen if England made a decision
 17 and Wales had a different decision? You know, you'd
 18 then even be splitting Wales into two halves.
 19 Q. If we just go to the top of the next page, I want to
 20 ask you about paragraph 8:
 21 "I mentioned to Dr Gunson that I had heard via PD
 22 that PHLS (Dr Mortimer) were soon to publish results
 23 of their experience of Chiron testing of presumed
 24 [non-A, non-B] samples. PD had been given to
 25 understand that PHLS would be making a recommendation

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1 SPMO because Med ISD at one stage did include blood.
 2 So I can't really answer that.
 3 Q. Don't worry. We can see that a trigger for this
 4 minute is a conversation with Dr McIntyre.
 5 A. Yes.
 6 Q. Now, Dr McIntyre was the SHHD representative, he'd
 7 been at the meeting of 3 July.
 8 A. Yes.
 9 Q. It appears that there might have been some uncertainty
 10 in his mind as to what the position was but, be that
 11 as it may, you say in paragraph 4:
 12 "I confirmed Dr McIntyre's impression that the
 13 ACVSB had decided that at present [non-A, non-B] was
 14 not to be screened for as a routine."
 15 If we then just go to the paragraph 2, it would
 16 appear that Dr McIntyre wanted to know whether it was
 17 correct that decisions on screening for non-A, non-B
 18 were to be a national decision. What was your
 19 understanding at the time, if any, of why it seemed to
 20 be thought that a decision had to be taken nationally?
 21 A. Well, I think, throughout the period when we were
 22 considering hepatitis C screening, it was agreed that
 23 a decision about testing should be taken across all
 24 four nations. And, otherwise, there would be
 25 difficulties in explaining to patients and to doctors

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1 for use of this test in this publication. Dr Gunson
 2 suggested that this would be very unhelpful to DH, and
 3 he hoped that Dr Mortimer who is a member of ACVSB
 4 would be sensible."
 5 First of all, who was "PD"?
 6 A. PD was procurement division, which I think later on
 7 became MDD, medical devices directorate. So,
 8 basically, they were the people who had responsibility
 9 for screening tests.
 10 Q. Now, I know you're reporting what Dr Gunson said to
 11 you here but why would a recommendation from PHLS that
 12 this was a useful test be unhelpful to the Department
 13 of Health?
 14 A. Well, this is Dr Gunson saying this. Now, one has to
 15 remember that Dr Gunson was actually head of the
 16 Transfusion Service in England and Wales, and so he
 17 might well have been -- when it talks about unhelpful
 18 to DH, he might also have meant unhelpful to the
 19 Transfusion Service as well. And I think one of the
 20 questions here was that would a report from PHLS on
 21 a test which was really only just appearing -- it
 22 depends, really, obviously, what PHLS said, really.
 23 If PHLS said, "Look, we've done this test and
 24 we've looked at" -- and I don't know which patients
 25 they were looking at. Were they looking at patients

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1 who had documented non-A, non-B transmission? Were
 2 they looking at -- I don't know. You see, it really
 3 depends exactly what PHLS were going to say.
 4 Here, I'm just reporting that Dr Gunson said
 5 that anything coming from PHLS which could be
 6 misconstrued, or which could lead people to think,
 7 "Oh, well, the Blood Transfusion Service is going
 8 to -- it's going to use this test, you know, pretty
 9 quickly", might have been unhelpful, generally, and so
 10 I suspect that what he's saying there, Dr Mortimer,
 11 who was on the ACVSB and obviously he was aware of the
 12 discussions that were going on in ACVSB, he was
 13 actually in PHLS and I'm not -- and, presumably, the
 14 work was being done within his bit of PHLS. He
 15 presumably would have actually taken that on board,
 16 and probably -- may well have not have actually needed
 17 any reminder of that.

18 Q. One reading might be that the Department of Health, in
 19 Dr Gunson's view at least, wasn't keen on introducing
 20 testing at this point in time.

21 A. Well, I think the point is that -- sorry, what's the
 22 date of this? It's May '89?

23 Q. This is August '89.

24 A. August, '89? So it's just after the May --

25 Q. The July meeting.

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1 Q. Well, this is your minute, Dr Rejman.

2 A. Yes.

3 Q. And you're saying two things about the procurement
 4 directorate here. First of all, they've told you that
 5 PHLS are going to be publishing results. Now, that
 6 can't be what Dr Gunson thought was unhelpful, the
 7 mere publication of results, can it?

8 A. No, no, I suspect -- I mean to say, reading between
 9 the lines -- well, not even reading between the lines,
 10 but my assumption -- as I say, I cannot remember this
 11 minute, but my assumption reading this minute, and
 12 recollecting what I can of the individuals concerned,
 13 is that Dr Gunson was worried about what else would be
 14 there.

15 If PHLS had literally just published the results
 16 and said, "We tested" -- and again, it's not clear
 17 from there whether they're testing samples from
 18 patients who had been identified as having had
 19 non-A, non-B hepatitis, or is it a screen -- whatever,
 20 I don't know, it doesn't say there what it was going
 21 to be about. But Dr Gunson's anxiety might have been
 22 that if, in addition to publishing the results, the
 23 commentary about the results -- and particularly if
 24 there were any recommendations with the results, that,
 25 I presume, was his concern.

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1 A. The July meeting. And basically at that meeting it
 2 was decided not to go ahead with Chiron testing yet.
 3 And so that was basically the decision of the experts.
 4 And I think Dr Gunson might well have there said that
 5 if PHLS start saying something which will muddy the
 6 waters -- and, you see, it also will depend upon who
 7 the authors of the PHLS report were. Because if you
 8 had Dr Mortimer as one of the authors, then people
 9 will start saying, "Ah, but he's a member of ACVSB".
 10 Because I don't think the membership of ACVSB was
 11 secret. I think that was well known. So people might
 12 then start -- jump to conclusions and say, "Look,
 13 Dr Mortimer, who's one of the members of ACVSB, has
 14 said, you know, as party to this report" -- and it
 15 really depends exactly what the report said.

16 So as I say, I think it was -- there's no
 17 suggestion there either that Dr Gunson knew what the
 18 report was going to say, because it just says there
 19 that procurement directorate, who obviously had -- who
 20 were responsible for screening tests, they had heard
 21 that PHLS were to publish results. Now, it's a case
 22 of what those results were, you know, exactly which
 23 patients or which people they'd been looking at, or
 24 which donors they'd been looking at, and precisely
 25 what they said as a result of their tests, their ...

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1 Q. So you don't -- do you agree with what was being said
 2 by Dr Gunson or did you agree with what was being said
 3 by Dr Gunson, that a recommendation for use of the
 4 test would be very unhelpful to the Department of
 5 Health?

6 A. I'm not -- in that minute, I don't think I actually
 7 say anything.

8 Q. You don't, that's why I'm asking --

9 A. I'm reporting. And I think that is what I'm doing.
 10 I'm reporting. And you see, because I'm reporting,
 11 and I'm reporting it to Dr Jones, suggests that he was
 12 probably Dr Pickles' line manager. Because obviously
 13 I've side copied Dr Pickles, but because I have --
 14 think that what I'm writing there is of significant
 15 importance, I'm writing it to him, and I think it was
 16 probably -- I'm not sure whether Dr Metters had yet
 17 taken over or not, at this time. Because if
 18 Dr Metters had taken over, I would have assumed that I
 19 would have written to Dr Metters. Because -- and
 20 I think the thing is that -- because my contacts with
 21 Dr Harris were much less than they were with
 22 Dr Metters, because normally this sort of thing
 23 I would have written to Dr Metters.

24 Q. My understanding is Dr Harris retired at the end of
 25 July of 1989, he chaired the 3 July '89 meeting, but

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1 Dr Metters attended as an observer, and therefore
 2 Dr Metters took over --
 3 A. That's right, he wasn't yet the chairman. Yes.
 4 Q. Dr Metters took over with effect from the beginning of
 5 August 1989.
 6 A. Yes, so I think this was probably at the time,
 7 otherwise I would have written to Dr Metters.
 8 Q. In any event, just for the sake of completeness, we
 9 can pick up what Dr Mortimer said to you, a couple of
 10 months later, in October '89, at DHSC0003557_041.
 11 We can see it's a letter of 17 October. We can
 12 see in the first paragraph it's a response to a
 13 request for information from Dr Metters. We can skip
 14 over the first half of the letter, which was about
 15 HTLV-I.
 16 The penultimate paragraph deals with hepatitis C
 17 testing. Dr Metters's view there:
 18 "... the case for screening is very strong and
 19 as soon as FDA approve screening by the Ortho test
 20 and/or Abbott test in USA I think we should endeavour
 21 to screen universally here. If we do not act fairly
 22 quickly and cases of post transfusion hepatitis
 23 attributable to HCV arise I think we shall be in
 24 a weak position."
 25 Now we'll look obviously at what the ACVSB

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1 many of them] came up positive for hepatitis C".
 2 Right? So then you know what you're talking about.
 3 If on the other hand you're looking at people
 4 where there is a low incidence of hepatitis C, such as
 5 the general population in the UK, then you might have
 6 a very different answer. So I think, you know, you've
 7 really got to look at that.
 8 And in a sense, you see, Dr Mortimer is saying,
 9 look, from his experience, the test seems to be useful
 10 or helpful or whatever and he thinks, with the FDA
 11 approval, that would be a major deciding factor.
 12 Now the question then, in fact, obviously, is
 13 how good is the FDA. Because I think if you look
 14 later on in the papers, it says, actually, that the
 15 FDA were not recommending either supplementary or
 16 confirmatory testing for a very long time, and people
 17 might well then question: how good were the FDA?
 18 Now obviously one shouldn't criticise them, but
 19 on the other hand, did they actually take on board
 20 everything that was going on or were they actually
 21 limiting themselves to a specific test and saying,
 22 "This looks as though it works"?
 23 Q. If we just then, before we move to the next set of
 24 minutes, look at the chairman's brief in advance of
 25 the next meeting, which was due for the

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1 subsequently did and didn't recommend, but did that
 2 piece of information -- would you expect that to have
 3 triggered a discussion within the Department at least
 4 about what was being said there in fairly strong
 5 terms?
 6 A. Well, I think the thing is obviously this was
 7 addressed to me, was it, this letter?
 8 Q. Yes, it is.
 9 A. Right, okay, then I presume I would have actually
 10 passed it on to Dr Metters, because obviously, you
 11 know, he needs to know. And I think the thing is, you
 12 see, this is still early days, and this was at the
 13 time when people were still not fully aware of the
 14 problems with specificity and sensitivity of these
 15 tests. And to a large extent, the tests obviously
 16 were being pushed by the manufacturers, who were
 17 obviously interested in sales, and they were obviously
 18 contacting anybody and everybody, and presumably
 19 Dr Mortimer used these tests, and presumably on the
 20 basis of these tests he said all he can say is that he
 21 found -- as I say, again, it doesn't tell you who the
 22 tests were about. You know, and I think this is the
 23 difficulty with a lot of these things. You have to
 24 actually say, "We tested patients who had non-A,
 25 non-B hepatitis, and a proportion of them [or however

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1 6 November 1989, it's DHSC0002495_064.
 2 If we go to the next page, we've got the heading
 3 "Non-A Non-B Hepatitis", there's reference to
 4 a suggestion of there being reports from Dr Gunson
 5 about, amongst other things, the Rome meeting that had
 6 taken place in the autumn of that year. Then third
 7 paragraph:
 8 "The main issue for the Committee is whether the
 9 time is right to make a decision about adopting the
 10 Chiron test.
 11 "Dr Gunson has suggested that the next step
 12 would be a field study ..."
 13 There's a reference to approaching the
 14 Department for £25,000 to purchase tests for a field
 15 study.
 16 Would this then have been something that at
 17 the -- a briefing meeting that you and Mr Canavan
 18 would have attended with Dr Metters by now, did those
 19 meetings -- which I don't think we have any record of,
 20 I don't think they were minuted, as such -- would
 21 there be a discussion about the pros and cons of what
 22 might be suggested or would you simply be identifying
 23 for Dr Metters the decisions that the Committee needed
 24 to consider?
 25 A. I don't think that Mr Canavan and I would actually put

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forward pros and cons because, in a sense, it's not us that is making the decision. It is because what we're saying to -- well, in a sense you see, we're continuing, as I said, our function was providing papers to the Committee. This briefing is actually highlighting to Dr Metters, you know, during this meeting, decisions, ideally, should be made or at least sort of some semblance of the way forward should be considered.

And I think, you know, Dr Metters was very busy. You know, blood transfusion -- not like me, where haematology was my life work. For him, haematology was one of a number of different committees -- the ACVSB -- I'm sure there are other committees he was chairing. So we are basically saying to him: "Look, there's a Committee meeting today that you've got in your diary, so you know you're going to it. This is what is likely to be discussed, and these are the things that you might want to raise with the Committee".

So, in a sense, it's an *aide memoire* for him, because, obviously, he's so busy. I mean to say, the next day he may have something completely different and, you know, we're obviously focused on this, so we provide him with an *aide memoire*, "Look, Committee is

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meetings where they happened to be there and they were forever saying to me "When are we going to introduce screening?" Because, obviously, they were interested from a commercial point of view.

Okay, sorry, I shouldn't say that because that suggests they're not interested in the safety. Obviously, they were interested in the safety, but their other interest was to sell their product. So, therefore, they were chasing us. So, therefore, I suspect that the number of communications relating to non-A, non-B during those four months would have been quite considerable, and to actually identify each of them and to give them a sort of priority list saying, "Because this letter has come from Dr Mortimer, who is a member of ACVSB, we ought to take this as being important, whereas because this has come from a company, we can ignore it", or "because it's come from another member of the ACVSB, who is not a virologist, we can ignore it".

So I suspect that this is very brief and what we would highlight there is either, if Dr Mortimer had said he was going to be presenting his letter -- and I think there was an occasion when Dr Lane sent me a letter and then we mentioned it in the briefing, that his letter, and that he was going to discuss it

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happening today, these are the things you need to consider asking them". Ultimately he decides what he wants to do. He's the chairman. We are prompting him.

Q. The prompts here don't include any reference to Dr Mortimer's views. Now, I appreciate entirely Dr Mortimer would be in attendance at the meeting, but the same would be true of Dr Gunson, of course. Are you able to assist in understanding why the fairly strong terms in which Dr Mortimer had expressed himself in that letter to you are not picked up in the briefing?

A. Well, I suspect -- I mean to say, this was in November. When was the previous meeting? In May?

Q. July.

A. July.

Q. So a four-month gap.

A. Four-month gap. Right, in the four months, I suspect we may well have had a number of letters about Chiron, you know, either from Dr Mortimer, other people on the ACVSB may have written to us. I'm pretty sure -- I mean to say, the commercial companies were very much knocking on our doors, and particularly when it came to Procurement Directorate, they were forever chasing them, and they were chasing me. I remember going to

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at the meeting, then obviously it would have appeared in that briefing. But Dr Mortimer's letter was yet another letter, in a sense, of a whole string of letters.

Q. Can we go then to the 6 November 1989 meeting, which was the fourth meeting, NHBT0005043.

If we'd go to page 4, please. We've got the discussion on non-A, non-B hepatitis. I'm not going to go through all of it but we see Dr Gunson presenting or speaking to his paper in paragraph 23.

Paragraph 24 refers to some concerns being expressed about the tests not appearing to be suitable for testing UK pooled plasma.

25 is Dr Tedder.

Then 26 is what I wanted to ask you about, first of all:

"Dr Metters explained that although the Department must bear in mind the possible litigation that could arise from a prolonged delay in the introduction of general screening, the NHS Management Executive would want to know more facts and figures before backing such a move."

Now, we know from you've already told us and from what others have told us, the ACVSB would produce a recommendation.

25

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(25) Pages 97 - 100

1 A. Yes.

2 Q. The understanding appears to be it would ultimately be

3 for the minister --

4 A. Yes.

5 Q. -- to take a decision and, in due course, we see that

6 in, I think, early 1991. What was the role, insofar

7 as you understood it, in that decision-making process

8 of the NHS Management Executive?

9 A. I suspect that what the reference there is, is that if

10 one is making a recommendation to minister, then,

11 basically, the non-management executive part of the

12 Department -- because after all Management Executive

13 was part of the Department, it was just different bit.

14 So you had the, sort of, policy side so to speak, and

15 the NHS Management Executive which were the function

16 side, to sort of make it very simple.

17 So I suspect that the NHS Management Executive

18 would need to know, you know, how is this going to

19 impact on the workings of the NHS, ie introducing

20 screening in Blood Transfusion Service, obviously

21 there were going to be costs of that but not only

22 costs but actually the time -- you know, the personnel

23 required and everything else. So there would be

24 an effect on the NHS generally over and above the

25 public health benefits to recipients.

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1 Just pausing there, is it right to understand

2 these minutes as essentially showing that there were

3 three conditions or further matters that needed to

4 take place before the ACVSB would reach a view: that

5 was confirmatory test, FDA approval and pilot studies?

6 Is that how you understood it?

7 A. That's what it would appear, yes.

8 Q. Then paragraph 29 continues:

9 "For these reasons it was felt that the

10 Committee should be developing an economic case (ie

11 [percentage of non-A, non-B] that would be prevented

12 and any other data to support) for the Department to

13 fund the routine use of the test ..."

14 Now, first of all, in relation to that, why was

15 the Committee getting involved in questions of

16 funding?

17 A. I don't think they're asking the Committee to -- well,

18 okay, they say the Committee should be developing it

19 but, in the end, the economic case was not considered

20 by the Committee at all. That was considered in-house

21 by DH. We were the ones that did the cost-benefit

22 analysis and everything and the Committee wasn't asked

23 to do that. I think, in essence, what they're seeking

24 here is that because the Committee had the experts who

25 could provide some of the background for the

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1 Q. If we go back to the full page, we can see bottom of

2 the page then refers to some figures about how many

3 patients might be going on to develop chronic

4 hepatitis, Dr Gunson is suggesting 1 in 200, others

5 are saying is it might be higher?

6 Top of the next page, paragraph 28:

7 "The feeling of the Committee, as summed up by

8 the Chairman, was that the test represented a major

9 step forward, but that the Committee need to know

10 a great deal more about it, and acknowledged the need

11 for a confirmatory test. It was agreed that while the

12 UK would not want to go on in advance of an FDA

13 decision, it could prove difficult if the FDA do not

14 decide in favour of the test. Nevertheless, it was

15 felt that if the UK do put the test into general use

16 the RTCs will need to have had experience with it, and

17 therefore pilot studies would go on in Birmingham,

18 Sheffield and Brentwood, to show the feasibility of

19 adding this test to routine practice."

20 Then the next paragraph:

21 "The Committee's feeling was that there was no

22 case for surrogate tests ... ACVSB would support the

23 general introduction of the Chiron test if the FDA

24 approves it, and the pilot shows it to be feasible and

25 non-problematic."

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1 cost-benefit analysis that the Department would then

2 do. So I think it's here not saying that the

3 Committee, in its totality, would be involved, it was

4 just that individual Committee members might be able

5 to contribute to help us develop the cost-benefit

6 analysis.

7 Q. Now, I don't want to take time up going through all

8 the documentation relating to the cost-benefit

9 analysis, there's quite a lot of material, and it

10 probably isn't all of it, in the material that you've

11 seen. You certainly produced a version of it, I think

12 others commented on it --

13 A. Yes.

14 Q. -- and it was considered by, I think, a number of

15 different branches and teams within the Department at

16 various stages.

17 In terms of ultimate funding, is it correct that

18 the Department didn't, in fact, stump up the funding

19 for the test, as things turned out? Regional Health

20 Authorities were required to fund it from their

21 existing resources?

22 A. Yes, you know, I'd have to look at every single detail

23 of that but, I mean to say, looking at it generally,

24 overall, it would appear that the Regional Health

25 Authorities were advised that this was to be

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1 considered an additional cost that they would have to
2 increase in their use of funding, and that they would
3 have to decide what other expenditure would have to
4 make way for this, at least temporarily, until the --

5 You see, because I think a lot of this is a case
6 of funding rounds from one year to the next. Because,
7 obviously, in the year in which the test was
8 introduced, then they might well be asked to find the
9 funds for it in that year but, obviously, for the
10 following year, they could then make a bid to the
11 Department saying: "Look, we've got this as an extra
12 pressure so you need to pay us that bit more."

13 **Q.** Now you were involved, as I said, in putting together
14 the economic case, the cost-benefit analysis. As far
15 as you can recall, did you have any part in the
16 Department's decision not to provide funding or
17 decision whether or not -- (overspeaking) --

18 **A.** That would be completely outside my role.

19 Sorry, I could sort of point out that with the
20 cost-benefit analysis, this is something that is
21 recommended internationally, and I think I've referred
22 to two particular documents where they say that, prior
23 to introducing a screening test for blood to prevent
24 transmission of infections, a cost-benefit analysis
25 should be undertaken.

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

2 **SIR BRIAN LANGSTAFF:** And it's a letter to Cash from Ortho
3 to say that an exporter licence had been granted, and
4 apparently the FDA told Gunson -- I think that's what
5 comes from the *AA and Others* litigation.

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

7 **A.** Thank you.

8 **MS RICHARDS:** Sir, I note the time, and we've got through
9 four of the nine meetings I need to ask Dr Rejman to
10 look at with me but I think perhaps we should break
11 for lunch now.

12 **SIR BRIAN LANGSTAFF:** Yes, well, we will take a break
13 until 2.00. So two o'clock.

14 (1.01 pm)

(The Short Adjournment)

16 (2.00 pm)

17 **MS RICHARDS:** Dr Rejman, the next meeting, the fifth
18 meeting of the ACVSB, was January 1990. Can we just
19 look at one of the documents that was prepared for the
20 meeting before we look at the minutes,
21 NHBT0000189_001.

22 This is paper 5 of 6 for the ACVSB "Cost-Benefit
23 of Hepatitis C Screening of Blood Donors in the UK".

24 If we just go to the next page, just so you can
25 recognise the document. I'm not going to ask you

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1 **Q.** Now that meeting was 6 November 1989. According to
2 the Penrose Report -- we haven't provided you with
3 this but I hope you'll take it from me -- the Chiron
4 test was approved for export, not yet FDA licensed but
5 approved for export on 27 November 1989. Do you know
6 whether that came to your attention or Mr Canavan's
7 attention at the time or was the subject of discussion
8 within the Department? I haven't got any particular
9 document I can prompt you with, I'm afraid, so --

10 **A.** No, I can't really say -- I mean to say --

11 **SIR BRIAN LANGSTAFF:** -- (overspeaking) --

12 **A.** The people that would have -- sorry.

13 The people that would have known about it would
14 obviously have been procurement division, I think they
15 still were procurement division at that stage, because
16 obviously they were the people that were involved --
17 one of their functions was screening tests, and
18 obviously they were the ones that were in direct
19 contact with the companies, and they would know
20 everything that was going on there.

21 **MS RICHARDS:** So in the Penrose Report it is

22 paragraph 31.154 of the --

23 **SIR BRIAN LANGSTAFF:** There is a reference to the source
24 of it, it's a letter from Ortho. It's at
25 NHBT0000188_123.

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1 about the detail of this, but that's the document, it
2 continues for three pages. If you go back to the
3 first page, I just wanted to ask you about the first
4 paragraph. Before I do so, my understanding from the
5 surrounding documents is that this is the paper that
6 you wrote and that Dr Pickles then made some
7 amendments and to then I think it was Dr Pickles who
8 spoke to it at the meeting.

9 **A.** I don't know. My understanding from the papers is
10 that it is Dr Pickles' document, not mine.

11 **Q.** Okay.

12 **A.** Because, I mean to say, looking at the wording,
13 et cetera, it doesn't seem the sort of wording
14 that I would have used.

15 **Q.** Okay, well, let me show you one other document but it
16 may then be that I can pick up the substance of it
17 with Dr Pickles. DHSC0003545_004. This is Dr Pickles
18 saying:

19 "I have reworked Dr Rejman's paper into something
20 that might be possible for the ACVSB."

21 So you had some involvement in it but are you
22 suggesting in that --

23 **A.** I think I provided some of the background and I think
24 there was a sort of a very scruffy, without heading or
25 anything, just bits and pieces, which I think was

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(27) Pages 105 - 108

1 there. And I think that Dr Pickles based her paper on
2 that. Obviously, the point is that, if one provides
3 background, it is up to the author, the final author,
4 to decide how much of that is appropriate, how much of
5 that they agree with -- because, obviously, Dr Pickles
6 is entitled to her own views, which may not always be
7 the same as mine.

8 So, you know, in a sense, the final document she
9 takes ownership of, whereas I might well have
10 contributed a lot of the background.

11 Q. That's fine. My question was about the introductory
12 part of it, so I'll ask that of Dr Pickles tomorrow.

13 A. All right, yes.

14 Q. Let's go straight to the meeting of 17 January 1990,
15 PRSE0001477. Now, there's a detailed discussion,
16 which begins at the bottom of the second page. I'm
17 not going to take you through the detail of it,
18 Dr Rejman, but we can see it begins with Dr Gunson
19 speaking to one of his papers.

20 If we go over the page, we can see at
21 paragraph 16 the chair poses the question or invites
22 the Committee to address the question of whether the
23 time has now come for the introduction of routine
24 hepatitis C screening.

25 There is then various contributions recorded,

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1 point:

2 "the Committee could give no further scientific
3 advice at this point, but would discuss the matter
4 further at the next meeting ... which would be after
5 the International Hepatitis Meeting in Houston."

6 Then there's reference to Dr Pickles speaking to
7 paper ACVSB 5/6.

8 Do you have either any recollection now or any
9 informed view, having looked back at the papers for
10 the purposes of giving your evidence, as to why it was
11 that the Committee was apparently unwilling to give
12 what's described here as "no further scientific
13 advice" but not yet grasped the nettle and take
14 a decision, why it wanted to await the meeting in
15 Houston that's referred to?

16 A. Well, I think this is, what, this is January 1990?

17 Q. This is January 1990, yes.

18 A. Right, okay, and the first Chiron test was when?
19 April/May 1989? Something like that.

20 Q. I'm not going to be prompting you, I'm afraid.

21 A. Well, it was something of the sort, but anyway,
22 six months before this, roughly speaking, give or
23 take. I think that, in essence, there was enough
24 disquiet about false positives and false negatives,
25 and not having a confirmatory test, even at this early

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1 which I won't take you through, maybe that there are
2 differences of view, to some extent, from the various
3 members.

4 But if we pick it up over the bottom of the next
5 page, please, if we zoom in on the last
6 two paragraphs, Paul. So paragraph 28 refers to the
7 funding having to be found from the existing health
8 vote allocation, and then paragraph 29:

9 "The Chairman summed up the general consensus of
10 the Committee ...

11 "routine testing should not be introduced in
12 advance of the FDA decision ..."

13 Top of the next page:

14 "scientifically, not enough is known yet, but
15 there is agreement that the test does detect some
16 people who will transmit; and

17 "the overall prevalence figure of non-A non-B
18 following blood transfusion, for the UK may be
19 10,000 [per annum], subject to very wide margins of
20 error."

21 There is then the chair asking members for their
22 opinions as to what action should be taken, and then
23 there's reference to a view of Dr Tedder, and then
24 there's a Committee agreeing, this is right, they're
25 going to look at costs, and then the third bullet

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1 stage. Now, I know that Dr Mortimer, at the
2 beginning, said this sounds as though this is a test
3 that we could introduce and various people at various
4 times said "Yes, it's obviously doing something". But
5 I think Committee members seemed to be of the view
6 that there were too many doubts, to put it bluntly.

7 And that is my reading now, now -- obviously, it
8 wasn't my decision, it was a Committee decision, and
9 the Committee obviously would have decided.

10 I don't think at the time there was anybody --
11 you know, Dr Canavan, I suspect, had no view, ie they
12 might have said, "Do you have a view, should we really
13 be pushing for this?" And I suspect that my answer to
14 that would have been, "Look, I'm not an expert
15 virologist remotely. Not at all. All that I'm doing
16 is I'm bringing together papers, I'm trying to bring
17 together the best information I can for the Committee
18 to make a judgment. Don't ask me, you have to ask the
19 Committee".

20 And if the Committee feels that, despite our
21 best efforts at giving them all the data that we have,
22 that they're still not sure, then that is it.

23 Q. Let's pick matters up, then, at the next meeting, the
24 sixth meeting, April 1990, NHBT0000072_098. Second
25 page, please, Paul.

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We can see there that paragraph 8, under the heading "Hepatitis C", refers to the Ortho symposium and there's a reference to paper ACVSB 6/2:

"The abstracts from this symposium had been circulated with the secretariat's comments. Dr Rejman said the overall impression was that the test was not sensitive or specific enough for reliable testing. A confirmatory test and more information about the submission of positive test results were needed before the Ortho test could be used for the routine screening of healthy donors."

Then there's a reference to Dr Mortimer and the discussion continues.

I wanted to ask you just about your own contribution here. Now, this reads as though you're not simply repeating what the symposium says but you're providing your own comments on it.

A. Yes, and I think I have actually mentioned in my report to the Penrose Inquiry, and definitely in my third statement here, that the quote there about what I said is not exactly what is said on the front page of that report. Because my recollection -- I'd have to check the exact wording -- is that the overall impression confirmed by informal discussion with others was. So it was not just my view; it was the

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to other people that I knew, you know, from elsewhere, they were of the same opinion as to this being the overall impression.

Q. Is it your evidence, Dr Rejman, that you're simply relaying what was being said to you, and relaying that to the ACVSB, or was it your own view, that was shared by others, that you were relaying to the ACVSB?

A. Well, I was at the meeting. So, therefore, I heard what people said. And this particular paper is about 32 pages long, because it contains the abstracts of all the talks, and with most of the talks there's a covering sheet from me giving additional information to what is in the abstract. So when somebody in the Penrose Inquiry said it was a brief paper, I don't accept that. This was a detailed paper, giving information from a meeting that I had been asked to attend by ACVSB, and to report back on that meeting, which is what this is. This is a report-back on that meeting. And if one is going to report back, people are bound to ask, "Well, you know, what was -- what did you come away with? As a non-expert, non-virologist, you know, not claiming to be either of those, what was your general view?"

And that is what I have given.

Q. Now you're aware, obviously, from your statement to

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view of other people that I had spoken to at that meeting.

And then later on, at this meeting, both Professor Zuckerman and Dr Mortimer, who were both at that meeting, said the same thing: that the tests were not sensitive -- that the test was not sensitive or specific enough for reliable testing. And they confirmed that.

Q. If we just go to PRSE0004275, this is the paper referred to in the minutes "Report on Ortho HCV Symposium". Then the summary:

"We append the Ortho abstracts, recently received and supplementary notes. The overall impression [and here's the reference to informal discussion, Dr Rejman], reinforced by formal discussion with delegates, is that the test is not sensitive or specific enough and, in the absence of appropriate confirmatory testing, is unable to give data upon which appropriate clinical decision-making can be reliably based."

Who --

A. Yes, so I think that I was basically reporting. I'd been to this meeting, which I think was a whole day meeting, and obviously one chats to people during breaks and during lunch, et cetera, and, having spoken

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the Penrose Inquiry that there was also Dr Boulton who reported upon --

A. Yes.

Q. -- or produced his own notes of the same meeting. I'm not going to take you through those. But can I just ask you to look at Dr Boulton's letter to Professor Cash. You wouldn't have seen it at the time but obviously you saw it, I think, when you were writing your statement to Penrose?

A. Yes, I saw it for the first time when the Penrose Inquiry wrote to me with Article 13 or whatever.

Q. So PRSE0001562. Then, in the second paragraph, Dr Boulton says:

"Could I just add that in spite of obvious difficulties with the current Ortho Elisa assay ... I have developed a very strong feeling that the screening of donors for HCV antibodies should be introduced at the earliest possible opportunity. This not because of the 'science', but because there appears to be little doubt that people have contracted HCV as a result of transfusions which they would not have received had those transfusions been screened for HCV antibody."

Then he goes on to talk about the concerns about

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1 future litigation and so on.

2 Now within the Department you, Dr Canavan,
3 Dr Metters, Dr Pickles, others, discussing this,
4 considering this issue, within the ACVSB, was the
5 decision about introducing screening ever looked at
6 from this perspective? Not on the basis of this
7 letter, of course, but from this perspective, the
8 simple yet principal point: there are all sorts of
9 potential problems and difficulties but ultimately we
10 can stop people being infected to some extent if we
11 introduce screening now?

12 **A.** Well, it was not up to the Department, number one.
13 The Department was not going to introduce this test
14 off its own back. It couldn't because it would have
15 to justify it, if nothing else, to the people that pay
16 for the costs of testing. So if the Department were
17 to go out on the limb and say, "We're going to
18 introduce this testing", then obviously the RHAs would
19 say, "Okay, fair enough, and you will pay us for it,
20 for everything, the cost of the tests, the cost of the
21 manpower, any downside to us which is caused by this."

22 And I cannot -- well, I don't know, obviously
23 I haven't been in the Department -- I wasn't in the
24 Department that long, but it would be a very odd thing
25 to happen for a department to, you know, go against

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1 the two reports. No doubt the chair can do so as
2 required.

3 **SIR BRIAN LANGSTAFF:** May I just ask one thing?

4 **A.** Yes?

5 **SIR BRIAN LANGSTAFF:** Can I understand what the basis is
6 for your saying that if you were to take every
7 200th donation and bin it, you would reduce the
8 incidence of hepatitis C.

9 **A.** Yes.

10 **SIR BRIAN LANGSTAFF:** It might be thought that if the
11 incidence -- let us suppose, just for the sake of the
12 argument -- is 1 per cent, that you don't know whether
13 the 200th donation is in one or 99.

14 **A.** No, but that is the whole point with false positives,
15 because with the false positives, 90 per cent of the
16 original screening tests were incorrect. Only
17 10 per cent of the positives were true. And I've
18 given details about that in my statement. So what it
19 means is that if you take 100 donations, if you test
20 all of them for hep C, you would get whatever
21 proportion, you know, 0.6 per cent would be positive
22 under the first screening system, and they would
23 therefore be counted as positives but only one-tenth
24 of those were actually truly positive. So in a sense,
25 it's not far from being just a random choice.

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1 advice of a committee that was set up to give it that
2 particular advice.

3 I think with this letter from Professor Boulton,
4 I think the importance is the word "science" in
5 inverted commas. He obviously is not interested in
6 false positives, false negatives, confirmation or
7 anything. All that he is saying is that if we apply
8 this test, some people will not get HCV.

9 But I would put it to you that if you were to
10 take every 200th donation and just bin it, you would
11 reduce the incident of HCV by chance.

12 So I think the thing is that he is actually --
13 his letter contains no science at all. His main
14 factor is the litigation, which I think is the bottom
15 bit, which I think is the driving force.

16 And also I would put it to you that his report
17 of the meeting is nowhere near as detailed as mine,
18 and I think in my statement I put forward the idea
19 that if you have two people attending the same
20 meeting, they may well produce a completely different
21 report, and I gave an example of a meeting that
22 Harold Gunson had attended and Ruthven Mitchell had
23 attended, and if you look at their two reports, there
24 are significant differences.

25 **Q.** As I say, I'm not going to take time with comparing

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1 **SIR BRIAN LANGSTAFF:** But the fact would be, would it not,
2 that you would actually, although you'll produce
3 a number of false positives, you would actually
4 exclude things which were positive. And if you caught
5 10 per cent of those, you would reduce the infection
6 rate by 10 per cent?

7 **A.** Well, that's correct, and if you want to abolish all
8 infection you don't give any blood transfusions.
9 Well, no, no, that is the corollary -- ultimately
10 that is the thing.

11 And this is what the discussion is about. We need
12 a Transfusion Service, we need donors so that
13 recipients can have the blood. And the whole problem
14 with the false positives was, what do you say to
15 donors? Now originally, at the beginning, the
16 assumption was that we only had 50 per cent false
17 positives. Now the true figure was that we had
18 90 per cent false positives, which is way in excess of
19 what would be acceptable in most circumstances. And
20 we don't know how many false negatives there were,
21 there obviously were some false negatives judging by
22 the fact that some people who were tested for hep C
23 with the original tests did transmit non-A, non-B --
24 hepatitis C.

25 So I think what you have to look at is the

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broader picture, in a sense, and say, "Look, we need these transfusions. What we need is a test that will give us two things: confidence in the validity of the test, what does it mean; secondly, it isn't going to decimate our donor population". Because if you're throwing out -- nine tenths of your donors that you're excluding on this test are people that you could have used, then that is reducing your blood supply quite significantly.

So I think, you know, there are all sorts of aspects to this, and I think that the Committee was well aware of this, even though, as I say, initially they thought the number of false positives was significantly less than it proved to be. So I think, you know, we were -- we're faced with a situation that you have a test which a lot of people, significant numbers of people, say is a defective test. Now, I went -- I'm not sure whether we're going to discuss this business about other countries and everything, are we?

MS RICHARDS: Next question.

A. We will do. Okay, right, fine, so we'll leave that until later. But basically that would be my point.

SIR BRIAN LANGSTAFF: Yes, well, I think I understand what you would have thought at the time.

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us. I think, probably, it was not news to Harold Gunson and Ruthven Mitchell. Well, of the virologists, I suspect most of those would have known. The people that wouldn't have known would have been, for example, the people the general haematologists and possibly one or two others. So I'm not sure how much of that was new information for people or just really a statement of fact, "Look, other countries are introducing this, so we need to sort of bear that in mind", type of thing. And I think that would have been the end of it.

Q. Then we can see, bottom of the page, the chair remarking:

"... science seemed to have advanced little ... still questions whether the anti HCV test was reliable and a useful step forward or created too many problems at this stage."

If we go over the page again, I'm not going to go through the detail of each of the individual contributions, we have the minutes. We can pick up at the bottom paragraph, the chair's summing-up of the situation:

"... inadequate scientific data to support the introduction of the Ortho test ...

"[we need] a confirmatory test ...

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A. Thank you.

MS RICHARDS: Just for the transcript, the reference for Dr Boulton's report from the symposium is PRSE0004402.

If we can return to the minutes of the sixth meeting, NHBT0000072_098, and turn to page 3., we can see if we go to the bottom two paragraphs on the page, please, paragraph 21, the chair reporting that:

"... France, Belgium and Luxembourg had introduced routine screening ... Italy had introduced a test on a voluntary basis."

Now, what we don't pick up from the minutes, Dr Rejman, and, as you, yourself, have observed, the minutes are not a full account of the discussion, what we don't pick up is what weight was given to that, whether there was any discussion about that, whether there was any concern expressed about the UK lagging behind. Do you have any recollection either as to what the Committee thought about the significance of screening being introduced in other countries or whether there were any discussions within the Department that you can recall on the significance of those facts?

A. Well, as you say, this is just a statement from the chairman saying something that I presume John Canavan and I would have known anyway, so it wasn't news to

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"... FDA had not yet approved the test ... would be reassuring if the regulatory authority in the country of origin had done so;

"... need to learn more about the donor panels and the significance of positive reaction ..."

Then there's reference to there being a prospective study proposed, involving 25,000 to 50,000 donors to generate positives for confirmatory testing.

Top of the next page, we can see there's then reference to a protocol for the pilot study, reference to a paper by the economic advisor's office and a note is going to be prepared for ministers.

So still no recommendation --

A. No.

Q. -- for the production of anti-HCV screening. It may be said, it may well be submitted in due course, looking at the stage we'd reached so far, April 1990, that the ACVSB and/or the Department were not approaching this with a sufficient sense of urgency of looking at it from the pure public health perspective of what lives could be saved or transmissions of hepatitis C could be prevented. What would you say, if anything, in response to that?

A. Well, I think I've actually mentioned, in my third

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statement, that one of the problems with the false positives was actually what you do with donors. And we'll go on to this when we talk about other countries, et cetera, but, basically, in this country -- sorry, what I'll talk about later on.

But, in essence, the problem was that the Committee felt that there were too many downsides to this test and, as I have said earlier, you know, if the test is not doing its job, then, you know, if by chance you just happen to be reducing the number of infections, well, as I said, you know, what is the purpose of using the test?

And I think the Committee looked at it, and the Committee, at the end of the day, the Committee are the experts. They looked at it and they said that, at that stage, there was insufficient there. They felt that the FDA giving it approval would, at least, sort of be something. Although, as I've said earlier, FDA is not always so wonderful.

And so that was an impediment at this stage, and they basically were not happy with the test.

Q. If we go on, then, two months to the 22 June 1990 by which time FDA approval had been given, there's a memo from you to Dr Metters, NHBT0000061_148. So second paragraph, you refer to a conversation with

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actually on the basis of the initial test, which, in fact, was actually nine-tenths of that 0.6 per cent, in fact, were false positives, so it's only a tenth of that 0.6 per cent that is actually true positives.

But I think what I'm basically saying is, yes, there may be benefit to recipients, and one thing that one has to bear in mind is that hepatitis C was much, much less common in the UK than it was in the US and various other countries, particularly in southern Europe, where there was much higher incidence.

So we're talking here about small numbers of positives, and, from the point of view of the recipients, I can't remember what the figures are, that 50 per cent of recipients would be dead within a year or two of having that the transfusion. So one looks -- and, obviously, therefore they are not going to get chronic hepatitis and cirrhosis and liver cancer.

And, also, the other thing is, I can't remember what the figures are, whether it's about 20 or 25 per cent of -- 50 per cent of recipients could go on to some form of chronic hepatitis, which might be just chronic persistent, as opposed to chronic aggressive hepatitis; a proportion would go on to cirrhosis; a very small proportion would go on to

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Dr Mortimer. Third paragraph, you set out some matters relating to the available tests. You refer to a Lancet report, and so on.

You then set out a number of other matters in paragraphs 4, 5 and 6. 6 you summarise a table from a paper that you had come across.

And then you say this, by way of summary:

"In summary it would appear that screening of blood donations for hepatitis C is of benefit to recipients, but could pose major problems to donors who might be incorrectly labelled as being at risk of developing chronic non-A non-B hepatitis themselves with all the implications of counselling, gastroenterology follow-up, and reduced ability to obtain life insurance and endowment policies etc."

Then you give some suggested figures.

Now, is it correct to read this minute and, in particular, what you say in paragraph 7, as expressing your assessment? You're not simply here reporting somebody else's, are you?

A. I probably would have discussed it with John Canavan, almost certainly. He's a copy recipient. Who else I would have discussed it with? I may well have discussed it with Dr Pickles, I do not know. I think what I'm basically saying there -- and this is

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liver cancer.

So one is talking about smaller and smaller and smaller numbers. And the question, really, is if one did anything that would damage the donor base, then this would be a very major problem.

Q. I'll pick up on some of the themes in relation to false positives and donors once we finish going through the documents but let's move, then, to the meeting that took place shortly after your minutes, so meeting of the 2 July 1990, PRSE0000976. If we go to the next page, we can see it's the seventh meeting, 2 July, bottom of the page you're asked to summarise the course of events since the last meeting. So we can pick up from this, FDA approval, America has introduced screening, other countries following, and more studies have been carried out, RIBA available as a supplementary test, meeting brought forward so a decision on the introduction of hepatitis C testing could be reached.

So that's your update, as I read the minutes.

A. Yes.

Q. Over the next page, paragraph 6 reports the chair saying, in terms of the purpose of the meeting, it's to:

"... reconsider the principle of Hepatitis C

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screening. The secondary purpose was to look at the draft protocol and decide which tests to use."

There's then contributions from Professor Zuckerman and Dr Gunson. Paragraph 8: "After further discussion the Committee concluded they should recommend to Ministers that hepatitis C screening should be introduced in the UK, but that first a pilot study using the Ortho and Abbott tests was necessary to decide which was the better test for the Regional Transfusion Centres."

Then the discussion continues further in relation to, in particular, that latter point.

This is what has been described elsewhere, and I think is probably clear from the face of the minutes, is "the decision in principle". The ACVSB are now saying, "Yes, we should definitely introduce this".

A. Yes.

Q. But the actual introduction is deferred, effectively, pending now a decision as to which of the tests to be used.

A. Well, my reading of this, and as I say, it's a long time ago, is that, by that stage, you had two tests, competitor tests. Because it's never a good idea if you just have one test. Unless that test is

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infallible and guaranteed and is 100 per cent, and (a) gives the correct result all the time, and, secondly, is user-friendly to all the RTCs, then one probably wouldn't go for a single test.

By this stage, there's a second test and, therefore, one has a choice as to which of them gives more accurate results or more true results and, also, which one is feasible to use in the context of a transfusion service, because, obviously, this is an additional test on top of already their hepatitis B, their HIV, I don't know whether they do a syphilis -- already there are various tests they're doing and this is yet another addition to that. And the thing is to look at the practicalities of introducing it because I think when it came to some other countries, particularly for example, the US, if you're talking about tests the commercial side of blood products, you know, costs a little bit more, you just put the price up of your product, and that is it.

And so, therefore, they're not worried about practicalities, and also they're not particularly worried about donors or donors being upset, about being told -- well, the donors might be upset, particularly if the donor is relying upon that as a source of income, if they're told that they can't

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donate, but then they might go to yet another place to give their blood.

Q. Why not, at this stage -- and what I'm asking for is your understanding of what the Committee's thinking was at the time, or your understanding of what the Department's thinking was at the time -- why not say -- given that the decision in principle has been taken, to just say, "Get on with it. The Regional Transfusion Centres, one can use one test, one can use the other, and then we can look at it in four to six months' time and see whether we now recommend that they should focus on one and not the other"? Why not just crack on?

A. Well, ultimately the Department is guided by the experts on the Committee, experts on the Committee which included people at the sharp end. So in fact it had two people from the Transfusion Service who would have been, presumably, in a position to say how reasonable would it be to just introduce the test on that basis.

Now they knew that there was going to be a significant number. Originally we thought it was only going to be 50 per cent false positives, later on we found out it was 90 per cent false positives. They knew that they were going to be stuck with false

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positives. Now we'll go into other countries, et cetera, but basically in the UK, if you ask a donor to come -- if you invite a donor to come and give blood, they come of their own free will. There is no pressure on them. They're not compelled to do it. What you're giving them is a biscuit and a cup of tea. That is it. So you're not paying them, so there's nothing to encourage them for any other reason. So they are coming of their own goodwill, they're doing it as a contribution to the public welfare.

So to then say to these people, "We've tested you and you've come up positive" -- now the first thing is, what do you say to that person? Because the doctors in the Transfusion Centres wanted to be honest with their donors. They wanted to say to them, "Look" -- for example, if you go back, for example, to HIV, if you tested them and they come back HIV positive, well, first of all you see them confidentially and say to them, "Look, we've tested your blood and it's come up HIV positive. Do you know, is there any reason why you might be HIV positive?" And then they may say, well, actually, they're a homosexual or a drug abuser or they were in the past or whatever. Some reason. There may be no reason. But anyway you say to them, "Look

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1 unfortunately we've found you're HIV positive, and the
2 impact of this is you have to be careful about sexual
3 relationships so as not to pass it on to anybody."

4 At that time obviously -- well, I'm not sure
5 exactly when AZT came on board, but there would have
6 been the start of some form of treatment available, so
7 they could have referred them to infectious diseases
8 unit. So therefore the donor has had some benefit
9 from being told that they're positive.

10 In this case you have a donation which comes up
11 positive and you say to the donor, "You've come up
12 positive, but we don't know, actually, whether you're
13 truly positive or whether this is a duff result. We
14 don't know". And the donor is going to say, "But
15 you're the experts, you know about this. You sort
16 it."

17 Well, I can't sort it because I don't know.

18 And it's a difficulty because, you see, once one
19 donor has that, they tell their friends, and they tell
20 their friends, and before you know where you are, the
21 number of your donors goes down significantly. And
22 I think that is a very, very important concept to bear
23 in mind.

24 Q. Dr Rejman, you've been at pains to point out that you
25 were not a member of the Committee --

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1 Abbott test."

2 So the decision in principle has shifted now in
3 the sense there's a greater degree of urgency. It's
4 now "as soon as practicable".

5 A. Yes.

6 Q. And indeed, the choice is now to be left to RTCs as to
7 which test to use.

8 A. Yes. Because I think -- by this stage, I think we'd
9 had the results of the first pilot comparing the two
10 tests. And generally speaking my understanding is
11 that there wasn't much to tell between them.

12 The interesting thing was that the repeat
13 positives for one test were not always repeat
14 positives for the other test. So which test was
15 better? We couldn't know. And I think Dr Gunson in
16 his report from that first screening said that the
17 supplementary, and I think what he meant was
18 confirmatory, testing would be the arbiter.

19 So what we were saying here is that if people
20 were positive then presumably you would go on to RIBA,
21 which was the original, the RIBA I, and then I can't
22 remember exactly when P -- well, it actually says
23 here, "to PCR" so we were already talking about PCR.
24 PCR was the gold standard for telling whether a test
25 was a true positive. It tells you nothing about true

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1 A. No.

2 Q. -- and your role was the role you've described, of
3 being the medical secretary.

4 A. Yes.

5 Q. But it might be said, listening to your evidence, that
6 it was a topic upon which at the time you had very
7 strong and firm views. Is that fair?

8 A. No. I would say I was aware of the concerns of the
9 Transfusion Service because they were made clear to
10 us. You know, Dr Gunson and others said to us, you
11 know, what the problems were. So what I'm doing here
12 is I'm recounting to you what I was told at the time.
13 I had no view. And anyway, even if I had a view, it
14 would be of no relevance because I did not work in the
15 Transfusion Service, I had no contact with donors,
16 therefore everything I say to you is a report of what
17 I was told by others.

18 Q. Let's just move on, then, to the eighth meeting,
19 21 November 1990, NHBT0000073_718.

20 I think we can go straight to the chair's summary
21 of the discussion, page 4, paragraph 18, where:

22 "The Chairman summed up the discussion by saying
23 that there was agreement that the UK should introduce
24 hepatitis C testing as soon as practicable. RTCs
25 would decide individually whether to use Ortho or

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1 negatives; it only tells you about true positives.

2 And the PCR was available so presumably, even at this
3 stage, what I think is being suggested here is that if
4 you have a donation that is repeat positive -- that
5 means you do the test once, it comes up positive, you
6 then repeat a test on that same sample, and it comes
7 up positive, so it's repeat positive -- you then do
8 either the RIBA or you do the RIBA and the PCR to
9 confirm. And those that are confirmed as positive,
10 those you can then tell the donor, "Look, I'm very
11 sorry, we've found out that you've got hepatitis C.
12 Now, we don't know how long you've had it for, we
13 don't know why. We're not asking you why you're
14 positive. That's nothing to do with us. We're just
15 telling you this". And from then on -- and then you
16 could refer them to a gastroenterologist and various
17 other people.

18 Q. Now the ACVSB, having said in November of 1990 that
19 the screening should be introduced as soon as
20 practicable --

21 A. Yes.

22 Q. -- we know that, with the exception of Newcastle, it
23 wasn't introduced until September of 1991.

24 A. Yes.

25 Q. Do you recall being yourself troubled or concerned

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1 about that delay?
 2 A. Well, I think people in the Department -- and I think
 3 there's a minute there from Hilary Pickles, when she
 4 was talking about the introduction originally in
 5 July 1991 -- I would say, reading that minute, she
 6 obviously was concerned, and she said, "Well, look,
 7 you know, Harold Gunson has said the earliest we can
 8 possibly do it is July 1991."

9 And I think that there was concern but ultimately,
 10 as it says there, it's as soon as practicable. That
 11 means as soon as it can actually be put into action.
 12 And the delays, I don't know -- I mean to say, one
 13 would have to -- I mean to say, there was that ACTD
 14 summary of the history of hepatitis C screening,
 15 I think you've come across that, where they actually
 16 put in all of the various stages between the
 17 recommendation from November 1990 and the final
 18 introduction in September 199 -- you've got that
 19 document, haven't you?

20 Q. I think so, yes.

21 A. So they've actually explained that Harold Gunson went
 22 to the RTC directors asking them how quickly can they
 23 actually get their show on the road, and they got
 24 various replies and they agreed a particular date.
 25 And then the problem then was that there was a second

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1 the end, it was a case of what the Transfusion Service
 2 could actually manage.

3 Q. You're right that it was the ninth meeting, but
 4 I don't think we need to look at it, on
 5 25 February 1991, PRSE0002280, I think, or
 6 alternatively -- we don't need to pull this up, it's
 7 just for the transcript, NHBT0000042_058, which says
 8 "Well, now we're going to look at the second
 9 generation testing", so the introduction is deferred,
 10 pending that.

11 What I wanted to do is to just ask you to look at
 12 one final document from the contemporaneous decision
 13 making, which sets out Dr Metters' perspective, as at
 14 the end of 1990, NHBT0000061_201.

15 It is Metters to Canavan, 18 December 1990,
 16 copied to you, Dr Pickles and others. We can see --
 17 if we just bring up the text at paragraphs 1 to 5 --
 18 a bit more closely, thank you -- we can see that the
 19 context is that the content of the draft submission
 20 that's going to go to ministers to ask for endorsement
 21 of the ACVSB's recommendation, and then we can see
 22 here Dr Metters' take upon the Committee's decision
 23 making. Paragraph 2, he says:

24 "The Committee in July reached the conclusion
 25 that HCV screening could prevent a significant

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1 generation of hepatitis C tests that came out, and the
 2 first generation were going to be got rid of, so
 3 therefore you'd only have the second generation, so
 4 therefore it was suggested that probably a good idea
 5 to try out this second generation because nobody had
 6 evaluated the second generation tests at all,
 7 anywhere. So it was suggested if we can check to see
 8 how these second generation tests work. How
 9 practicable are they? Do they work? Are their
 10 results better? And the idea was that the second
 11 generation would generate a lot fewer false positives,
 12 which obviously would have the benefit that you would
 13 be able to -- well, probably the most important
 14 benefit is that if you had a more accurate test it
 15 meant that you had a higher number of donations that
 16 you could make available quickly. That means, you
 17 know, people -- like platelets, which might be in --
 18 need to give them within a matter of hours or
 19 whatever, so you could do that much better if you've
 20 got a more -- a better test available.

21 So I think all this worked through, and there
 22 were various reasons why things sort of took longer
 23 than ideally they should have done and I think people
 24 in the Department were anxious that in fact that the
 25 tests should come on board as soon as possible, but in

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1 proportion of post-transfusion hepatitis."

2 Paragraph 3, he says:

3 "Furthermore, the Committee's view is that with
 4 the existence of the current test procedures, to
 5 continue a policy of not screening poses
 6 an unacceptable risk to the health of recipients of
 7 blood and plasma."

8 Paragraph 6 (*sic*):

9 "The Committee recognise that detailed cost
 10 benefits ... could not be quantified. Nevertheless,
 11 their unanimous conclusion is that the UK should
 12 follow the lead of an increasingly long list of
 13 countries ... who have now introduced HCV screening in
 14 order to significantly reduce the load of non A -- non
 15 B post-transfusion hepatitis."

16 Then he asks that the submission must convey
 17 those points more clearly.

18 Now, Dr Metters' is writing there in what one
 19 might be thought to be quite strong terms about what's
 20 regarded by him as the Committee's view, it would seem
 21 shared by him as chair of the Committee, that the
 22 status quo posed an unacceptable risk to the health of
 23 recipients, and yet, notwithstanding that, the ACVSB
 24 essentially say "Well, we'll look at second generation
 25 tests", and testing is not introduced for a further

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1 nine months or so.

2 Do you recall whether that was something which
3 was then troubling Dr Metters in the course of 1991?
4 Was there concern at how long things were taking to
5 get to the actual stage of introducing it?

6 A. Well, I think what you need to do is you need to look
7 at the list of copy recipients, of this minute.
8 Right. You have Mr Heppell who was the deputy
9 secretary, so that means a grade 2 on the
10 administrative side. Dr Walford, who, at that stage,
11 presumably was the medical director in the management
12 executive in Leeds, Mr Malone-Lee, who -- I think he
13 was also a dep sec, or at least a grade 3, if not, and
14 then Mr Dobson was the AS, Dr Pickles and myself.
15 Mr Anderson was the person who was involved in the
16 cost-benefit analysis, so he was from the finance
17 people.

18 So -- sorry, or EOR, sorry, not finance, the
19 economic appraisal people.

20 So he, obviously -- this minute is sent to the
21 great and the good, so to speak. So this is copied to
22 people high up in the administrative and medical
23 hierarchy within DH and the Management Executive. So
24 he is there basically saying to Mr Canavan, "Look, you
25 need to beef up this bit of the submission to stress

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1 told us about having regular interactions with
2 Dr Metters, do you recall this being a subject for
3 concern, Dr Metters expressing frustration at how long
4 it was taking? Anything of that kind?

5 A. I honestly cannot remember. I mean to say -- reading
6 through the papers, I mean to say, I suspect that
7 people within the Department were not happy with the
8 fact that it was taking as long as it did but, having
9 said that, I think people recognised that we live in
10 the real world. It's a case of what actually can be
11 done, and ultimately, you know, we're in the hands --
12 we are not the people running the Transfusion Service.

13 We are not in a position to be able to say to the
14 Transfusion Service, "You've got to drop that, drop
15 that, drop that, do this, this is your priority".
16 Because, obviously, the Transfusion Service was very
17 busy anyway. I don't think there was any -- you know,
18 nobody was, sort of, sitting on their hands doing
19 nothing, they were very busy doing all sorts of
20 things. And, here, you're giving them another task,
21 which is a significant task, because I don't think --
22 this was something which I think took two-and-a-half
23 or three hours or something like this, easy to test.
24 It wasn't a sort of, you know, just a dip in it. It's
25 not, you know, a pregnancy test from -- you know, this

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1 this, stress that or whatever". And I think that
2 would be my reading of it, is that Mr Canavan
3 presumably sent him -- you see what was the date of
4 that Committee meeting, the ACVSB, 18 November, or
5 something?

6 Q. It was 21 November.

7 A. So, you know, this is actually going quite quickly,
8 isn't it? Because if Mr Canavan has already prepared
9 a draft submission before 18 December and, in fact,
10 I think the final submission went on 21 December, it
11 was actually put in place pretty quickly for
12 a submission because, sometimes, submissions take
13 quite a long time.

14 And I think the thing is here, Dr Metters is just
15 saying to Mr Canavan, "Look, we need to make sure that
16 ministers have absolutely no doubt that this is what
17 we must do".

18 Q. My question to you, Dr Rejman, is not about so much
19 the interpretation of this or the speed of the
20 submission; it's trying to reconcile what we see said
21 here in strong terms by Dr Metters with what we know
22 happened, as a matter of fact, which was it took
23 a number of further months before testing was
24 introduced.

25 My question to you is: do you recall -- you've

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1 is a serious test that requires time and effort,
2 requires people, requires good quality assurance, and
3 everything -- you know, there's a whole gamut of
4 things involved in introducing a test.

5 So I think we in the Department -- ideally, we'd
6 have wanted it done the next day, in an ideal world.
7 But you can't because there's practicalities.

8 Q. When Dr Lloyd at Newcastle did introduce the test
9 earlier than other centres, consternation was
10 expressed certainly by some other Regional Transfusion
11 Directors, you wrote a minute to Dr Metters about it,
12 NHBT0000062_054, and we can see there paragraph 2
13 refers to the introduction of screening in Newcastle.
14 You say in paragraph 3 it was despite the agreed
15 policy by the ACVSB that it should be simultaneous.

16 Paragraph 5 refers to problems in terms of the
17 other major competitive company and problems in
18 Scotland. And then in paragraph 7, you say you're
19 copying this to members of the Management Executive:
20 "... to determine whether action is required where
21 an individual Region decided to oppose a universal
22 agreement."

23 Were you irritated by, concerned by, troubled
24 by, Dr Lloyd's decision to introduce testing early?

25 A. Well, I think here I'm -- well, you see I'm

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1 enclosing -- the only way that I knew about this was
 2 Harold Gunson had written to John Canavan and I think
 3 this actually illustrates the fact that John Canavan
 4 may have had more -- well, the administrators had more
 5 ... well, not control, but they were much more
 6 involved in the operation of the Transfusion Centres.
 7 I wasn't. That was operational, that was nothing to
 8 do with me at all. That was not medical.
 9 So therefore anything operational from the
 10 Transfusion Centres would go to him, medical things
 11 would come to me. This was an operational matter
 12 which is why Dr Gunson wrote to Mr Canavan.
 13 Now, you could have said, well, Mr Canavan could
 14 have written to Dr Metters, which presumably he could
 15 have done. But, for whatever reason, I was asked by
 16 John Canavan "Could you write to Dr Metters and say,
 17 look, Dr Gunson is quite concerned about this
 18 development?" And, basically, the rest of what is
 19 said there is administrative. It's nothing -- there's
 20 nothing medical there.
 21 **Q.** My question is: did you have a view and, if so, what,
 22 was it?
 23 **A.** Well, I cannot --
 24 **Q.** You may not have had one because --
 25 **A.** I can't remember, to be honest. I mean to say, I'm

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1 Dr Garson to send you a copy of the latest draft of
 2 the paper intended for publication. Can we look at
 3 the handwriting please? It's not your handwriting?
 4 **A.** That's definitely not me --
 5 **Q.** But it refers to you --
 6 **A.** It may have been John Canavan's, I don't know. I mean
 7 to say, I say they've copied John Canavan, so that may
 8 be him. Rutherford was the HEO I think, at that
 9 stage, after David Burrage, and I think -- it's not my
 10 writing anyway.
 11 **Q.** What I want to do is just see what's written here and
 12 then look at the letter you then subsequently wrote
 13 or -- yes, a letter you wrote. So:
 14 "Dr Rejman is minuting Dr Metters about this.
 15 MDD" --
 16 **A.** Which is Procurement -- well, in fact that's Medical
 17 Devices Directorate which is a successor to
 18 Procurement Directorate.
 19 **Q.** "... have picked up some technical [that might be
 20 inaccuracies]. In addition it doesn't give DH
 21 sufficient credit as", and that might say "sponsoring
 22 the evaluation", something along that line?
 23 **A.** Yes.
 24 **Q.** "It also ..."
 25 I'm not sure what the rest of it says but, in any

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1 sure that people would have been upset, whether it's
 2 a view or whether it's just being -- feeling upset,
 3 that somebody has --
 4 **SIR BRIAN LANGSTAFF:** I think the question was about your
 5 view. Not about other people's views.
 6 **A.** I can't tell you. I cannot recall. All that I can
 7 intimate, all that I can guess from the way that the
 8 papers have been presented to me is that there was
 9 general upset within the Department, and I suspect
 10 that that would have incorporated me but I cannot
 11 recall what I said or felt at the time.
 12 Here, I am reporting to Dr Metters, and everything
 13 in there is -- nothing medical remotely there. This
 14 has all come from Mr Canavan, who could just as easily
 15 have written the minute to Dr Metters, and I don't
 16 know why he asked me to do it, or whether he felt --
 17 **SIR BRIAN LANGSTAFF:** I'm sorry to cut you short but
 18 I think you've answered counsel's question.
 19 **A.** Yes ... thank you.
 20 **MS RICHARDS:** If we move, then, to September 1991, the
 21 tests are introduced, and then you're sent a copy of
 22 a paper intended for publication by Dr Gunson at
 23 WITN4486065.
 24 I just want to look, so we can see the date of
 25 it, 3 September, we can see Dr Gunson's asked

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1 event, what I wanted to ask you about in a moment when
 2 we look at another document is --
 3 **A.** No, it says there, if I could --
 4 "It did [something] but supplementary tests were
 5 always available ..."
 6 So I think -- "which they weren't" -- so I think
 7 he's there talking about -- because I think in the
 8 paper they talk about supplementary tests but they
 9 don't actually mention that these are only available
 10 at a later stage.
 11 **Q.** In any event, this appears to be a note saying you're
 12 going to minute Dr Metters --
 13 **SIR BRIAN LANGSTAFF:** I think "It also makes it appear",
 14 looks like, the wording.
 15 **MS RICHARDS:** Yes, I think you're right, sir.
 16 **SIR BRIAN LANGSTAFF:** "... that supplementary tests were
 17 always available -- which is not the case."
 18 **A.** Yes. Thank you.
 19 **MS RICHARDS:** So the suggestion there is that this draft
 20 paper isn't giving the Department of Health sufficient
 21 credit as sponsors of the evaluation.
 22 Can we then pick it up with your letter to
 23 Dr Gunson about the paper, NHBT0000015_117,
 24 11 September 1991. You to Dr Gunson, and you talk
 25 about the paper and refer to anxieties that:

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1 "... there were several changes needed in the
2 paper some of which was simply to correct inaccuracies
3 [and I don't need to ask you about any of those,
4 Dr Rejman] while others might prevent
5 misinterpretation which is often very relevant in
6 these litigious times."

7 Then you say you've discussed the paper with
8 Mr Canavan and Mr Fuller and you give below "some of
9 our anxieties".

10 I just want to ask you about, really, what's
11 said in paragraph 3:

12 "The final sentence in the first paragraph of
13 the introduction could be read as being critical of
14 the UK for not introducing screening of blood
15 donations earlier, and so we feel that the beginning
16 of the third paragraph of the introduction on page 4
17 should be amended to defend our position."

18 Then you set out a suggested new paragraph, and
19 then over the page there are some other suggestions
20 that are made. I'm not going to go through the detail
21 of them, if we just go back to that first page. What
22 business was it of the Department of Health to try to
23 get amended a publication by the director of the
24 National Blood Transfusion Service, Dr Gunson, so as
25 to avoid criticism of the decision-making process?

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1 Q. The introduction starts on page 4. The last sentence
2 of that first paragraph reads:

3 "Despite these doubts concerning specificity,
4 blood transfusion services in many countries have
5 introduced the assays for screening donations."

6 So you wanted that taken out?

7 A. Yes. Well, actually, reading that, in essence -- and
8 in fact Dr Gunson did agree in his reply to me that we
9 could -- that in fact it would be perfectly reasonable
10 to exclude that sentence because it does not -- it's
11 not a scientific comment remotely. This is supposed
12 to be a scientific paper and scientific papers usually
13 should not make commentaries on policy or other
14 matters. If it is that, then it should be a leader
15 article or it should be straightforward, a commentary,
16 and people should know that. This is supposed to be
17 a scientific paper reporting the results of tests.

18 Q. With respect, Dr Rejman, that's not the reason you
19 give in your letter to Dr Gunson. The reason you give
20 is it could be subject to misinterpretation, we could
21 be criticised, these are "litigious times"?

22 A. Yes, well, I'm basically just -- you see, Dr Gunson is
23 one of the co-authors of this paper. He's not the
24 main author; he is a co-author. And what I'm saying
25 there is -- and when I talk about defending our

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1 A. Well, I obviously had discussed this with
2 John Canavan, who was obviously the administrator
3 involved. Mark Fuller was from PDD, so that was --
4 his contribution was about the deficiencies from about
5 RIBA I and RIBA II, et cetera. I think two things.
6 This paper was actually reporting on evaluations that
7 had actually been funded by the Department. This was
8 not as though the -- we'd actually paid for this. The
9 work that was being reported in this paper was paid
10 for by the Department. So we owned it financially.

11 And, as you know, with commercial companies, if
12 they actually pay people to do research, there's
13 usually some agreement about what the person writing
14 the final paper can say about the company, they're
15 usually told "You cannot criticise the company" and --
16 you know, and then there are debates about how much
17 they are allowed to say.

18 Now, I'd have to read again that final sentence.
19 Have you got it there with you?

20 Q. The text of the report? Yes, it's the --

21 A. The draft.

22 Q. The draft is at WITN4486065. If you go to -- I'm
23 afraid I don't know what paragraph you were referring
24 to?

25 A. It was page 4, wasn't it?

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1 position, I don't know but I suspect it may well have
2 been that I wasn't defending the Department's position
3 only but also the position of the Blood Transfusion
4 Service. Because obviously the Blood Transfusion
5 Service was very much tied into the decision making
6 about the timing of the HCV testing. So Dr Gunson
7 agreed with me that it was an unnecessary sentence.
8 Obviously I didn't actually -- you see, I think the
9 thing is if you're writing a letter to somebody, you
10 know, you can spend a lot of time going through every
11 single little bit, but I suspect that I was just there
12 highlighting: look, this sentence is a problem, do you
13 think that we need it?

14 Q. Dr Rejman, you've set out in your witness statement in
15 some detail in paragraph -- or section 73, and indeed
16 in other places within your statement, and I'm talking
17 about the third statement, your perspective on the
18 decision-making process in terms of how long it took,
19 and the comparison with other countries.

20 I'm not going to go through that, because frankly
21 we simply don't have time, and you've dealt with it in
22 some detail in your statement. I just want to explore
23 with you a couple of broader points, but to do so on
24 the basis of recognising that your statement obviously
25 sets out your perspective.

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1 In your statement, in your oral evidence, you've
2 emphasised the position of donors.

3 A. Yes.

4 Q. It might be said, looking at the ACVSB's
5 decision-making process and the Department's
6 involvement in that, that in the UK, in contrast to
7 a number of the other countries, it was thought more
8 important to prioritise the wellbeing of donors than
9 the physical health of the recipients of blood and its
10 components.

11 A. No.

12 Q. Is that a fair comment?

13 A. No, that is not a fair comment. I think the way that
14 the Department from -- my understanding of the way the
15 Department looked at this was, obviously the recipient
16 must come number one, because the recipient is the
17 person who is most at risk in any situation where
18 there is a potential for transmitting infection to a
19 patient. So he or she must be the number one
20 priority. But having said that, one has to look at
21 the broader picture of all patients within the Health
22 Service. And if you have a substantial reduction in
23 the number of donations in the Health Service, then a
24 lot of people will be disadvantaged; you will not have
25 sufficient to give to everybody what they need.

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1 "We've had a question mark test over you", they'd just
2 test it again, and if it came back positive again,
3 they'd do the same thing again. So the donor at no
4 stage was told that there was the potential that they
5 might have a serious illness.

6 They obviously felt -- and when I discussed this
7 with them, it was quite obvious that they were very
8 wary, that anything that was said that would damage
9 donor confidence they just didn't want to do. So, you
10 know, that was how it operated. And I've actually
11 quoted that in my third statement.

12 Q. Can I move, then, to the question of look-back.

13 A. Yes.

14 Q. Which we can take I think much more shortly.

15 Early 1995 was when it was announced that there
16 would be a national look-back, in relation to
17 hepatitis C.

18 A. Yes.

19 Q. That followed discussions in what was the successor to
20 ACVSB, the advisory Committee on Microbiological
21 Safety of Blood and Tissues. Would it have been open
22 to the Department to decide that there should be
23 a national look-back before that?

24 A. Well, I think the reasons why the look-back was
25 started when it was, was first of all, by that stage,

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1 Q. Was there, as far as you can recall, any attempt at
2 the time, not just to note what other countries were
3 doing, but to try to explore how other countries were
4 going about dealing with these kinds of problems and
5 build on those experiences?

6 A. Well, I've mentioned in my report to the Penrose,
7 which I quoted in my third statement, I explained that
8 in a number of these other countries -- and
9 Professor Leikola, for example, who was the one that
10 was the most critical of me, he said that if he had
11 a positive donor, he would just say to them, "Oh,
12 well, there's" -- I can't remember the exact words,
13 but basically he was saying it, "Oh, well, there's
14 a problem with your donation, we don't need to do
15 anything about it. Come back next time and if it's
16 still positive, we'll then think about whether
17 anything needs to be done."

18 Which, you know, is not the way that we operate
19 in this -- or operated in this country.

20 Some of the other people responsible for blood
21 transfusion in other countries basically said that if
22 they had a positive donation, they would just bin that
23 donation, get rid of it, throw it away, and they would
24 then, if the donor came back three months later to
25 give another donation, they wouldn't tell them that,

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1 we were more certain of the tests and the validity of
2 the tests. Probably the crucial points were that the
3 feasibility of a look-back had been demonstrated
4 because in Scotland -- I can't remember whether it was
5 in Edinburgh or wherever, they had actually done
6 a pilot of a look-back, and they had said that, having
7 done it, they could actually say that it should
8 probably work and work well. And also about this time
9 we had a licensed treatment for hepatitis C. So
10 therefore, if you found that a recipient was positive,
11 you had something to offer them apart from telling
12 them, "Look, you're hepatitis C positive and that is
13 it". So therefore I think those were the sort of --
14 I think those were the main things -- I've obviously
15 put them down in detail in my statement but I think
16 those were the relevant factors at the time.

17 And I think one of the points that is worth
18 bearing in mind is that Patricia Hewitt, when she
19 wrote to Angela Robinson, I was in this hepatitis C
20 look-back working party and at the beginning of
21 January I sent a fax, which I think I mentioned, to
22 Angela Robinson and to Aileen Keel, and this was
23 an early proposal as to how look-back should operate.
24 You know, the various bits, what the responsibilities
25 would be of GPs, consultants, who had been involved in

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1 the transfusion and everything else. And Dr Robinson
2 had sent my fax, copies of it, to various transfusion
3 directors -- and I think I've mentioned in my
4 statement -- three of these there. And one of them
5 was from Patricia Hewitt from North London Blood
6 Transfusion Centre. And in it she mentions the HIV
7 look-back. Which was something that I never knew
8 about prior to this, and it's only recently that I've
9 actually gone through some of the papers that were
10 relevant to it.

11 And Patricia Hewitt, both in her statement to
12 this Inquiry, and also this was mentioned, I think, at
13 the hearings, refers to the HIV look-back. And
14 looking at it, I understand that there was something
15 of a sort of reverse look-back initially suggested
16 before HIV testing was available in the Blood
17 Transfusion Service. So it was suggested that anybody
18 with AIDS would be asked have they ever had a blood
19 transfusion, and to try to do it that way. But then
20 once the HIV blood testing was available, then they
21 very quickly started an HIV look-back, but they had
22 major problems with co-operation, particularly from
23 clinicians, because a lot of them said, "I don't want
24 to be worrying my patients about this, they've got
25 enough worries on their minds anyway"; to tell them

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1 particular reference that well, because it's one that
2 was brought to my attention, and actually was
3 mentioned by Dr Metters. This is the -- Jungner's
4 article about whether you should actually introduce
5 screening if there is any -- if there's no form of
6 treatment. And I think that -- because Dr Metters
7 obviously was aware of that particular article, and
8 I wasn't at the time. And he actually mentions it in
9 one of his minutes. And the question really is, if
10 you know -- if there is no effective treatment, it's
11 a case of how much benefit there would be.

12 Now, as you rightly say, sexual transmission is,
13 you know, very, very small in comparison to HIV. How
14 much else will it affect their lifestyle? Probably
15 not much.

16 **SIR BRIAN LANGSTAFF:** Can I just interrupt for a moment.

17 I think the question was not about your views on
18 the matter, interesting though they are, but about
19 whether there was any discussion in the Department, as
20 you remember it, about the benefits of introducing
21 screening earlier than was done, the look-back earlier
22 than was done.

23 **A.** I'm not -- well, I'm not sure whether it would have
24 been -- well, I didn't -- I cannot recall discussing
25 it. And looking through the papers I can't see any

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1 that they've got what could be a fatal disease for
2 which we have no treatment was not in their -- not to
3 their benefit.

4 So I think those were the main reasons why the
5 look-back in HIV was considered a failure.

6 **Q.** In terms of lack of effective treatment, and then
7 interferon becoming available as a reason for not
8 having done a look-back earlier --

9 **A.** Yes.

10 **Q.** -- can I just pose this to you. The fact that there
11 may not have been an effective treatment before then
12 doesn't mean, does it, that there's no point or
13 benefit in informing people that they have
14 hepatitis C? Because there are a range of measures an
15 individual might wish to take, lifestyle choices,
16 alcohol reduction or avoidance, knowing what to look
17 out for and knowing when to seek medical attention,
18 risk of transmission, which, although obviously not of
19 the same magnitude at all as HIV, it was not
20 infinitesimally small. All of those would be
21 practical advantages to telling people that they had
22 hepatitis C. Was any consideration given, as far as
23 you can recall, to those advantages at any point
24 within the Department, between 1991 and 1994?

25 **A.** Yes, well, I'd refer you -- I honestly don't know this

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1 discussion. And I suspect to a large extent this was
2 basically left to the Committee. And because it had
3 been mentioned at various times, because it was
4 mentioned right at the beginning by the Committee, and
5 it was mentioned at various Committee meetings, and
6 the fact that the Committee kept on saying, "Not yet,
7 not yet, not yet", and I'm not -- I'm not aware of any
8 internal documentation to say that the Department
9 said: We should be doing this. Irrespective of what
10 the Committee says.

11 **MS RICHARDS:** Can I then just ask you one matter arising
12 out of the MSBT's meeting on 15 December 1994, or
13 rather the minutes in relation to that meeting.

14 PRSE0003635.

15 This is the fourth meeting of the MSBT.
16 15 December '94. We can see you're present there as
17 a member of the secretariat.

18 The discussion on look-back begins back on page 5,
19 and continues over on to page 7. I just want to pick
20 it up on page 7.

21 Paragraph 7.10, we see the Chief Medical Officer
22 saying an urgent decision was needed on the matter as
23 a principle.

24 Then at the bottom of the page we can see what's
25 said there in the minutes to be the advice of the

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Committee to ministers. The first of which is:

"In the Committee's view there is a duty of care towards those infected with HCV as a result of NHS treatment. It follows that the procedures should be put in place to identify those patients at risk."

Then it goes on to talk about some of the detail.

Now those are the final minutes of the meeting on 15 December.

If we just go to WITN4460088, we can see that on the day after the meeting, Dr Metters wrote or drafted a document setting out the decision "reached by the MSBT yesterday", and we can see that same terminology, of the Department having a duty of care towards those infected with hepatitis C. So that's Dr Metters' narrative of the reasoning of the Committee.

Can I then ask you to look at DHSC0003544_075.

You wrote a memo, 16 December, so that same day as Dr Metters, and we can see you're referring -- which it looks like it had been provided to you by Mr Scofield but anyway, you say:

"Thank you for your minute of earlier today."

Then, in terms of the wording, paragraph 44 (sic), you say:

"... the [Secretary of State's] duty of care in

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these people"; as opposed to any legal niceties.

Here -- and, in fact, you would have noticed on that minute from Dr Metters that I had actually scrawled on the left-hand side there that this needs solicitors to look at, because, having been involved in the HIV Haemophilia Litigation, Dr Metters obviously is aware of it but he wasn't as closely involved as I was, and therefore I had been aware that this had been a subject that had been raised on more than one occasion during the litigation, and I'm not even sure whether the haemophilia solicitors may have actually -- I'm not sure whether they raised it -- but anyway it was raised on a number of occasions, therefore I thought this was something that we needed to make sure, particularly if there was going to be -- and the likelihood was that there was going to be some sort of press notice so as to make sure that the wording in anything that came out of the Department was appropriate.

Q. But it wasn't appropriate, was it, to change the reasoning, or suggest a change to the reasoning of the MSBT? You might think it was poor reasoning, you might disagree with the reasoning but, if that was their reasoning, that is what should be reflected in the minutes, should it not?

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respect of individuals has not been tested ..."

You refer to the HIV Haemophilia Litigation.

SIR BRIAN LANGSTAFF: Sorry, where are we?

MS RICHARDS: Paragraph 4.

SIR BRIAN LANGSTAFF: Thank you.

MS RICHARDS: And you say the main trial never happened.

Then you suggest alternative wording that you say might be more appropriate:

"... On the assumption that the NHS has responsibility toward those infected ..."

Why did you think it appropriate to try to change the reasoning that the MSBT had, according to Dr Metters' note --

A. Well, I think the --

-- that had been the basis for the MSBT's decision?

A. Well, the MSBT decision talked about a duty of care. It didn't say who had that duty of care.

And also, the MSBT is not a legal body, and they -- I don't think we had any lawyers on the MSBT, therefore they were probably unaware of the sensitivities of talking about a duty of care. I mean to say, they talked about it in a general, you know, layman's terminology of duty of care, whereby, you know, they're saying: yes, we have a duty of care, we should look after these people. You know, "look after

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A. Yes, but I think the question, really, in fact, is you would have to ask them, when you're -- and I think in the minutes, you will see that Dr Metters there refers, and I think in my minute I say there that Dr Metters -- or somewhere I referred to Dr Metters in those minutes, he actually refers to lawyers deciding about this aspect. And I -- you know, I'd have to check exactly where in my statement I've put it but, in fact, I did actually -- if you look in the minutes of that meeting, I can't remember which paragraph it is, Dr Metters actually refers to lawyers.

Q. We can check that no doubt.

Just, finally, in relation then to look-back, you were involved I think from the Department's perspective with the implementation of the look-back. Obviously it wasn't being done by the Department.

A. Yes.

Q. I think I can probably ask you this quite simply and to get it out as a matter of record without going through the detail, that you produced, I think, a series of minutes or communications in late 1995 early 1996, which recorded that the look-back was taking longer than predicted --

A. Yes.

Q. -- and you used the phrase "not being pursued with

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1 enough vigour".
2 Did the Department take any particular steps to
3 try to improve or speed up the process that you can
4 recall?

5 **A.** Yes, well I think there's a minute which actually
6 gives us several options about how -- you see, I think
7 the point was with the look-back, people had said,
8 "Oh, we will probably have this number of patients",
9 and, in fact, the number of patients that are
10 identified, I think, were significantly smaller than
11 the amount -- than the numbers that had been
12 predicted, and people were aware that there were
13 problems with the look-back, and I think I'd have to
14 look through all the papers, but there is a paper
15 which actually gives options --

16 Well, first of all, it talks about the problems,
17 and I think the problems were things like counselling
18 and I can't remember what the other -- there were
19 a whole string of problems and there were two that
20 were particularly important, and there was
21 a submission to minister about this, and saying that
22 these are the problems and these are the suggested
23 remedies, and the suggested remedies came both from
24 the MSBT and from the Blood Transfusion Service.

25 So that was all put together in a submission to

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1 **A.** Yes.
2 **SIR BRIAN LANGSTAFF:** So that takes time. The choice is
3 between having a break now, 20 minutes, let's say, and
4 then counsel goes on for half an hour, and then there
5 will be another break for half an hour, probably,
6 maybe longer, because there may be number of
7 questions.

8 **A.** Yes.

9 **SIR BRIAN LANGSTAFF:** Then we're already getting fairly
10 late in the evening.

11 **A.** Yes.

12 **SIR BRIAN LANGSTAFF:** So the choice is yours, really. If
13 you want a break now, you can certainly have one, but
14 if you'd rather soldier on, if I can put it that way,
15 then we've got about half an hour or so before we
16 can -- we will have a very extended break, probably of
17 30 or 40 minutes, and come back for what I would
18 imagine would be the final session. I couldn't
19 promise you now long that will be.

20 **A.** Well, no, I think that it will probably be better
21 to -- let's finish what we're doing now because
22 obviously it allows counsel to continue and finish.

23 **SIR BRIAN LANGSTAFF:** Thank you very much.

24 **A.** Thank you.

25 **MS RICHARDS:** Dr Rejman, I want to ask you next, without,

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1 the minister and saying to the minister: is he happy?
2 Because I think one of the options that was suggested
3 was that we completely scrap look-back completely, and
4 just basically say to people "Have you had a blood
5 transfusion? Come along and have a hepatitis C test".

6 And that was decided that that was not
7 appropriate. So there was a whole -- there was a lot
8 of discussion about it.

9 **MS RICHARDS:** Sir, I note the time. I've still got some
10 questions of my own for Dr Rejman, and there's also
11 going to need to be obviously the opportunity,
12 probably quite a long opportunity for the Core
13 Participants to suggest questions. I could keep going
14 now but I'd say I've certainly got another half
15 an hour, even with the best use of my red pen.

16 **SIR BRIAN LANGSTAFF:** Yes, well, let me offer the choice
17 to Dr Rejman.

18 Doctor, the position is that, at some stage,
19 there has to be a -- when counsel has finished her
20 questions to you, a break -- you may have picked this
21 up if you have been watching the Inquiry processes --
22 so that those who are Core Participants can put
23 questions to counsel for her to ask you after the
24 break. They are participant in this Inquiry and must
25 be given that opportunity.

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1 I think, on this topic going to any particular
2 document going to any document about hepatitis C
3 financial support.

4 So we looked at the haemophilia litigation, we
5 have looked more briefly at the establishment of what
6 became the Eileen Trust. It's right, I think, that,
7 throughout the 1990s, but probably particularly acute
8 in 1994, 1995 and 1996, the question of whether to
9 provide compensation or financial support to those
10 infected with hepatitis C, was raised --

11 **A.** Yes.

12 **Q.** -- through a number of different means, and it was
13 raised on behalf of people with haemophilia and, not
14 least, by the Haemophilia Society, it was raised by
15 MPs and so on, but also the question of financial
16 support for those infected with hepatitis C through
17 blood transfusion.

18 **A.** Yes. Yes.

19 **Q.** Now, I know we provided you with a number of
20 documents, but there are probably a number of other
21 witnesses with whom I can explore this in more depth,
22 so I'm going to take it quite shortly, just to this
23 end. There are discussions about what a scheme might
24 look like but, ultimately, during the period of time
25 that you were at the Department of Health, is this

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1 right: it remained the Department's position that it
2 was not going to provide, whether compensation or any
3 form of financial support, to those infected with
4 hepatitis C.

5 **A.** Reading -- yes, and reading through the papers, that,
6 I seem to think, was the case.

7 **Q.** Yes, and you're copied into various documents relating
8 to that?

9 **A.** Yes.

10 **Q.** But, as I say, I think I can pick that up with other
11 witnesses, and you're largely, I think, a recipient of
12 those communications rather than the author of them.

13 **A.** Yes, because I think, in a sense, you see, that was
14 not a medical decision and, in a sense, it was --
15 basically, administrators were looking at the
16 advantages or disadvantages of having some sort of
17 scheme and they were then recommending to ministers,
18 and ministers were, on a number of occasions, asked
19 whether they were content with the current situation,
20 or whether they wanted to change anything.

21 And obviously, it was up to a minister, if
22 a minister felt strongly that the amount of -- number
23 of MPs that had been asking about this or pursuing
24 this justified a change, then obviously the minister
25 would then make that decision.

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1 Now, what does that refer to, and what was agreed
2 in terms of those rules?

3 **A.** Well, I'm not sure whether there were any rules, as
4 such, agreed. I think, in essence -- because these --
5 I'm not sure whether they'd already had some writs or
6 something, it was decided that discovery needed to be
7 provided and there were a number of minutes between me
8 and various other people about, you know, should I be
9 providing this discovery, who's supposed to be doing
10 it and how much discovery and what discovery did they
11 want?

12 I think the final upshot was these -- this --
13 these papers in, I think it was early June 1995, where
14 I gave those lists of hepatitis C discovery 1989 to
15 1991 -- which you should have.

16 And I think -- as I say, there were all sorts of
17 discussions backwards and forwards, and I recall there
18 was one minute from Dr Metters actually instructing me
19 to do this work, because I think I'd actually said,
20 "Look, I'm doing other work, how important is this?"
21 And Dr Metters actually wrote back to say, "You have
22 to make this your top priority."

23 **MS RICHARDS:** Sorry, sir, I understand that the
24 stenographers are asking for a break. So I think we
25 are going to have to take a break. Perhaps I can just

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1 **Q.** But, although you were not a -- perhaps the -- perhaps
2 the most active player in that debate, you did have
3 a role on the Department's behalf in relation to
4 hepatitis C litigation.

5 **A.** Yes.

6 **Q.** Either litigation that was anticipated or actual
7 litigation that was ongoing --

8 **A.** Yes.

9 **Q.** -- in the course of the mid-'90s. I want to pick up
10 on a handful of points relating to that, if we could
11 start with DHSC0006352_081.

12 So this is a minute dated 12 April from
13 Mr Scofield to you, it refers to some -- a chronology
14 that you've provided, and so on, which we'll come back
15 to when we look at the issue of what happened to some
16 of the documents. But I wanted to ask you, first of
17 all, about paragraph 3. Mr Scofield says that:

18 "We [and that's you and him]" --

19 **A.** Yes.

20 **Q.** -- "agreed it would be helpful if SolB4 [that's the
21 relevant part of the solicitors office], CA-OPU
22 [that's the branch to which you now belong or are
23 about to belong] and yourself agreed the 'rules' [in
24 quotation marks] for 'discovering' [in quotation
25 marks] relevant papers."

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1 finish this -- the question in relation to this
2 document, and then take a break?

3 **SIR BRIAN LANGSTAFF:** Yes.

4 **MS RICHARDS:** But the message has come through that the
5 stenographers need a rest, which is entirely
6 understandable.

7 I'm sorry to have interrupted you but I think we
8 can -- we'll pick up some of those points on another
9 topic.

10 **A.** Yes.

11 **Q.** If we just look at this document and then take
12 a break, next page, paragraph 10, and I wanted to ask
13 your observations on paragraphs 10 through to 12.
14 Paragraph 10, bottom of the page. Mr Scofield says
15 this:

16 "As I understand it, our worry is as much about
17 what might come out in the course of a court action as
18 the actual verdict and I suggest therefore that any
19 examination of documents should be addressed as much
20 to their presentational significance as to the case
21 for negligence itself."

22 Then he goes on to set out his perspective on
23 the decision-making process in relation to hepatitis C
24 screening, including a concern that there was
25 inordinate administrative or bureaucratic delay, and

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1 that's the next page, paragraph 12.

2 I'm not going to ask you about the substance of
3 his concerns about the screening process because we've
4 addressed that, but it's that point in paragraph 10,
5 "our worry is as much about what might come out in the
6 course of a court action as the actual verdict".

7 Do you recall that being part of your discussion
8 with Mr Scofield? Was that your concern?

9 **A.** Well, I don't know. You see, I suspect Roger Scofield
10 is just giving a view that it would be nice if the
11 discovery only gave a good impression of what the
12 Department was doing. Now, obviously, Mr Scofield,
13 with the best will in the world -- Mr Scofield wasn't
14 there at the HIV Haemophilia Litigation, so I think
15 you have to remember that. And, therefore, he is
16 making these comments without actually having had the
17 benefit of knowing what happened then. And if he had
18 been around then, he would have known discovery is
19 what it means.

20 That means all the documents you have that may be
21 relevant are in the discovery. There's no choosing
22 these are nice, those are less good for our case,
23 therefore they're not discovered. And I suspect that,
24 you know, if he had gone back to this and read it
25 again, I suspect he may well have revised what he

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1 on. I'm not going to ask you about the substance of
2 that at all, but we've got the contemporaneous
3 documents.

4 **A.** Yes.

5 **Q.** I just wanted to ask you about what you say in
6 paragraph 5 on this page. Having expressed your views
7 about the advice that had been given and your
8 disagreement with it, you said:

9 "... we should not ask Counsel to do any further
10 work ... I would fully support Counsel's view that any
11 request to go outside, to specialists such as
12 Professor Ian Kennedy and others, poses a very major
13 risk of our enquiries becoming public, which could
14 well prejudice Ministers' freedom of action."

15 Then the minute goes on to again discuss aspects
16 of the advice, and issues relating to -- or I think
17 the campaign for compensation. It's just that
18 paragraph 5.

19 Why were you concerned that the Department's
20 consideration of this rather important issue about
21 blood products and whether they were covered by --
22 blood and whether it was covered by the Consumer
23 Protection Act should become public?

24 **A.** Um ... I presume I would have discussed this with,
25 although John Canavan isn't on the copy -- oh, sorry,

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1 said.

2 **MS RICHARDS:** Sir, I think in light of the stenographer's
3 request, we must take a break.

4 **SIR BRIAN LANGSTAFF:** Yes, we will take a break, then,
5 until 3.55.

6 **MS RICHARDS:** Thank you.

7 **SIR BRIAN LANGSTAFF:** So a 20-minute break. Slightly
8 shorter, in view of the situation.

9 (3.35 pm)

(A short break)

11 (3.57 pm)

12 **SIR BRIAN LANGSTAFF:** Yes.

13 **MS RICHARDS:** Dr Rejman, this is still within the context
14 of the HCV Litigation but I'm not asking you about the
15 details of the litigation.

16 Could we go to WITN5426048 -- no, WITN5426028.

17 This is a message you wrote to Mrs James, that's
18 Anita James, in the solicitors department,
19 28 September 1995. Now, just to put it in context,
20 but I'm not asking about the bigger picture, I'm just
21 going to ask you about one paragraph, there had been
22 advice from counsel to the Department of Health about
23 whether blood fell within the Consumer Protection Act.
24 You weren't convinced by counsel's advice, you raised
25 some views about you thought it might be wrong, and so

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1 Mr Pudlo, this is after Mr Pudlo had taken on board.

2 I suspect that I would have discussed this with

3 Mr Pudlo because, after all, it was more of

4 an administrative matter than obviously one for me.

5 And, basically, counsel had said that, at the present
6 time, when nothing really is happening, then -- and
7 what I'm saying there, basically, is that, you know,

8 I've had this -- my view and counsel's view were not

9 quite the same. But having said that, I didn't think

10 there was any point in counsel doing any more work on
11 it because the litigation seemed to have come to a --

12 Well, not to a stop but, basically, it wasn't

13 progressing. Put it like that. And, therefore,

14 I thought, well, counsel really shouldn't be wasting

15 his time doing this until such time as we knew that

16 something was going to happen with the litigation.

17 Then the second bit about -- it's counsel's view, not

18 mine, if you go outside, then there's a risk of it

19 going public. Now, Professor Ian Kennedy obviously is

20 a very well known figure and presumably was at that

21 time, and presumably it was a possibility that if he

22 or somebody else was asked something, then, you know,

23 it would get into the press and -- in a sense, you

24 see, it's a case of if it's not necessary, why take

25 a risk of things causing difficulties?

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1 Q. My question was a slightly different one, Dr Rejman.
 2 It's more: what's the problem if things become public?
 3 Why is that something to fear or try to avoid?
 4 A. Well, it's said there that it might prejudice
 5 ministers' freedom of action. Now, you don't want to
 6 be in a position where somebody says something about
 7 something and that affects what a minister can or
 8 cannot do, particularly if there's some sort of
 9 suggestion that the person whose advice has been
 10 sought is actually linked to the Department, because
 11 I think this goes back to the question of
 12 confidentiality and ACVSB.
 13 Basically, it's a case that if people know
 14 something and particularly -- and if whatever they
 15 know, it's suggested that that is something that is
 16 being advised to a minister, then that minister may be
 17 in a difficult position, particularly in the House,
 18 because MPs may say to him, "Look, you've been given
 19 this advice and why aren't you following it?"
 20 And I suspect, you know, without knowing all the
 21 detail, reading this today, that would be my
 22 interpretation.
 23 Q. On a similar theme, but relating to different
 24 materials, can we go to WITN5426007. This is a minute
 25 from you, 7 March 1995, to Mr Blake and the solicitors

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1 say -- well, it says, "minutes" and their AIDS group,
 2 now is it only the AIDS group minutes or is it all
 3 their minutes?
 4 And I think I'm asking Mr Blake "How do I reply to
 5 this letter, and, secondly, by the way, there was
 6 discussion of non-A, non-B at various times at the
 7 UKHCDO, and because currently we're in the situation
 8 of litigation here, start with writs being issued here
 9 against DH, would it be best for that sort of
 10 information not to go" -- because, you see, these are
 11 minutes that are supposed to be confidential, this is
 12 a point that I think is important.
 13 These minutes of the UKHCDO were not actually
 14 publicly available. They were actually confidential
 15 minutes and, as such, you know, that was the reason
 16 why they were asking for them. Because, if they were
 17 in the public domain, then there would have been no
 18 question about them, they could have just got them, no
 19 problem. But these minutes were confidential to the
 20 directors.
 21 Now, I don't know, I cannot remember at this
 22 period of time, exactly what my concerns were about
 23 it, but I suspect that it was linked in to the writs
 24 that had been issued or were about to be issued
 25 against DH.

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1 Department. It's in response to a letter that had
 2 been received by you from Dr Colvin about whether
 3 documents relating to UKHCDO minutes should go to
 4 the -- Professor Hardisty in relation to some Irish
 5 litigation. Again, I'm not asking you about the
 6 detail of that, it's the observation at paragraph 5.
 7 So you talk through that and you ask for advice on how
 8 to reply to Dr Colvin's letter. Then at paragraph 5,
 9 you say this:
 10 "Among the papers will be a significant amount
 11 of discussion regarding [non-A, non-B] (hepatitis C)
 12 which we might not wish to have in the public domain
 13 at the present time or in the near future."
 14 What was it about documentation relating to
 15 non-A, non-B hepatitis that you thought might be
 16 disadvantageous to the Department to have in the
 17 public domain?
 18 A. Well, obviously -- well, there are two things with
 19 this particular minute. It's not clear precisely
 20 which minutes the -- well, in fact, it's the
 21 commercial -- I think it's the commercial
 22 manufacturers who provided Factor VIII in Ireland.
 23 I think that's my reading, that they wanted these
 24 minutes to be available so that they could use them in
 25 their defence in Ireland. But it doesn't actually

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1 Q. I'm going to ask you now, as my final main topic of
 2 questions, about issues relating to the destruction or
 3 loss of documents. So some of the matters you
 4 explored in your first statement to the Inquiry and
 5 also, to some extent, in your second statement to the
 6 Inquiry.
 7 A. Yes.
 8 Q. Before I look at a handful of the documents with you,
 9 when you were at the Department, so from '89 through
 10 to '97/'98, as far as you can recall, what were the
 11 systems in place for the storage and retention of
 12 documents that might be relevant to risks of infection
 13 from blood or blood products?
 14 A. They were -- I had no idea because it was not part of
 15 my work and I never came across it.
 16 Q. Now, you've been provided with a copy of a statement
 17 from Anita James --
 18 A. Yes.
 19 Q. -- a detailed statement, I don't need to ask you about
 20 most of it. But she set out in part of her statement,
 21 and I'll just give the reference -- I don't think we
 22 need to have it on screen but let me know if you
 23 disagree it's WITN5426001, paragraph 4.108. She set
 24 out an understanding that policy files generally had
 25 a 20-year destruction date. Was that your

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1 understanding or was that not something you had any
 2 knowledge of?
 3 A. I had no knowledge of it. I think at the time when
 4 I was starting looking at the papers for my first
 5 statement, I became aware that five years was the
 6 standard timeframe at which papers were to be
 7 reviewed, and that was actually shown up on the
 8 dockets that were included in those particular ACVSB
 9 files, where it had a review date, which was
 10 five years after the final date of that particular
 11 volume.
 12 Q. Now, in 1995, you were asked, I think pursuant to
 13 a request from Mr Scofield, but also a request from
 14 Mrs James, to identify relevant documents relating to
 15 the decision-making process regarding hepatitis C
 16 screening.
 17 A. Yes.
 18 Q. Again, you've referred to those documents. I'm just
 19 going to read a couple of references into the
 20 transcript.
 21 A. Yes.
 22 Q. I don't think we need to look at it. So WITN4486997,
 23 WITN4486008 -- no, sorry, that's the wrong reference,
 24 the first one, it should be 4486007, I think, 008 --
 25 and WITN4486009 and 10.

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1 title of a set of -- a particular set of files?
 2 A. Yes, I was trying to work out what that stood for.
 3 I suspect it may stand for "general blood". It is not
 4 ACVSB, it is "GEB".
 5 Q. Then we can see you list the volumes, so volume 1 and
 6 2 not relevant, volume 3, "2 extracted". What do you
 7 mean by "extracted"?
 8 A. I would assume that meant was that I had extracted two
 9 documents from that file which were not documents that
 10 I had in my files.
 11 Q. So that I get the sequence of things right, is this
 12 correct, I think your memo to Mrs James suggested it
 13 might be, you, first of all, went through your own
 14 files?
 15 A. Yes.
 16 Q. You told us yesterday about your files. Then you went
 17 through the official files?
 18 A. Yes.
 19 Q. I want to ask you more about what those were in
 20 a moment. So this is the official files.
 21 A. Yes.
 22 Q. You're picking out documents that you think are
 23 relevant for discovery and which you haven't already
 24 got from your own files?
 25 A. That is correct, yes.

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1 So that happens in the spring of 1995. Then if we
 2 can just look at a document you provided -- a minute
 3 you provided in response to one of those documents.
 4 So, Paul, if we can have on screen WITN4486011.
 5 So on 19 May, you wrote to Mrs James a brief
 6 note to bring her up to date on how far you've got
 7 with the process. You say:
 8 "[You have] gone through all [your] files, and
 9 am now partway through the official files held by
 10 Mr Burrage. This first phase of the discovery is
 11 limited to the period 1989-1991", the relevance of
 12 which is obviously apparent.
 13 Then you say:
 14 "So far I have listed approximately 600
 15 documents, and I hope to have completed this part of
 16 the exercise by the end of next week or early the
 17 following week."
 18 Then, before I ask you a question, if we can
 19 then look at WITN4486012, and can we go to the second
 20 page of this, first of all. So this is some
 21 handwritten notes --
 22 A. These are Post-it notes, yes.
 23 Q. This is your writing?
 24 A. Yes, very much so.
 25 Q. It says, "GEB". Now that, as I understand it, is the

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1 Q. So I don't think we need to go through each volume but
 2 on the left-hand side of this Post-it note you've
 3 written "[Volume] 4 missing", and then it looks like
 4 it says, "destroyed"?
 5 A. "1989". Now, what I -- my reading of that is volume 4
 6 "missing", underlined, "1989" underlined. So it's
 7 1989 is the date of that volume. And then I've put
 8 down under there as an additional comment "Destroyed".
 9 Q. So you couldn't look at volume 4 because your
 10 understanding was that it had been destroyed.
 11 A. Yes.
 12 Q. But you were able to look at volumes 1 to 3 and then
 13 5 to 7 and then if we go back to the first page,
 14 8 through to 14.
 15 A. Yes.
 16 Q. Now, when you extracted documents, what did you do?
 17 Did you copy them in and put them back or did you
 18 leave the files filleted of those documents?
 19 A. Well, looking at the word I've used there,
 20 "extracted", that would suggest to me that I would
 21 have physically taken the document out of the file and
 22 probably put a Post-it note or whatever in the file to
 23 say, you know -- so that I knew roughly where I was,
 24 although having said that, they were all in date order
 25 so that wasn't 100 per cent necessary, and I would

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1 have then extracted those, put those to one side,
 2 asked my secretary to photocopy them and then the
 3 originals would go back to the file, so the file would
 4 have all its originals and I would have a photocopy,
 5 which I could then pass on to Anita James.
 6 **Q.** Now, in terms of the kind of documents that you found
 7 in these files, do you recall what kind of documents
 8 they were?
 9 **A.** Well, that is actually in that listing. That listing
 10 which says "HCV discovery 1989 to 1991", that will
 11 actually tell you. By looking at that listing, there
 12 were things like scientific papers, there were
 13 minutes, and what was quite interesting was that, with
 14 some of those minutes, it would say, "annotation". So
 15 if a minute had an annotation on it, that was
 16 a separate document. If it had a second annotation,
 17 that was yet another document. And if it had a third
 18 annotation, so that was yet another document.
 19 So each -- I tried to do it as thoroughly as
 20 I could so that, in essence, when it came to
 21 discovery, people could actually see and, quite often,
 22 having the three documents with the different
 23 annotations could be quite informative.
 24 **Q.** At this stage, when you were looking at the files and
 25 taking documents out to copy in the way that you've

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1 **Q.** Yes.
 2 **A.** If they were in DRO, then presumably David Burrage
 3 contacted them and said to them "Look, we need these
 4 files, could you please send them to us?" So the
 5 files then turned up in David Burrage's office. Now,
 6 I can't recall today, my assumption is that I would
 7 have given to David Burrage's office and I would have
 8 said to him "Can you give me two or three of these
 9 files?" Because, obviously, I wasn't going to bring
 10 all 14 to my -- and I would have taken them to my
 11 office and, in my office, I would have done the
 12 extraction.
 13 Having done the extraction, I would then take the
 14 files back to David Burrage in his office -- or this
 15 is the other possibility, that I ask my secretary to
 16 do the photocopying and then I put the original back
 17 in the file and then took -- I don't know.
 18 **Q.** Again, just so you can help us with the understanding
 19 on the detail, DRO, when you say it had been DRO'd --
 20 **A.** Yes.
 21 **Q.** -- where physically would that mean they were?
 22 **A.** Well, that's probably the Departmental Records Office.
 23 That's my guess as to what those initials stand for.
 24 And that would have been not on a DH site. That would
 25 have -- I don't know whether that was Lancashire or

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1 described for the list and chronology you were
 2 building up --
 3 **A.** Yes.
 4 **Q.** -- for Mrs James, were you considering possible PII
 5 and not taking documents that might be covered by PII?
 6 **A.** No, I think the PII concerns came later. I think at
 7 that stage I was literally just getting everything
 8 out, because I think to have been considering PII
 9 would have made it a much more difficult task. It was
 10 a difficult enough task anyway because I think
 11 Roger Scofield originally thought it would take
 12 a couple of days but, in fact, it took a number of
 13 weeks to do, obviously because I had other work to do
 14 at the same time. You know, this wasn't all that I
 15 was doing all the time.
 16 **Q.** Where did you obtain those files from to the best of
 17 your recollection?
 18 **A.** From David Burrage because, basically, I wouldn't have
 19 them because I didn't have the -- well, I wouldn't
 20 store files. So my understanding is that I must
 21 have -- now, did I ask him to get the files or did
 22 somebody else tell him to get the files? Some -- I or
 23 somebody else asked him to get the files. Unless --
 24 because, according to the dockets, they would have
 25 been at DRO at that time.

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1 wherever it was, I don't know. It was somewhere not
 2 in DH anyway.
 3 **Q.** So is it your evidence that you had no dealings with
 4 DRO?
 5 **A.** No, there would have been no reason for me to.
 6 **Q.** So your dealings were with Mr Burrage --
 7 **A.** Yes.
 8 **Q.** -- and you don't know what steps he took or asked to
 9 be taken in order to get the GEB files and provide
 10 them to you?
 11 **A.** Well, presumably he -- I don't know whether he sent
 12 them a minute or phoned them or whatever, and he told
 13 them what files they wanted, and obviously DRO must
 14 have had a good system whereby they could identify the
 15 files, and they sent it on to him. Then I looked at
 16 them, did my extractions, photocopied them, put back
 17 the originals, and then David Burrage presumably would
 18 have sent the files back to DRO.
 19 **Q.** Then if we just look at WITN4486013, please.
 20 These are some of the dockets.
 21 **A.** Yes.
 22 **Q.** And we looked at this during some earlier evidence
 23 last year. With volume 4, which is the one that was
 24 missing, and we can see the time period it covered,
 25 we're told, is 16 May '89 to 19 July 1990. And then

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1 we have -- it's recorded as "Destroyed on", and then
 2 it's not entirely clear, I think, in terms of what the
 3 significance of the various dates are. We've got
 4 "Sent to DRO" 30 July 1993, then we've got
 5 "Destroyed". Then we've got "Destroyed on", and then
 6 we've got a date of 9 February 1993, and then we've
 7 got dates of what were supposed to be branch review
 8 decisions.

9 **A.** Yes, but you see one of the difficulties for me in
 10 reading these dockets, is that it says, "Closed file
 11 sent to DRO Repository" on 9 February 1983, but then,
 12 on the right-hand side, it says, "Sent to DRO 30 July
 13 1993". So I don't know why there are the two dates.

14 **Q.** Were any of these dockets first of all completed by
 15 you?

16 **A.** No. Now, when I was -- I first became aware of these
 17 dockets when I was preparing my statement, my first
 18 statement. I had never -- you know, I may well have
 19 seen them, but I couldn't recall them. And my guess
 20 is that these dockets -- these dockets, as opposed to
 21 the other dockets, these dockets would have been
 22 either stapled -- well, presumably stapled to the
 23 front of the individual volume, so that, obviously --
 24 and my understanding is that where -- they talk there
 25 about branch review decision, which, as I said

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1 **SIR BRIAN LANGSTAFF:** -- in the light of your worrying
 2 about the different dates, suggest an interpretation
 3 of the top left-hand quadrant of this screen to you?

4 **A.** Yes.

5 **SIR BRIAN LANGSTAFF:** If you look at each of the four
 6 dockets, they all have the same date, 9/2/93 --

7 **A.** Yes.

8 **SIR BRIAN LANGSTAFF:** -- of the date when the closed file
 9 was sent to the DRO repository.

10 **A.** Yes.

11 **SIR BRIAN LANGSTAFF:** You have told us that your
 12 understanding is that there is a five-year period from
 13 the date the file was finished before it was going to
 14 be reviewed.

15 **A.** Yes.

16 **SIR BRIAN LANGSTAFF:** So the 19/7/90 closed date would
 17 result in 19/7/95, and if you look at each of the
 18 other dates, you still had the same exact five-year
 19 period afterwards.

20 **A.** Yes.

21 **SIR BRIAN LANGSTAFF:** Now in only one of them are there
 22 two different dates for branch review decision. All
 23 the others have a branch review decision which is
 24 five years on.

25 **A.** Yes.

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1 earlier, is five years after the last date on the --
 2 when the file refers to and so, at some stage, the
 3 branch review, which presumably would have been
 4 David Burrage branch would have reviewed it --
 5 presumably, I mean that's my guess, because it doesn't
 6 say, "DRO reviewed them", it is the branch review and
 7 presumably decide whether the document can be
 8 destroyed or not or whether it needs a further review.

9 And I think one of them -- well, yes, the 15 up
 10 there, actually gives a crossed out to the original
 11 review date and have had put in a different review
 12 date, for some reason.

13 So I think that -- as I say, I didn't
 14 see -- I cannot recall these. If they were there on
 15 the volumes when I had them, I suspect they would have
 16 been stapled to the front of the volume.

17 **Q.** Did you -- first of all, did you cause the destruction
 18 of any of these files as far as you're concerned?

19 **A.** No.

20 **Q.** Were you consulted by anybody about whether these
 21 files should or should not be destroyed?

22 **A.** It would not have been my job to do so.

23 **Q.** Can we then look at --

24 **SIR BRIAN LANGSTAFF:** Can I just --

25 **A.** Yes.

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1 **SIR BRIAN LANGSTAFF:** It might be, might it, that at the
 2 top left-hand corner, someone has written "Destroyed
 3 on" and it reads right across, 29/9/94.

4 **A.** Yes.

5 **SIR BRIAN LANGSTAFF:** So that looks as though that's the
 6 date of destruction.

7 **A.** Yes.

8 **SIR BRIAN LANGSTAFF:** Does that make sense to you as
 9 a possible reading?

10 **A.** Well, I -- I think that is the correct -- well, from
 11 my judgment that would be the correct reading. But
 12 the interesting thing is I think it's the only docket
 13 that actually says, "Destroyed on". I don't think any
 14 of the others have any reference to destruction. Not
 15 these dockets. The other ones do. The DRO dockets.
 16 Because there are separate dockets apart from these.
 17 But these dockets -- that one actually says "Destroyed
 18 on" but I cannot see any of the others that actually
 19 were -- where it's actually said, on these dockets,
 20 the date of destruction.

21 So I don't know, you see. As I say, it wasn't
 22 something that I would have been involved in in any
 23 shape or form.

24 Now, presumably somebody from the branch would
 25 have filled in the details about when the file starts

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1 and when it finishes, although it is interesting that
 2 the writing from the start and the finish seems not to
 3 be the same person. Or it's done at different times.
 4 So I don't know. Obviously there was a system that
 5 was worked up. And they're all part of this grouping
 6 of GEB 1, and -- I can't really help you any more than
 7 that, I'm afraid.

8 **SIR BRIAN LANGSTAFF:** No. It will remain for other
 9 evidence, no doubt, to deal with why it should be --
 10 or why it was that there was a destruction within the
 11 five-year period.

12 **A.** Yes.

13 **MS RICHARDS:** Now the -- just in terms of the entries for
 14 Branch Review Decision, there's "Made by", and then
 15 you'll see the stamp "GROC", and that's this Inquiry's
 16 own redaction of signatures. You've appended the
 17 unredacted form to your witness statement. Is the
 18 signature yours on these dockets?

19 **A.** Which docket?

20 **Q.** So these dockets here, if we look -- if you look at
 21 the stamp "GROC".

22 **A.** Sorry, yes. Oh, no -- no, sorry, I wouldn't have been
 23 involved in that at all.

24 **Q.** It's not yours? That's what I just wanted to just ask
 25 you to confirm. Then you refer to other dockets.

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1 the management dockets, the earlier ones, I may --
 2 I can't say definitely -- I may have seen those if
 3 they were on the files at the time when I saw the
 4 files. I would definitely not have seen these
 5 dockets.
 6 **Q.** Then if we then just go back to your own
 7 communications at the time, WITN4486016, this is you
 8 writing to Mrs James on 7 June and you have explained
 9 there that you've:
 10 "... gone through all [your] files, and gone
 11 through the files made available to me by Mr Burrage,
 12 GEB [volumes] 1-14. Unfortunately vol 4 for part of
 13 1989 has apparently been destroyed. Mr Burrage has
 14 asked for the individuals responsible to write to him
 15 formally confirming this."

16 Did you have any discussions yourself with
 17 Mr Burrage or anybody else that you can recall about
 18 what had happened to volume 4?

19 **A.** From the papers that have been made available to me it
 20 doesn't appear that I did, and I assume that basically
 21 I was doing discovery, and discovery is documents you
 22 have. Documents you don't have you can't do discovery
 23 of. So therefore I was highlighting to Mrs James, and
 24 obviously I told Mr Burrage about this, that there's
 25 a file missing. I obviously can't do any discovery on

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1 **A.** Yes.

2 **Q.** If we go to WITN4486014 --

3 **A.** Right.

4 **Q.** -- these are what you describe I think in your
 5 statement as the DRO dockets?

6 **A.** That's right. The early ones I refer to as management
 7 dockets because basically they're actually saying what
 8 is actually happening to that particular file, whereas
 9 these presumably were generated by DRO, and in fact
 10 they're just basically saying this particular volume
 11 has been destroyed on such-and-such a date.

12 **Q.** And so we can see that a number of GEB files are
 13 destroyed at various dates. We've got 1998 there,

14 1997 -- if we go over the page, because these are not
 15 I think in order, volume 4, which was the one that was
 16 missing when you looked at them, we can see there the
 17 date, 29 September 1994 --

18 **A.** Yes.

19 **Q.** -- as the date of destruction.

20 **A.** Yes.

21 **Q.** That appears to be the only file destroyed that early.

22 **A.** Yes.

23 **Q.** The others are all destroyed in either 1997 or 1998.
 24 Is that your understanding?

25 **A.** Yes. And I would point out also that whereas

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1 it if -- and here Mr Burrage is obviously just
 2 checking to make sure that that is indeed the case,
 3 that it has been destroyed, because obviously the
 4 management dockets saying "Destroyed" obviously he
 5 didn't have that, because that would have been with
 6 the volume that was destroyed. And obviously he
 7 wouldn't have had the DRO dockets because they
 8 wouldn't, presumably, have gone back to -- I assume
 9 they wouldn't have gone back to David Burrage, they
 10 would have been kept in a DRO.

11 **Q.** Do you have any knowledge as to who authorised or
 12 caused the destruction of volume 4?

13 **A.** No, I -- the information I have is literally what is
 14 written on that Post-it note.

15 **Q.** Now, did you -- you've flagged up there that volume 4
 16 has apparently been destroyed. Did you put in motion
 17 any steps to try to prevent the destruction of any of
 18 the other GEB files?

19 **A.** No, I -- basically I -- in essence, official files had
 20 nothing to do with me at all. So therefore I would
 21 not either be contributing to those -- you know,
 22 I would not be putting papers into those official
 23 files, and I would also not be sending off those
 24 official files. So I had no responsibility in any
 25 shape or form for the official files. That was other

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1 individuals. I mean David Burrage obviously had the
 2 responsibility for putting the papers into the
 3 official file. He obviously, or his successors had
 4 the responsibility to send the files to DRO, where --
 5 and I assume what happened was that as the files were
 6 filled up, then, to prevent his own office being too
 7 cluttered, he would have just sent the files off to
 8 DRO for safekeeping. And that would have been it. So
 9 I would not have been involved.

10 **Q.** Did you have any discussions with Mr Burrage that you
 11 can recall about this issue?

12 **A.** I can't recall anything, no.

13 **Q.** Then I think the issue came up again in the course
 14 of 1996, you've exhibited some of the documents to
 15 your first statement, but, again, this was in the
 16 context of disclosure in relation to hepatitis C
 17 litigation, and, is this right: a question was raised
 18 about going back to the disclosure from the HIV
 19 Litigation?

20 **A.** Yes.

21 **Q.** I don't need to trouble you with the exchange of views
 22 about whether that was a worthwhile exercise or not,
 23 but is this your understanding: that it seemed to come
 24 to light that there was some material missing from the
 25 HIV Litigation disclosure?

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1 **A.** No. I mean to say, the first time I became aware of
 2 that audit report was when I was preparing the
 3 documents for my first statement.

4 **Q.** Can we just then look at that internal audit report.
 5 Paul, can we have DHSC5087801.

6 **SIR BRIAN LANGSTAFF:** Give the number again.

7 **MS RICHARDS:** DHSC -- actually, this doesn't look right.
 8 5087801?

9 **MR HOSKING:** Yes, it is.

10 **MS RICHARDS:** It's right? Mr Hosking, who is the guru of
 11 documents, tells me that's correct.

12 If not, we have it in an unredacted format but I'd
 13 rather look at it in -- sorry, in a redacted format.
 14 I'd rather look at it in an unredacted format.
 15 Brilliant.

16 Now, others will speak to the detail of this
 17 internal audit process. I just want to ask you about
 18 what is said about you at paragraph 4.7. So this is
 19 page 6, please. So it says 4.7:

20 "Two questions remain unanswered from our
 21 review:
 22 "once the Department was aware it would need to
 23 collect relevant documentation together, Dr Rejman,
 24 who provided the secretariat role for the ACVSB, and
 25 who had previous experience of *non-party discovery*,

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1 **A.** Reading the papers that had been given to me, yes, it
 2 appears that that was the case. That in essence,
 3 I think, what the feeling was, particularly when it
 4 came to -- well, when it came to the writs about
 5 haemophilia patients, then the HIV Litigation, which
 6 obviously contained a lot of documents relating to
 7 hepatitis C, that those documents that were listed in
 8 the HIV discovery should be then considered for
 9 discovery in HCV litigation against haemophilia --
 10 brought on by solicitors acting for haemophilia
 11 patients.

12 **Q.** Now after you left the Department, there was an
 13 internal investigation or audit as to what had
 14 happened to the GEB files, because not only, by then,
 15 had volume 4 been destroyed but also, as we saw from
 16 the dockets, a number of the other remaining volumes
 17 had been destroyed.

18 You've seen, I think, a minute from --

19 **A.** Yes.

20 **Q.** -- in 2000 suggesting that there should be this
 21 Inquiry, an investigation process, and that a number
 22 of people should be contacted, including yourself.

23 **A.** Yes.

24 **Q.** Were you contacted for the purposes of that internal
 25 audit?

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1 began the process of collecting information. This was
 2 in 1994. However, Dr Rejman did not recall the ACVSB
 3 files from DRO, extracting information instead from
 4 other policy files. Some of the ACVSB files were
 5 still available, unrecalled, as late as 1997 and 1998
 6 therefore. Dr Rejman retired in 1994 [which
 7 obviously, I think, is incorrect] as part of the FMR,
 8 and we do not know why the ACVSB files, available at
 9 DRO, were not recalled ..."

10 Do you have any observations about that
 11 paragraph?

12 **A.** Yes. I have gone into it in some detail in my first
 13 statement. Right. The errors that -- one of the
 14 problems was, as you say, I think it was
 15 Marilynne Morgan that suggested that Dr Metters and
 16 I should be interviewed as part of this internal
 17 audit. I don't know whether Dr Metters was
 18 interviewed or whether there's no reference to
 19 an interview with Dr Metters in this report, but
 20 I definitely wasn't interviewed.

21 And I think that is the reason why so many
 22 errors have crept into this report. Right. Okay.

23 Yes, it is correct. I provided the secretariat
 24 role for ACVSB. No, it is incorrect that I had
 25 previous experience of non-party discovery. No, it is

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incorrect, I did not do the process of collecting information in 1994. There was no reason why I should recall ACVSB files from DRO. And I did actually obtain that information from the ACVSB files and not from other policy files. And I did not retire in 1994 as part of the functions and manpower review. So there are several errors in that paragraph.

Q. Then can I ask you then finally on this to look at the statement of Mrs James, just one paragraph. So it's WITN5426001, please. If we could go to -- I think it's page 100. Yes, paragraph 6.32. I wanted to pick it up, about a third of the way down that paragraph. She says:

"... I can see from the audit report that some of the volumes were destroyed after June 1995, that is to say after Mr Burrage, Dr Rejman and I had been alerted to the destruction of volume 4. That is why I have made clear ... above [I don't think we need to look at the other passage], that between us we *should have* ensured that a clear message was delivered that such files obviously be retained/marked for lengthier retention."

Now, do you agree -- leave aside for a moment the question of which individual should have done this, do you agree that, once it became apparent to

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he did. The difficulty is he may well have said that to an individual but where that went from then on, who is to know? That is always the difficulty.

Q. You were well placed to appreciate that these were potentially important files, should you have done something about it?

A. Well, basically, I mean to say, in my report there, I said that had I had any indication that there was a possibility of these files being destroyed, I would definitely have said, "Look, these files are relevant and important, and should not be destroyed". But, looking at the files that I had in May/June 1985, I assume that there was nothing in those files saying that this file is likely to be destroyed, because if the only docket that was on there was a review date, then I would have assumed review date is what that means. That means somebody makes a review on that date.

MS RICHARDS: Sir, those are the questions I'm proposing to ask Dr Rejman but we do now need, obviously, to afford an opportunity to Core Participants to suggest further questions arising out of Dr Rejman's evidence.

I'm afraid I think it's -- I'll certainly need half an hour, if not a little longer, so could I say 5.15?

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the Department in 1995 that volume 4 had been destroyed when it shouldn't have been, that steps should have been taken to send that clear message, which would have prevented the destruction of the remaining GEB files?

A. Well, I think that somebody, and I presume in this case it would have been David Burrage, when he was asking about has volume 4 actually been destroyed, it is possible, I don't know, I have -- there is no evidence to this -- but David Burrage was quite a conscientious individual, and I would have thought -- you know, my guess is that he may well have said to the person he spoke to, "Look, you know, we really don't want our files destroyed, particularly not before their review date", which I think was the crucial point with that file, that it was before the review date that it was destroyed.

And he -- I assume that he may well have said to the person he spoke to, "Could you make sure that our files are kept at least to the review date, and that when the review date comes up, please contact us so that we can decide whether they need further retention".

So, as I say, David Burrage was a conscientious individual. I would not be surprised if that is what

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SIR BRIAN LANGSTAFF: Yes, well, shall we say not before 5.15. So not before 5.15 and as soon as possible, obviously, thereafter.

MS RICHARDS: Thank you.

(4.38 pm)

(A short break)

(5.20 pm)

THE WITNESS: I'm sorry, before we start I wonder if I could make a correction to something I think I said during the earlier session. It was about HIV look-back. And I think I said at the end that it was a failure. I think that is probably too harsh a commentary, and Patricia Hewitt, in particular, spent a lot of time and did make a success -- at least a partial success of it. Some of the other RTCs were not able to cope as well with the problems. So if that could be put on the record.

MS RICHARDS: Yes, of course. Thank you.

Now, the questions I'm going to ask come from a range of sources so they'll dot from topic to topic, rather than being either chronological or following an issue-based order.

Could we look at NHBT0015117_001, please. If we go to the second page. This is just to clarify something, Dr Rejman.

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1 A. Yes.

2 Q. I'd asked you about cut-off dates for the scheme for
3 those who were infected by transfusion and -- or
4 tissue.

5 A. Yes.

6 Q. I think the answer is clear from this document, so
7 it's really just to make the position clear. So this
8 is a submission from Mr Scofield to the
9 Secretary of State, 20 February 1992. It goes through
10 a range of issues relating to the shape of the scheme,
11 and we can see it was copied to you.

12 If we just go to the next page, please, Paul.

13 Paragraph 5 deals with this issue of a cut-off
14 date, it says:

15 "Most HIV infections from blood/tissue will have
16 occurred between 1979 and October 1985 when testing
17 was introduced but it would be difficult to apply
18 a cut-off date. It is still possible that infection
19 could be transmitted from a donor who was in the
20 'window period' at the time of testing. Moreover, one
21 of the reported tissue cases was infected in 1986."

22 Then there's a reference to the circumstances of
23 that:

24 "Apart from that one tissue case there have been
25 no reports of infection transmitted since 1985 but we

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1 The next question goes back to the issue of
2 hepatitis C screening. I think I can ask this without
3 looking at any of the documents. You've said in your
4 witness statement, and indeed in your statement to the
5 Penrose Inquiry in response to the warning letter,
6 that if a donor in the UK tested positive the BTS had
7 an obligation to inform them.

8 A. Yes.

9 Q. That was your perspective.

10 A. Yes.

11 Q. Can you recall this: was it the case during the trial,
12 or the trials and pilot studies that were undertaken,
13 that the practice was not to inform donors who tested
14 positive?

15 A. I don't know.

16 Q. Okay, fine.

17 A. I mean to say, I think that would have been presumably
18 up to the RTC directors to make that decision, but it
19 wasn't something that was discussed.

20 Q. Then, on an unrelated topic, if we could go to
21 WITN4486016, and we looked at this shortly before the
22 break, this is the issue of the GEB files and what
23 happened to them, and it's your minute of 7 June 1995.
24 I just wanted to pick up on what you said in the last
25 sentence of the first paragraph. You say there:

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1 think it would be better to leave the scheme open
2 rather than fix a closing date which might result in
3 hard cases. However, claims of infection from blood
4 or tissue after 1985 would have to be examined
5 particularly closely in view of the safeguards then in
6 place."

7 So is it right to understand that that's the
8 rationale for the absence of a cut-off date in
9 relation to this scheme?

10 A. I think so and this actually came into play with that
11 transmission of HIV in Liverpool that was part of the
12 documentation.

13 Q. Yes. That was, I think, around 1977.

14 A. That's right.

15 Q. There was the documentations in the materials --

16 A. That's right and --

17 Q. -- but there was a transmission and the understanding
18 was that that had probably occurred because of the
19 window period.

20 A. The window period. Yes, that's correct. And in fact
21 there was one individual that was -- there were three
22 individuals infected because red cells, platelets and
23 plasma were used in three different individuals, and
24 all three individuals were covered by the scheme.

25 Q. Thank you.

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1 "Mr Burrage has asked for the individuals
2 responsible to write to him formally confirming this."

3 Now that would suggest, would this be right,
4 that you must have had a conversation with Mr Burrage
5 about this issue?

6 A. Oh, yes. I would have thought so, yes.

7 Q. Do you have any recollection now, any more about what
8 the context or who the individuals were that
9 Mr Burrage was going to contact or anything along
10 those lines?

11 A. Well, looking through the files, it would appear that
12 he tried -- well, I don't know because -- oh, this was
13 the thing. Mr Burrage left the Department about this
14 time, and I think there's some reference in one of the
15 papers to that fact, that he had left at that stage,
16 and then I think there was confusion between the loss
17 of that file and losses from the HIV Haemophilia
18 Litigation files.

19 Q. So you accept you must have had a conversation with
20 him?

21 A. Yes.

22 Q. But you can't add to what's in this minute?

23 A. No, sorry.

24 Q. We can take that down.

25 The next question is about HCV litigation but

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1 more general. What if any awareness did you have of
2 the HCV litigation taking place in Scotland at around
3 the time you were dealing with the HCV litigation in
4 England?

5 A. I'd have to look in the papers but I presume that I --
6 well, I think what you have to recall is that this HCV
7 litigation was in very early stages --

8 Q. Yes.

9 A. -- because we were actually -- reading from the
10 papers, it appears that we were chasing solicitors for
11 more information as to, you know, what they were
12 claiming, and I assume that we were probably busy
13 enough with what we were doing, without worrying about
14 what was going on in Scotland.

15 Q. Do you happen to know -- if you don't, please say
16 so -- who was performing a similar role to the role
17 you performed in relation to that -- to litigation in
18 Scotland?

19 A. Well, I presume the SMO relating to haematology, but
20 it would -- I don't know whether it was Aileen Keel
21 still at that time or somebody else.

22 Q. Well, we'll be able to ask Dr Keel about that.

23 A. Yes.

24 Q. Then, the next question relates to the timing on the
25 decision making in relation to hepatitis C screening?

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1 infection would not alert haemophiliacs to an issue
2 with signing a waiver, which included hepatitis C?

3 A. Well, I assume that a lot of the haemophiliacs may
4 well have been tested for hepatitis C by this time
5 anyway.

6 Q. Yes, the evidence the Inquiry has received, I should
7 say, suggests quite possibly not or, if they were
8 tested, they hadn't been informed. But leave that
9 aside. Was there a deliberate decision or a lack
10 of -- a deliberate lack of urgency on the part of the
11 Department of Health because they were conscious of
12 the simultaneous process of the settlement and, to put
13 it bluntly, didn't want haemophiliacs to know that
14 they'd been infected with hepatitis C because that
15 might deter individuals from signing the waiver?

16 A. I don't think that would have been a consideration at
17 all, because I think the thing is that, by that
18 stage -- and if you go back, I refer in my statement
19 to a paper from 1983 -- that's a long, long time
20 before this -- which suggested that the vast majority
21 of haemophiliacs would have been infected with
22 hepatitis C, and that was before hepatitis C had been
23 discovered, but non-A, non-B at that time. And so
24 I can't see how this would have related at all to
25 that.

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1 A. Yes.

2 Q. So we're looking at that period 1989 thorough to 1991.
3 Is it correct to understand that the trials and
4 studies being undertaken with the various HCV tests
5 that we see referred to in the ACVSB minutes would
6 validate the tests for diagnostic as well as screening
7 purpose? So they could be used to diagnose
8 hepatitis C in patients?

9 A. That might have been a side issue but I think the main
10 purpose of the validation was to see in a -- you see,
11 the point is you're talking about a low-frequency
12 group, ie donors, whereas if you're talking about
13 diagnosis, you would probably be talking about
14 a high-frequency group. And I think

15 Professor Zuckerman and others pointed out that, with
16 the first screening tests, they were good for people
17 where there was a high incidence, where obviously
18 you're going to get a high number of positives, and
19 they were less good where you had a low incidence,
20 such as blood donors.

21 Q. Was the implementation of the HCV screening, and tests
22 which might then have been used to test, for example,
23 people with haemophilia, might have revealed
24 haemophiliacs infected with HCV, was that delayed by
25 the Department of Health, so that the extent of such

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1 Q. If we go back, then, to the conduct of the
2 HIV Haemophilia Litigation, I think at one point in
3 your evidence you used the phrase of asking experts to
4 "tone down" parts of their reports. Was that because
5 the Department of Health didn't agree with the
6 experts' opinions or the opinions were critical of the
7 Department of Health?

8 A. Well, I don't know. I would have to look at the
9 individual expert reports because, for example, we
10 talked about Professor Bloom's report. Now, if we had
11 another report from somebody where there was -- there
12 seemed to be too much defence of a personal nature,
13 then that might be an appropriate thing to tone down,
14 for example. I don't know. I'd have to actually look
15 at the specifics.

16 Q. Okay. Understood.

17 It may be submitted that the Department, in
18 trying to secure experts for the haemophilia
19 litigation, were engaged in a form of expert shopping,
20 trying to find experts who supported the DH stance in
21 the litigation. What if any response would you have
22 to that submission if it were made?

23 A. Well, I think I explained yesterday that in essence
24 the way we selected the expert witnesses were people
25 I knew or people I knew of, or people, you know,

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1 that I could easily access, and then some of them
 2 obviously were from abroad. But in essence it was
 3 a case of, you know, you get an expert witness, and
 4 what you're really trying to get from that expert
 5 witness is what they can honestly say. Now,
 6 obviously, as we alluded to yesterday, if an expert
 7 witness comes up and they basically are critical of
 8 the Department from beginning to end, then I suspect
 9 we would not use them as an expert witness when
 10 a court case came, and that, I think, presumably would
 11 have been the judgment of the QC, Justin Fenwick.

12 But I think those were a relatively small
 13 minority. I think the majority of the expert
 14 witnesses were trying to give their best evidence as
 15 they could see it.
 16 Q. Do you know whether either Dr Walford or Dr Smithies,
 17 or both, were asked to provide statements of fact for
 18 the purposes of the HIV Litigation regarding the steps
 19 that were being taken by the Department at the
 20 relevant time in which they'd have been closely
 21 involved?

22 A. I was not aware. I don't think I was ever asked to
 23 comment.

24 Q. Just so it's clear, was it part of your role in the
 25 litigation to try to get those statements of fact or

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1 be conflicting hepatitis B there with non-A, non-B
 2 hepatitis/hepatitis C, which wouldn't necessarily
 3 cause jaundice?

4 A. No, I think the thing is, when you look at that report
 5 that I included, the 1983 report, the way they
 6 assessed who had non-A, non-B was on the basis of --
 7 most of them, on the basis of jaundice, some on the
 8 basis of raised liver function tests.

9 Q. Would you accept that the mere fact that an individual
 10 had had jaundice, whether it's due to hepatitis B or
 11 non-A, non-B hepatitis, wouldn't for one moment
 12 connote a knowledge of the severity of hepatitis C or
 13 the potential severity?

14 A. It would not give them any idea of the severity, no.

15 Q. Again, when we were talking about the process of your
 16 involvement in the HIV Haemophilia Litigation, you
 17 referred, I think, to a couple of occasions or you
 18 referred on two occasions when you took files or
 19 documents home.

20 A. Yes.

21 Q. I think one of those occasions you described was when
 22 you were looking at the individual statement of
 23 claims --

24 A. Yes.

25 Q. -- and producing your notes that would be in the

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1 was that being dealt with by somebody else?

2 A. Sorry? For -- oh, those expert -- evidence of fact?

3 Q. Yes.

4 A. No, it wasn't part of my role, no.

5 Q. Now, there was a point in your evidence yesterday when
 6 I was asking you about the HIV Haemophilia Litigation
 7 and the approach to the discovery exercise, where you
 8 talked about looking for and retaining documents that
 9 were considered to be helpful or useful. Was it your
 10 understanding when you were performing the task of
 11 looking at documents, trying to assist in putting
 12 together the Department's discovery, was it your
 13 understanding that the obligation was to provide all
 14 documents that were relevant, even if they undermined
 15 the Department's case?

16 A. Well, I think when I'm talking about helpful or
 17 useful, I am, basically, meaning relevant, as opposed
 18 to helpful to our case, because, at the end of the
 19 day, you know, if there were a document that we didn't
 20 discover, the chances are that the haemophiliacs'
 21 solicitors would have them anyway. So there's no
 22 advantage not to discover them.

23 Q. You talked about your assumption that haemophiliacs
 24 would know about hepatitis C, in part because a number
 25 of them may have had jaundice. Do you think you may

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1 Cardbox database, whatever it was. Is it possible
 2 that you may have taken any of the GEB files home?

3 A. No, I mean to say, I -- in fact I didn't take any
 4 files home. What I took was individual statements of
 5 claim, ie, the papers, I would take those home, and
 6 then obviously return them because obviously they were
 7 not mine to deal with.

8 Q. Can we look again at a document that we looked at --
 9 we've looked at already. It's DHSC0046962_061.

10 This was your minute of 12 November 1990. If we
 11 can go to the second page and just look at
 12 paragraph 10 again, this is where you suggested that
 13 the suggestion from the plaintiffs' representatives
 14 should be resisted fully, and you talk about how this
 15 might lead to:

16 "... absurd demands for all sorts of fancy drugs
 17 to be used as well as, for instance, giving high
 18 purity FVIII at whatever cost to these haemophiliacs."

19 Two questions I'm asked to ask you arising out
 20 of that. Were you suggesting that wanting high purity
 21 Factor VIII was wanting a sort of fancy drug?

22 A. Well, I can't recall this but I presume this was
 23 a time when you had intermediate and high-purity
 24 Factor VIII in circulation. And I think I referred in
 25 one of my -- one of the papers, there's a reference,

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I can't remember whether it was -- was it a CBLA accountability review or something like that? There's a reference there about high-purity Factor VIII, and it was stated there that I was quoting, probably, from what the UKHCDO people had said, was that at that stage there was no evidence -- no scientific evidence that there was any particular benefit from high-purity Factor VIII.

So I think this comment, and I'd actually obviously have to see exactly what was said in the compromise, but I basically, I think, was saying there that we have to be wary about any commitment to any open -- any open-ended commitment, and I think that was my -- what I'm pointing out here. It's a case that the Department would probably be quite happy to have a sort of general commitment but not something that was open-ended and could be used, you know, for other purposes.

Q. Then if we just look at the phrase "to these haemophiliacs", that particular phrase in the penultimate sentence of "giving high purity FVIII at whatever cost to these haemophiliacs", does the wording "to these haemophiliacs" suggest that you thought it was right to make a differentiation between treatment for the infected and treatment for those who

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them from? And I think the thing really is probably from unfair criticism as much as anything else. If one could see that, for example -- I don't know -- I mean to say, the Information Division that was forever sort of having to tackle comments in the press, and if we felt that the comment in the press was inaccurate, then we would obviously -- ID would ask us, you know, for a comment, you know, "Is this correct?"

And if we said, "No, we don't believe this is correct", then obviously ID would then contact the particular newspaper and say, "Look, you need to amend how you've actually put this".

So I'm not sure whether we actually were protecting ministers, as such. I think it was a case of trying to do our best to give the information that we had at our disposal to ministers, and so that they -- so that the information was there, and so that if any information, which was counter to that, then we might be trying to make sure that the correct information was out there.

MS RICHARDS: Sir, those are the questions I'm proposing to ask from the suggestions from Core Participants. I'm just going to turn and see whether Ms Grey -- no, Ms Grey has no questions.

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were uninfected?

A. Well, the way the compromise was phrased, it obviously was referring to people within the litigation. So I think what I'm saying there is that we cannot commit to them. And obviously any changes in DH's stance about use of more expensive drugs obviously would not only relate to these haemophiliacs but to all of them. And I think there I'm saying that we can't just say, "Well, these people can have this wonderful treatment", because that's what the compromise said. The compromise referred to "these haemophiliacs".

Q. Final question, or couple of questions.

To what extent did you regard it as the role of the civil servant, whether medical officer or someone who was within the administrative branch, to protect the Department or protect ministers from criticism?

A. I don't think it was a role of -- well, you see, it depends exactly what you mean by criticism of minister. Because I think what -- I think we tried to do was we tried to present advice to ministers which we thought genuinely was appropriate, in the given circumstances. And to say protecting ministers -- I think you might refer to sort of protecting ministers ... well, it's difficult to understand, because I think, you know, what are you protecting

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Do you have any, sir?

SIR BRIAN LANGSTAFF: No, I don't.

MS RICHARDS: Dr Rejman, is there anything you would wish to add?

A. Well, it's been a long day so I'll just give a very brief comment, if I may, and that is I just wanted to say again that I wish to express my genuine sympathy for those infected and their loved ones. I appreciate that this has been the cause of much distress.

I hope that my statements, based mainly on papers from the time, rather than my poor memory, has provided some additional information about events in the Department of Health at that time, thank you.

SIR BRIAN LANGSTAFF: Well, I'd like to thank you. It's often the case, and you have, I think, demonstrated it yet again, that the picture presented by oral evidence is much more revealing than the printed page. So I'd like to thank you for coming to give evidence, and enabling us to see that picture. I have a feeling that I am much clearer about your views and your approach, which has been really helpful to appreciate. So thank you very much.

And thank you for your endurance, in particular today, given the time, and I shan't take up any more of it for that reason.

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1 **THE WITNESS:** Thank you very much.
2 **MS RICHARDS:** Sir, tomorrow we hear from Dr Pickles.
3 **SIR BRIAN LANGSTAFF:** Yes, so ten o'clock tomorrow,
4 Dr Pickles.
5 (5.43 pm)
6 (The hearing adjourned until 10.00 am the following day)
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1	I N D E X	
2	ANDRZEJ STEFAN MIROSLAW REJMAN	1
3	(continued)	
4	Questioned by MS RICHARDS (continued)	1
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