ANONYMOUS

Witness Name: GRO-B
Statement No.: WITN3209001
Exhibits: WITN3209002 - WITN3209010
Dated: 31 July 2019

THE INFECTED BLOOD INQUIRY

EXHIBIT WITN3209009

ANONYMOUS

PRIVATE AND CONFIDENTIAL

RECEIVED 06 MAR 2012

THE SKIPTON FUND

ADDITIONAL PAYMENT APPLICATION FORM

PO Box 50107 London SW1H 0YF Telephone: 02078081160 Email: apply@skiptonfund.org www.skiptonfund.org

GRO-B

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28/02/12 GRO-B

FOR AN APPLICANT WHO HAS ALREADY RECEIVED THE £20,000 BASIC PAYMENT FROM THE SKIPTON FUND – PLEASE NOTE THIS FORM SHOULD ALSO BE USED WITH RESPECT TO A DECEASED PERSON.

GUIDANCE FOR THE APPLICANT

Please read the accompanying Guidance Notes before filling in this application form.

This form is only for use when the additional £50,000 payment (for anybody with an advanced stage of illness) is being claimed. Only an applicant with chronic hepatitis C infection who has developed cirrhosis or primary liver cancer or has received a liver transplant or is awaiting a transplant or has developed B-cell non-Hodgkin's lymphoma is eligible for this payment.

Most of this form must be completed by a doctor. It is intended that the existence of cirrhosis should be assessed using (a) existing biopsy data or (b) the results of non-invasive tests. A liver biopsy should not be performed purely for the purpose of making this claim.

You yourself should only sign and date this form at the bottom of this page. After that you should pass the form to the consultant physician who is responsible for your care. If applying with respect to somebody who has died, the trustees should sign and date the form instead.

DATA PROTECTION

Your personal information will only be used by the Skipton Fund on behalf of the Department of Health to check your eligibility for a payment and to administer your application. In the event of a dispute as to your eligibility for payment, your information may be disclosed to the Appeals Panel. Your information will otherwise be held in the strictest confidence and will not be shared with any other organisation.

By submitting this form to a medical professional, you consent to your medical details requested in Sections 1 to 6 inclusive being supplied to the Skipton Fund for the purpose of administering your application. If your application is deemed to be ineligible, the Fund may keep your application form on file so that we have a full historical record in the event that you lodge an appeal or if you reapply for a payment at a later stage. If you have any questions regarding the use of your information, please contact the Fund, by telephone on 020 7808 1160, by Email to apply@skiptonfund.org, or in writing to Skipton Fund Limited, Freepost NAT 18555, London SW1H 0BR.

I wish to apply for a £50,000 ex gratia payment and consent to my specialist doctor supplying to the Skipton Fund answers to the questions in Sections 1 to 6.

Signature of Applicant GRO-B **Date** 02 03 12

By signing this form I declare that the information I have given on the form is correct and complete and that I have not previously claimed for the second stage ex-gratia payment of £50,000 from the Skipton Fund. I understand that if I knowingly provide false information that I may be liable for prosecution and civil recovery proceedings. I consent to the disclosure of the information from this form to and by the Skipton Fund and the NHS Counter Fraud and Security Management Service for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

GUIDANCE FOR THE PHYSICIAN COMPLETING THE FORM

This form is only for use when the additional £50,000 payment (for an applicant with an advanced stage of illness) is being claimed. This payment is additional to that of £20,000 that the applicant will have already received from the Skipton Fund. If you are passed the form by the relatives of somebody who has died, please complete the form with respect to the deceased person.

Sections 1 – 6 of the form should be completed (as appropriate) by the consultant physician currently in charge of the applicant's care only if the applicant has primary liver cancer, has developed B-cell non-Hodgkin's lymphoma, has undergone a liver transplant or is awaiting a transplant, or if there is a distinct possibility that the applicant has cirrhosis. It is intended that the existence of cirrhosis should be assessed using (a) existing biopsy data or (b) the results of non-invasive tests. Liver biopsy should not be performed purely for the purpose of making this claim.

LAYOUT AND COMPLETION OF THIS APPLICATION FORM

Section 1 This section asks whether the applicant has undergone liver transplantation, is currently awaiting a transplant or has developed primary liver cancer. If any of these circumstances pertain, sections 2, 3, 4, 5 and 6 need not be completed.

Section 2 This section seeks information of liver histology, where available. Where histological proof of cirrhosis is available, sections 1, 3, 4, 5 and 6 need not be completed.

Section 3 This section asks whether the applicant has developed B-cell non-Hodgkin's lymphoma. If this is the case, sections 1, 2, 4, 5 and 6 need not be completed.

Section 4 This section should be completed for applicants for whom a liver biopsy has never been performed or without recent liver histology. It asks for the calculation of two simple indices, based upon readily available laboratory tests, which have been used to predict cirrhosis. The chosen indices require recent and repeatable measurements (two samples not less than three months apart) of the two liver enzymes, aspartate aminotransferase (AST) and alanine aminotransferase (ALT), and the platelet count.

INDICES:

(i) Aspartate aminotransferase to platelet ratio index (APRI)†

This index has been developed to amplify the opposing effects of liver fibrosis on the level of aspartate aminotransferase and the platelet count.

$$APRI = \frac{(AST/ULN) \times 100}{Platelets(10^9)/L}$$

where AST is in IU/L and ULN is the upper limit of normal

For example, where a patient has a platelet count of 120 x 109 and an AST level of 90 (ULN = 45), the APRI is calculated as:

$$APRI = \frac{(90/45) \times 100}{120} = \frac{2 \times 100}{120} = 1.67$$

† Wai C-T, Greenson JK, Fontana RJ, Lalbfleisch JD, Marrero JA, Conjeevaram HS, Lok AS-F. A simple noninvasive index can predict both significant fibrosis and cirrhosis in patients with chronic hepatitis C. *Hepatology* 2003; 38: 518-526

(ii) Aspartate aminotransferase-alanine aminotransferase (AST/ALT) ratio index‡

This index is based upon the observation that, as chronic liver disease progresses, AST levels increase more than ALT levels.

$$Ratio = \frac{AST}{ALT}$$

Where AST and ALT are measured in IU/L

‡Giannini E, Risso D, Botta F, Choarbonello B et al. Validity and clinical utility of the aspartate aminotransferase-alanine aminotransferase ratio in assessing disease severity and prognosis in patients with hepatitis C virus related chronic liver disease. *Arch Intern Med.* 2003; 163(2): 218-24

With regard to the additional £50,000 payment, an APRI ≥ 2.0 together with an AST/ALT ratio ≥ 1.0 will be accepted as presumptive evidence for cirrhosis. Where both these indices are at or above these cut-offs, sections 5 and 6 need not be completed. If the two indices produce discordant results, or are both below the cut-off levels, then sections 5 and 6 should also be completed.

Section 5 This section should be completed for an applicant whose application depends on establishing a diagnosis of cirrhosis and for whom a liver biopsy has not been performed (or has not been performed recently), and where the simple indices used in Section 4 do not predict cirrhosis. The purpose of this section is to record any other information already available that may assist the Skipton Fund in determining whether cirrhosis is likely to be present. This may include transient elastography (e.g. Fibro Scan®) results.

Section 6 This section must be completed in respect of an applicant who is relying upon information supplied in section 5 to support the application. It seeks an overall clinical opinion as to whether or not cirrhosis is likely to be present.

Section 7 This section asks for details and the signature of the physician who has completed the form and must be completed.

SECTION 1: LIVER TRANSPLANTATION AND LIVER CANCER

The applicant is on the waiting list for a transplant YES/NO*

The applicant has undergone a liver transplantation YES/NO*

Date(s) of transplantation (if applicable)

The applicant has developed primary liver cancer YES/NO*
(If YES, give supporting evidence in the space below)

If the applicant has undergone a liver transplantation, is on the waiting list for a transplant, or has developed primary liver cancer, please ignore sections 2, 3, 4, 5 and 6 and go straight to section 7.
**Delete as appropriate.*

SECTION 2: LIVER HISTOLOGY

Where a liver biopsy has already been undertaken as part of the applicant's clinical management, please give the following details.

Date of biopsy:

Details of histology report and diagnosis reached:

***Note:** if there is histological evidence of cirrhosis, please ignore sections 1, 3, 4, 5 and 6 and go straight to section 7.*

SECTION 3: B-CELL NON-HODGKIN'S LYMPHOMA

The applicant has developed B-cell non-Hodgkin's lymphoma YES/NO*
(If YES, give supporting evidence in the space below)

***Note:** if the applicant has developed B-cell non-Hodgkin's lymphoma, please ignore sections 1, 2, 4, 5 and 6 and go straight to section 7.*

**Delete as appropriate.*

SECTION 4: SIMPLE INDICES PREDICTIVE OF CIRRHOSIS

This section is to be completed for an applicant for whom a liver biopsy has not been performed, or without recent liver histology. The chosen indices require recent and repeatable measurements (two samples not less than three months apart) of the two liver enzymes, aspartate aminotransferase (AST) and alanine aminotransferase (ALT), and also the platelet count.

	First test result	Second test result	Upper limit of normal (ULN)
Date test performed			-
AST (IU/L)			-
ALT (IU/L)			-
Platelets x 10^9/L			

Calculated indices (See explanatory notes on pages 2 and 3)

	First measurement	Second measurement
APRI		
AST/ALT ratio		

With regard to the additional £50,000 payment, an APRI $\geq$ 2.0 together with an AST/ALT ratio $\geq$ 1.0 will be accepted as presumptive evidence for cirrhosis.

Notes:

1. *if both of these indices are at or above the specified cut-off values, go straight to section 7.*
2. *If these indices give discordant results, or both are below the specified cut-off values, please proceed to and complete sections 5 and 6.*

SECTION 5: OTHER INFORMATION

Note: Any signs of portal hypertension and/or evidence of episodes of hepatic decompensation should be mentioned in this section.

(I) CLINICAL STATUS

Clinical status and findings on physical examination:

(II) OTHER BIOCHEMICAL AND HAEMATOLOGICAL TESTS (WHERE AVAILABLE)

Date of test:

	Result	Normal range	
Bilirubin			µmol/litre
Albumin			g/l
Globulin			g/l
Alkaline phosphatase			IU/L
Alpha-fetoprotein			IU/ml
Prothrombin time			Secs
(Give normal range for laboratory)			Secs

(i) Any special tests undertaken that may predict the degree of fibrosis or presence of cirrhosis

Some clinicians may have used other tests as markers of fibrosis (e.g. hyaluronic acid). Any such tests undertaken, and the basis for their interpretation, should be described below, stating the particular test(s) used, results obtained and the basis for their interpretation.

(III) ABDOMINAL ULTRASOUND (OF LIVER, SPLEEN)

Date:

Report:

(IV) TRANSIENT ELASTOGRAPHY - e.g. Fibro Scan®.

Date:

Report:

(V) OTHER RADIOLOGICAL EXAMINATIONS - e.g. MRI, CAT Scan

Date:

Report:

(VI) ENDOSCOPY

Date:

(VII) OTHER

Report any other test results that may be relevant

Note: If section 5 has been completed, please also complete section 6.

SECTION 6: OVERALL CLINICAL OPINION

This section must be completed in respect of an applicant who is relying on information provided in section 5 as a basis for the application. It seeks an overall clinical view as to whether the applicant is thought likely to have cirrhosis based on the evidence provided in Section 5

Clinical assessment

AS PER DEATH CERTIFICATE.

SECTION 7: IDENTITY AND AUTHORITY OF THE PHYSICIAN COMPLETING SECTIONS 1-7

Name of clinician: DR GARY BENSON

Department: N IRELAND HAEMOPHILIA CENTRE

Hospital: BELFAST CITY HOSPITAL

Address: 9 LISBURN ROAD

BELFAST

Postcode: BT9 7AB

BELFAST CITY
HOSPITAL TRUST

Hospital stamp:

Clinician's GMC number: 4621997

GRO-C

Signature of clinician:

By signing this form I confirm that the information contained within parts 1 – 7 of the form is true to the best of my knowledge and belief and that if I knowingly authorise false information this may result in disciplinary action and I may be liable to prosecution. I consent to the disclosure of information from this form to and by the Trust and the NHS Counter Fraud and Security Management Service for the purpose of verification of this claim and for the investigation, prevention, detection and prosecution of fraud.

Please return the form in the freepost envelope provided to:

Skipton Fund Limited
FREEPOST NAT 18555
London SW1H 0BR