

Monday, 22nd March 2021

(10.01 am)

SIR BRIAN LANGSTAFF: Good morning, Ms Richards.

MS RICHARDS: Good morning, sir.

SIR BRIAN LANGSTAFF: You are going to tell us a bit more about this week and what to expect and what not to expect, I think.

MS RICHARDS: I am, sir. This morning I will be talking a bit about the Skipton documents and the Skipton decision-making processes. This afternoon we have Ann Lloyd, Chair of the Caxton Foundation. We then have Nick Fish on Tuesday, administrator to the Skipton Fund, also with some involvement with the Macfarlane and Caxton Foundation. We have Professor Howard Thomas on Wednesday, trustee of Caxton and director of Skipton. Then on Thursday we have Professor Mark Mildred, Skipton Appeals Panel Chair, and then Charles Lister, who we anticipate will start on Thursday but probably continue on to Friday, who was a trustee of the Caxton Foundation.

With the exception of Mr Fish, those other witnesses all potentially have evidence to give which is relevant to other aspects of the Inquiry's terms of reference. And I just wanted to explain what the Inquiry is doing in relation to that so that everyone

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significance as a witness more generally in relation to the Department of Health.

Professor Mildred will also only be asked this week about his time as Chair of the Skipton Appeal Panel. He was, as many people listening will know, one of the lead solicitors for the plaintiffs in the HIV litigation, and the Inquiry intends to ask him to provide a further witness statement to it in relation to those matters, so he won't be asked about that this week.

In relation to Ms Lloyd, some Core Participants have suggested some questions which arise out of her role with NHS Wales. Those are going to be picked up through a request for a further witness statement. So, again, when she gives evidence today, the questions will focus upon her role with the Caxton Foundation.

The one witness with whom we are taking a slightly different course is Professor Howard Thomas. He will be asked this week both about his role with the Caxton Foundation and the Skipton Fund and more generally about his work in the field of hepatitis, and there is no intention to recall him to give further oral evidence.

So that's the position in relation to this

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is clear what they will or will not be asked about this week.

Mr Lister --

SIR BRIAN LANGSTAFF: It is important they should know that because if they have questions for you to ask, they need to know if the questions relate to the parts which you are not covering in questioning this week, there is another opportunity to ask them at a later stage, and that's when they should be put forward to you for consideration.

MS RICHARDS: Yes, exactly, sir.

In relation to Mr Lister, Mr Lister was head of blood policy at the Department of Health from 1998-2003. We are not going to be asking him questions about his work for the Department of Health this week. We will be asking him to provide a further statement, and we anticipate it is likely to be a fairly substantial statement about that work, and it is likely that he will be called again to give oral evidence at a later hearing when you are hearing evidence more generally, as regards Government decision-making.

So the questions this week will simply be arising out of his connection with his work for the Caxton Foundation, but we are very alive to his

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week's witnesses, sir.

SIR BRIAN LANGSTAFF: Yes. Thank you very much.

MS RICHARDS: I am going to turn then to the Skipton fund.

The Inquiry has been investigating the decision-making of the Skipton Fund, in particular through analysis of applicant beneficiary files with a specific focus upon applications that were rejected. The written note that we have prepared and which has been provided to Core Participants summarises what has emerged from those investigations so far and also provides some context and background in relation to the Skipton Fund in advance of the oral evidence we will hear tomorrow and in the course of the week.

What I am going to do this morning is really just talk about some of the documents and some of the data that has emerged in the course of the Inquiry's investigation.

In terms of key dates, the Skipton Fund started operations on 5 July 2004 and continued until 2017 when its functions were transferred to each of the four Infected Blood Payment Schemes administered by the four national administrations. It operated a formal Appeal Panel, so again a contrast with what we have heard about the other Trusts thus far. The Appeal Panel held its first meeting in October 2006,

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1 and again we will be looking a little this morning at
 2 how it operated but in more detail with
 3 Professor Mildred when he gives his oral evidence this
 4 week.
 5 If I can just start with a couple of documents
 6 which assist with understanding the background to the
 7 establishment of the Skipton Fund. Soumik, could we
 8 have NHBT0015207_002?
 9 My screen is not working. Sorry, sir. Is your
 10 screen working?
 11 **SIR BRIAN LANGSTAFF:** It is, yes.
 12 **MS RICHARDS:** Well, I can start because I have hard copies
 13 of the document. I will just have to look at the
 14 large screen to check it's the correct one. So this
 15 was the announcement in relation to England by the
 16 then Health Secretary, John Reid, 29th August 2003 --
 17 it is now working -- we can see in the second
 18 paragraph it says:
 19 "Mr Reid said: 'After becoming Secretary of
 20 State, I looked at the history of this issue and
 21 decided on compassionate grounds this is the right
 22 thing to do in this situation.'
 23 "'I have therefore decided in principle that
 24 English hepatitis C sufferers should receive ex-gratia
 25 payments from the Department of Health.'"

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1 We will just look at that. It is HSOC0020367.
 2 You will see it is the Report of the Expert
 3 Group of Financial and Other Support March 2003 and we
 4 can see it was commissioned by the Scottish Executive.
 5 If we go to what I think will be page 13
 6 electronically, we can see the recommendations in
 7 relation to financial payments. There were a number
 8 of other recommendations which I am not going to go
 9 through at this stage but recommendation 1 was that:
 10 "The Scottish Executive should agree to make
 11 compensation payments ..."
 12 Sir, you will note there the word
 13 "compensation" rather than "*ex gratia*":
 14 "... as a matter of urgency to all people who
 15 can demonstrate, on the balance of probabilities, that
 16 they received blood, blood products or tissue from the
 17 NHS in Scotland before the dates when they were made
 18 HCV-safe and who were subsequently found to be
 19 infected with Hepatitis C virus ..."
 20 Then we can see the specific recommendations:
 21 "... an initial lump sum of £10,000 to cover
 22 inevitable anxiety, stress and social disadvantage
 23 ..."
 24 So that would have encompassed all who were
 25 infected with hepatitis C, including what we will see

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1 Sir, you will see there, sir, the phrase
 2 "*ex gratia* payments" which we are familiar with from
 3 the evidence we have heard so far from the other
 4 Trusts and schemes and the reference to this said to
 5 be a decision based upon compassionate grounds.
 6 The press release records that the details of
 7 the payments have yet to be worked out.
 8 This was clearly, as we can see,
 9 an announcement in relation to England on
 10 29th August 2003. Similar announcements were made in
 11 relation to Scotland, Wales and Northern Ireland by
 12 the respective administrations. I will look in
 13 a minute at how the scheme came to be a UK-wide scheme
 14 ultimately administered by the Department of Health in
 15 London when we look at the agency agreement.
 16 The Skipton Fund, as it became called, was
 17 incorporated on 25th March 2004 as a private company
 18 limited by guarantee without share capital. So that's
 19 its legal form and status. Its incorporation and the
 20 press release that we have seen followed the
 21 conclusion of litigation in the High Court and the
 22 judgment of Mr Justice Burton in 2001 in *A v National*
 23 *Blood Authority*, but it also followed upon the
 24 publication of a report commissioned by the Scottish
 25 Executive in 2003, usually known as the Ross Report.

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1 is referred to as natural clearers who were ultimately
 2 excluded from the Skipton Fund scheme. Then:
 3 "an additional lump sum of £40,000 to those who
 4 develop chronic Hepatitis C to cover pain and
 5 suffering ..."
 6 So all those who moved from the acute stage to
 7 develop chronic hepatitis C would receive
 8 an additional £40,000 and then at C:
 9 "... those who subsequently suffer serious
 10 deterioration in physical condition because of their
 11 Hepatitis C infection eg cirrhosis, liver cancer or
 12 other similar serious condition(s), should be entitled
 13 to full compensation. This compensation should be
 14 calculated on the same basis as common law damages
 15 taking account of the payments made under A and B
 16 above."
 17 So the recommendation there, you will see, for
 18 those who -- ultimately, a similar cohort to those who
 19 became eligible for stage 2 payments under the Skipton
 20 Fund when established, the Ross Committee's
 21 recommendation was full compensation on a Common Law
 22 damages basis. Then if we look at D we see provision
 23 there in the recommendations where those who had died,
 24 the above payment should still be made but made to
 25 their executors.

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1 Then if we look just at the bottom of the page
2 at G:
3 "people who become infected with Hepatitis C as
4 a result of the virus being transmitted from a person
5 infected by blood, blood products or tissue from the
6 NHS in Scotland shall be entitled to compensation on
7 a similar basis to those who have been infected
8 directly in this manner."

9 So effectively partners, spouses, would be
10 treated in exactly the same way as those who were
11 infected directly through receipt of the blood or
12 blood products.

13 Those were the primary recommendations of the
14 Ross Report in terms of the quantification of the
15 compensation which was recommended.

16 **SIR BRIAN LANGSTAFF:** The way that is set out, it is very
17 similar indeed to full liability compensation, as it
18 would be in the courts.

19 **MS RICHARDS:** Yes, very similar. We have seen the term
20 "compensation" no doubt deliberately chosen by the
21 Ross Committee.

22 Now, the payments that were ultimately made
23 pursuant to the scheme set up fell some considerable
24 way short of these recommendations.

25 **SIR BRIAN LANGSTAFF:** They were not assessed on

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1 it's entitled:
2 "Hepatitis C from blood" ex gratia scheme ..."
3 So already we have gone from compensation
4 through John Reid's announcement in August 2003 of ex
5 gratia, and we see *ex gratia* is still the language

6 **used here:**

7 "... Details of proposed parameters and
8 administration.

9 "Purpose

10 "To seek Ministers endorsement of the detailed
11 parameters that will apply to the scheme and for the
12 proposals for administering it.

13 "Priority

14 "Immediate. Department of Health ... are
15 proposing that there is a joint announcement by the
16 four UK Health Ministers on either 18 or 19 December
17 and Mr Chisholm will wish to inform cabinet colleagues
18 before this."

19 Then if you look under the heading

20 "Discussion", paragraph numbered 1:

21 "This minute outlines the proposals jointly
22 agreed by the officials of the Scottish Executive, DH,
23 Welsh Assembly government and Northern Ireland
24 administration. The basic parameters already
25 announced in Scotland are retained (ie £20k basic

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1 a compensation basis.

2 **MS RICHARDS:** They were not and obviously nothing for
3 natural clearers who were effectively excluded from
4 the scheme once it was up and running. Then we will
5 look at the quantification of the payments for those
6 at stage 1 and stage 2, but very much less than the
7 sums contemplated here and not on a compensation basis
8 at all.

9 Clearly, the extent to which the
10 recommendations of the Ross Report were considered by
11 Government decision makers and the reasons why those
12 particular recommendations were not implemented will
13 need to be explored with relevant Government and civil
14 service witnesses in due course.

15 We do have some insight into some aspects of
16 Government thinking, however, from a document at
17 SCGV0000256_020.

18 If we go to the next page, please, Soumik, if
19 we carry on, this is an e-mail from Bob Stock,
20 11th December 2020, so it's an internal Scottish
21 Government document. It provides some insight into
22 the thinking of the Scottish Government but also some
23 broader insight into the thinking behind the
24 establishment of the Skipton Fund in place of the
25 recommendations of the Ross Committee. We can see

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1 award, £25k on reaching medical trigger, no payments
2 to those who clear the virus spontaneously or to
3 dependants of those who died before 29 August) ..."

4 Those are the features that the Skipton Fund
5 then provided:

6 "... but are then augmented to cover detail on
7 eligibility, supporting evidence and on how the scheme
8 would be administered."

9 Although this is a Scottish Government
10 document, it is said to reflect that which has been
11 agreed by the four respective Departments of Health.

12 If we go over a further two pages, please,
13 Soumik, and we can see there "Proposed scheme
14 parameters". I am not going to go through it
15 paragraph by paragraph but we will see broadly what
16 the Skipton Fund scheme was going to be and did
17 become. Under the heading "Eligibility date":

18 "No payments will be made in respect of people
19 who died before 29 August 2003."

20 Then the next heading:

21 "Eligibility for Basic Award of £20,000."

22 That's the stage 1 award, as it became known.
23 The "Criteria" are there set out:

24 "Potential beneficiaries will receive the basic
25 award of £20,000 if they have been infected with blood

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1 or blood products before September 1991."
 2 There we see the eligibility cut off date.
 3 Then if we go over to what I think will be page 8, we
 4 can see here the proposed arrangements for the
 5 administration of the fund. Under the heading "Single
 6 UK scheme".
 7 "It is proposed the four UK administrations
 8 operate essentially identical schemes with identical
 9 awards and that the most efficient way of dealing with
 10 this is for payments on behalf of all four
 11 administrations to be handled as part of a single UK
 12 scheme -- administered by a single independent Trust."
 13 In the next paragraph we learn why it is called
 14 Skipton Fund:
 15 "It has been suggested that this might be named
 16 Skipton Trust."
 17 It took the form ultimately of a limited
 18 company, not a charitable Trust:
 19 "The basis for this is that the substantive
 20 negotiations between officials of the four
 21 administrations took place in Skipton House, London."
 22 Then we see reference to the Macfarlane Trust,
 23 this is paragraph 3, having agreed to take on the task
 24 of setting up and administering the new trust. You
 25 will recall, sir, we have heard from Mr Peter Stevens

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1 29 August."
 2 Then there is a reference to the Haemophilia
 3 Society having recommended payments to dependants of
 4 the deceased and also the reference to the expert
 5 report. And it is recorded that Macfarlane and Eileen
 6 Trusts made such payments.
 7 **SIR BRIAN LANGSTAFF:** Indeed. It was part of the very
 8 original trust deed for Macfarlane that they should.
 9 **MS RICHARDS:** Yes. Then if we go down to "Presentation
 10 and Parliamentary implications":
 11 "In the event that all four UK health ministers
 12 agree that the scheme should proceed on the base
 13 described, then press, health and special advisers
 14 will need to liaise urgently with the other
 15 administrations, particularly the Department of
 16 Health, to develop a common approach to the media.
 17 This approach should attempt to emphasise positive
 18 aspects (compassionate gesture [that's the terminology
 19 used], non-bureaucratic path for making claims,
 20 independent nature of administration and scrutiny
 21 arrangements) whilst recognising that challenges will
 22 be made regarding award levels being too low and
 23 dependants of the deceased being excluded."
 24 Then if we go to the next page, please. If we
 25 look at the heading "Commentary on scheme parameters.

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1 about his involvement in that.
 2 "Financial arrangements
 3 "The four administrations would be billed by
 4 the Trust for awards paid out to beneficiaries
 5 attributable to the relevant country. The logical
 6 method of attribution would be that the beneficiary
 7 had been infected as a result of treatment in that
 8 country."
 9 Then there is an alternative, which would be
 10 that the beneficiary was currently resident in that
 11 country.
 12 5 tells us that:
 13 "Department of Health would take the lead in
 14 dealing with the new Trust. The four administrations
 15 would contribute to the establishment and running
 16 costs of the Trust and possibly also to an initial
 17 working capital fund."
 18 Then if we go to the next page, please, we see
 19 a heading "Key issues":
 20 "Sensitivities.
 21 "The Haemophilia Society has been made aware of
 22 the likely scheme parameters and believes them to be
 23 unacceptable. This is principally because they feel
 24 the awards are too low and because no payments are to
 25 be made to the dependants of those who died before

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1 Underlying philosophy", we see this in paragraph 8:
 2 "The underlying philosophy spelled out in
 3 previous public statements in Scotland is that
 4 establishment of the scheme is as follows"
 5 "This is a compassionate gesture -- not a tacit
 6 acknowledgment of liability or wrongdoing.
 7 "As such, awards are *ex gratia* payments -- not
 8 compensation.
 9 "Expenditure on scheme has to be balanced
 10 against the needs of other healthcare priorities (and
 11 the needs of other patients).
 12 "This means only limited funding can be spared.
 13 "Within the constraints of limited funding, the
 14 people who should be targeted for financial assistance
 15 are those who are still alive and suffering the
 16 adverse effects of being infected with hepatitis C."
 17 Whilst this obviously is, as it were,
 18 a discussion document, this does, I think, effectively
 19 reflect the way in which the Skipton Fund was within
 20 the weeks and months that followed set-up and the
 21 basis upon which it operated.
 22 There is then a discussion about the medical
 23 trigger for the additional £25,000 award, so for the
 24 stage 2 payments.
 25 Then if we go to the next page, we will see at

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the bottom of the page under the heading "Commentary on standard of evidence". This is a theme I will pick up in the course of the morning:

"The passage of time since the original infection means that potential beneficiaries face real problems in producing irrefutable evidence. In particular, clinicians who treated them may be retired or deceased, and hospitals may have difficulty in finding their medical records or may have legitimately destroyed them. In recognition of this, it is proposed that the lower standard of 'on the balance of probabilities (rather than 'beyond reasonable doubt') is adopted for evidence."

Then paragraph 16 says:

"It is certain that virtually all blood products produced from pooled donations will have been infected with hepatitis C. It is proposed that where Claimants have received such products, then no further evidence will be required to establish that they were infected via blood products. Virtually all haemophiliacs will fall into this category."

Just going back to the previous paragraph, paragraph 15, it is unclear from this why a standard of proof used in criminal proceedings might ever have been contemplated or thought to be a useful approach

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award."

Then this:

"People who receive payments under the scheme would undertake not to institute future legal proceedings against the NHS or ministers in relation to the situation that formed the basis of those payments."

Whether that is something that in practice was adopted is a matter I am hoping to explore with Mr Fish tomorrow. But you have heard evidence, sir, from one individual who had a recollection in relation to the Skipton Fund of being asked to sign an undertaking, although it is right to say the Inquiry's investigations of the beneficiaries' files have not found anything to suggest that that was the practice. But it is a matter we will want to take up with witnesses this week.

So those are a couple of relevant documents which precede the establishment of the scheme.

I want to turn next to the agency agreement that governed the way in which the scheme operated. It is at SKIP0000033_066, please, Soumik. Sir, we obviously heard a lot of evidence in relation to other financial schemes about the relationship between the Trust or the body and the Department of Health.

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to adopt. But, in any event, we see here what's said is that the lower standard of on the balance of probabilities should effectively allow for the difficulties that potential beneficiaries might face in finding evidence through records or being able to get evidence directly from clinicians.

SIR BRIAN LANGSTAFF: It would follow if this were the pattern adopted, but the absence of a medical record was and could not normally be decisive.

MS RICHARDS: Precisely. But as we will see, the absence of medical records led in practice to many applications being rejected.

SIR BRIAN LANGSTAFF: I have read a lot of statements to that effect, individual statements.

MS RICHARDS: Just one final part of this document. It is the next page, and it is the bottom of this page under the heading "Variations and conditions". We can see it says:

"People who have received compensation as a result of a successful legal action against the NHS (or an out-of-court settlement in relation to a legal action) would have that deducted from the total award.

"People who have received compensation as the result of a successful legal action against a product supplier would have that deducted from the total

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In relation to the Skipton Fund, the fund operated as an agent of the Department of Health, and this is the document that governed the relationship. This is the first signed agency agreement. There were then various variations and modifications made to the scheme as the years went by, but you will note the date: 22 May 2007. This is nearly three years after the Skipton Fund began to operate and received and began processing its first applications. Quite why it took three years for the agency agreement to be concluded is no doubt a matter we will want to ask relevant Department of Health witnesses in due course. And, again, you will recall I asked Mr Stevens about that.

If we go to page 3, please, Soumik, we can see that the parties are the Department of Health and Skipton Fund Limited. The background is set out at A:

"On 29 August 2003, the Secretary of State for Health and the health ministers of the devolved administrations simultaneously announced that a UK-wide scheme would be set up to make *ex gratia* payments to certain persons who were treated in the UK under the National Health Service by way of the receipt of blood, tissue, or a blood product and, as a result of that treatment, became infected with

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hepatitis C virus."

Sir, we looked at 29 August 2003 John Reid press announcement. You will see from this, as I indicated, simultaneous announcements were made by the health ministers for devolved administrations.

If we go to the bottom paragraph on this page, please, you will see there, in terms of the relationship between the Secretary of State for Health, as a party to this agreement, and the devolved administrations at C tells us:

"The Secretary of State for Health and the devolved administrations have entered into a service level agreement by which the Department of Health acts on behalf of the devolved administrations in relation to Skipton, and the parties contribute their proportionate shares to the funds distributed."

If you go to the top of the next page, paragraph D, top of the page:

"Skipton has been formed to provide services acting as the DH's agent on the basis set out in this agreement."

Then if we go just in this definitions section towards the bottom of the page, you will see there the reference to "Eligibility":

"Means eligibility of a qualifying person to

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and those who have received or are on the waiting list to receive a liver transplant are eligible to apply for a stage 2 payment."

Then if we look at the -- still on the screen "The scheme", in italics, we can see what's meant by that:

"A scheme set up to make *ex gratia* payments to eligible persons alive on 29 August 2003."

So there is the exclusion of those who had died prior to that date. And there, as part and parcel of the scheme, is the concept of these being *ex gratia* payments.

If we go to the next page, we then see a little more --

SIR BRIAN LANGSTAFF: Can you just go back two pages from this? And again. Yes, that's fine. Thank you.

MS RICHARDS: If we go to electronic page 6. Thank you.

That's it. We can see here a little more about the relationship between the department and Skipton. 2.1:

"In furtherance of a policy initiative, DH has resolved to appoint Skipton as its agent to implement and administer the services in and throughout the UK.

"DH appoints Skipton to be its agent in the UK for the delivery of the services and carrying out of the services subject to the terms and conditions set

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receive a payment under the scheme."

It's decisions on eligibility we will be focusing on with Skipton witnesses this week because there was no discretion then as to the amount of payment -- the payments followed a decision on eligibility.

Then if we go to the next page, bottom half of the page, we can see here the terminology used by the Skipton Fund and by the Department of Health of stage 1 payments and stage 2 payments, and that was the:

"... lump sum payment of £20,000 to any person who on the balance of probabilities has contracted HCV because of receiving blood, blood products or tissues from the NHS prior to September 1991, or in certain circumstances from the person who has received such treatment.

"Stage 2: an additional lump sum of £25,000 payable to a qualifying person who has an advanced stage of illness due to hepatitis C virus because of receiving blood, blood products or tissues", et cetera.

Then if we go over the page, we can see a little further information as to who qualifies for stage 2 at the top of the page:

"Persons with cirrhosis or primary liver cancer

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out in this agreement."

At 2.4:

"DH warrants it is the authorised representative of Scottish ministers, National Assembly for Wales and the Department of Health, Social Services and Public Safety (Northern Ireland), together being all the devolved administrations responsible for the provision of the NHS throughout the UK."

Then 2.5, and we looked at this with Mr Stevens; it's an important provision:

"Skipton acknowledges that:

"1. As a Government department, DH is directly accountable to the Secretary of State for Health.

"2. Government policy is subject to amendment from time to time.

"3. DH has a duty to act in accordance with the policy of the devolved administrations.

"4. It [that's Skipton] may only alert DH to operational issues and may not make proposals to amend Government policy."

So that's the constraint that was placed upon the kind of matters that the Skipton Fund could raise. And, again, you will recall Mr Stevens' evidence as to how effectively his understanding was. He couldn't

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say anything about Government policy or how the scheme should be reformed but only raise what was termed "operational issues".

If we look at clause 2.6 at the bottom of the page:

"Skipton acknowledges that the rights of DH detailed in clause 2.5 above shall be an overriding principle in the construction and performance of this agreement and shall take precedence over all other terms and conditions detailed herein, save that such rights shall not negate nor diminish the indemnity set out in clause 6.2."

So the idea that the Government policy is subject to amendment was effectively part of the overriding principles in the construction and performance of the agreement.

Then if we look further down this page, we see reference to Skipton's obligations:

"Skipton will provide the services in accordance with the specifications set out in schedule 1.

"Skipton shall be responsible for providing the services and shall, within the scope of Skipton's resources, meet the service levels."

Then if we go to the next page, clause 4.5:

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Soumik, I just want to flag up the confidentiality provisions:

"Confidential information [this is clause 9.1] includes all information relating to the claimants as well as to the plans, intentions, affairs and/or business of Skipton; and.

"The negotiations relating to this agreement."

And then we see in 9.2:

"Each party shall, subject to the DH's obligations to comply with the Freedom of Information Act and Governmental policy concerning that Act ...

"Keep all confidential information strictly confidential;

"Not disclose any confidential information to a third party [other than in limited circumstances]."

If we just go further down, 9.2.3:

"Use confidential information only in connection with the proper performance of this agreement."

So a very wide definition of confidential information not only relating obviously to individual beneficiaries where an obligation of confidentiality would be entirely understandable, but also negotiations relating to the agreement and the plans, intentions, affairs and business of Skipton all said

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"DH and Skipton shall meet every six months, or as required, to review operational issues [that phrase again] arising from the scheme. Additionally, both parties shall make themselves available for additional meetings on reasonable written notice from the other."

If we go over the page, clause 6.3, we can see reference there to an independent appeals panel:

"DH shall as soon as possible after the commencement date arrange for the provision of an independent appeals panel to adjudicate on claims rejected by Skipton."

So it was the Department of Health's responsibility to set up the appeals panel. Again, for reasons that are not entirely clear and may need to be explored with relevant witnesses from the Department of Health, that took over two years from the commencement of operations of the Skipton Fund, with the result that there was I think something of a backlog for the appeals panel when it first met in early October 2006. And obviously those who had had their applications rejected in that intervening two-year period had no appeals panel to whom they could immediately go for reconsideration of their application because it had not been set up.

If we then go a further two pages on, please,

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to be confidential.

If we go to the next page, clause 9.4, we can see a prohibition at 9.4 on Skipton making announcements or public statements about the services without the prior written agreement of the Department of Health.

If we then go to -- it is probably electronic page 21, Soumik, schedule 1. These are the services. So this is what the Skipton Fund was supposed to do as the Department of Health's agent. Paragraph 1:

"Skipton shall perform such services and no other as are necessary to administer the scheme."

Then paragraph 2 provides for a registration process, so a registration form being made available by post and online.

Then at 3, "Payments":

"On receipt of a completed application form for a stage 1 payment, Skipton will, having made appropriate checks of authenticity of both the claim and the clinicians supporting the claim, assess whether the Claimant's eligibility for such a payment has been established on the balance of probabilities and, if appropriate, make the payment to the bank account supplied by the Claimant on the completed registration form."

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1 So those are the two key elements of Skipton's
2 work. The decision on whether the individual was
3 eligible to be established on the balance of
4 probabilities, and then, two, if so, the mechanics of
5 making the payment to the individual applicant.
6 That's for stage 1.

7 Paragraph 3.2 tells us that:

8 "When making a stage 1 payment, Skipton will
9 tell the Claimant that an application form for a stage
10 2 payment will be available on request."

11 3.3:

12 "Where a claim for a stage 1 payment has been
13 refused, Skipton will inform the applicant of the
14 right of appeal."

15 Then 3.4 tells us the procedures for processing
16 claims for stage 2 payments will be broadly similar:

17 "If a claim for a stage 2 payment is rejected,
18 Skipton will inform the Claimant that a further claim
19 can be [I don't know whether "made" is missing] in the
20 future, should their disease progress. Applicants
21 whose stage 2 payment is rejected nevertheless have
22 the right to appeal."

23 Then over the page under the heading "Appeals":

24 "An independent appeals panel having been
25 provided in accordance with clause 6.1, Skipton will

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1 provide the secretariat and organise all necessary
2 meetings of the panel, prepare cases to be considered,
3 record the panel's decisions and communicate the
4 decision to each appellant."

5 Mr Fish, as we will hear tomorrow, acted as the
6 secretariat for the appeal panel as well as the
7 administrator of the Skipton Fund.

8 Then if we go to schedule 2, which is on the
9 next page, we can see it is headed "Qualifying
10 persons", and we see:

11 "A person is a qualifying person if ..."

12 Then there is a reference to being alive on
13 29th August, so the exclusion of those who died:

14 "And who, before September 1991 [so there we
15 have the cut-off date again] was treated with NHS
16 blood, blood products or tissue and as a result of
17 that treatment on the balance of probabilities became
18 infected with the hepatitis C virus and developed
19 chronic infection. People who acquired hepatitis C
20 but spontaneously cleared the virus in the acute stage
21 and did not develop chronic hepatitis C infection are
22 not eligible for payments under this scheme."

23 So there we see the exclusion of spontaneous or
24 natural clearers in contrast to the first
25 recommendation.

30

1 **SIR BRIAN LANGSTAFF:** Well, it is not quite the exclusion
2 of natural clearers. They would have to clear within
3 the first six months.

4 **MS RICHARDS:** Yes. Within the acute stage.

5 **SIR BRIAN LANGSTAFF:** Presumably -- this is a question --
6 the last sentence there, the issue of people who
7 spontaneously cleared in the acute stage and didn't
8 develop chronic hepatitis, that is also to be
9 determined on the balance of probability, isn't it?

10 **MS RICHARDS:** Yes. That's my understanding, but again it
11 is a matter to be explored with Mr Fish and
12 Professor Thomas.

13 **SIR BRIAN LANGSTAFF:** Well, if nothing were said in what
14 is effectively a legal document -- it is a legal
15 document -- you would assume balance of probabilities
16 unless some other standard were put forward.

17 **MS RICHARDS:** Yes.

18 **SIR BRIAN LANGSTAFF:** Yes.

19 **MS RICHARDS:** Then we can see the second aspect of being
20 a qualifying person. The first bullet point:
21 "... a person who has haemophilia or other
22 inherited or acquired bleeding disorders, whether or
23 not also infected with HIV. This will include all
24 those who have developed hepatitis C virus after been
25 treated with Factor VIII or Factor IX blood clotting

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1 factor, together with all those who have developed
2 hepatitis C virus after being treated with any of the
3 following products."

4 Then we see them set out:

5 "Cryoprecipitate, FEIBA, plasma, whole blood or
6 any components thereof (provided that the treatment
7 consisted of multiple doses)."

8 So that's the position for those who had
9 bleeding disorders.

10 Then the next bullet point deals with those:

11 "... without any bleeding disorders who
12 developed hepatitis C virus after being treated with
13 any of the following products:

14 "Whole blood or any components thereof,
15 albumin, bone marrow, intravenous immunoglobulin,
16 plasma, (including fresh, frozen plasma) and DEFIX."

17 **SIR BRIAN LANGSTAFF:** So what is the position of somebody
18 who actually has haemophilia but in the ordinary
19 course of events has a blood transfusion for some
20 other unrelated cause and that transfusion is infected
21 or contaminated? On the basis of this, he wouldn't
22 qualify, or she wouldn't qualify, because there's
23 a person who has haemophilia, and there wouldn't be
24 multiple doses.

25 **MS RICHARDS:** Yes. I don't know is the answer, sir.

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1 That's a very good question to raise with Mr Fish
2 tomorrow.
3 There are some guidance documents that I will
4 look at in the course of the morning. I am not sure
5 whether they help us answer that particular question
6 or not.
7 **SIR BRIAN LANGSTAFF:** It is a matter of interpretation of
8 the deed, and so the view of the administrator doesn't
9 really take us very far, does it?
10 **MS RICHARDS:** Only insofar as it tells us what as a matter
11 of practice was done in such cases, or if such cases
12 as a matter of fact arose.
13 **SIR BRIAN LANGSTAFF:** Yes.
14 **MS RICHARDS:** Then the third bullet point, so the third
15 category of qualifying person:
16 "Someone on the balance of probabilities
17 becomes infected by transmission of the virus from
18 a qualifying person (in the categories above) if at
19 the time of transmission that person was in one of the
20 following relationships with the qualifying person
21 from whom the virus was transmitted."
22 So this is what's I think termed in some places
23 in the documents "indirect infection". Such a person
24 who is infected is a qualifying person only if they
25 fall within certain categories of relationships:

33

1 If we look at one further document, you will
2 see a particular issue that seems to have arisen as
3 a result of that delay. It is SKIP0000071_017. If we
4 go to page 5. This is an e-mail from Mr Fish to
5 someone within the Scottish Executive, and he says in
6 the second paragraph:
7 "I have a query which I would like to run by
8 the Scottish Executive as they were responsible for
9 the particular section of the agency agreement that
10 I am questioning (as far as I'm aware)."
11 That is the bit about those who are indirectly
12 infected:
13 "A lady has applied to the Skipton Fund
14 following a needle stick injury sustained whilst
15 working as a nurse in England. The third party who
16 she was treating when she sustained the needle stick
17 injury was a successful recipient of the first stage
18 payment. Since the lady is not [then we see she
19 doesn't fall within any of the qualifying
20 relationships] a spouse or civil partner, or in
21 a similar relationship, or a cohabitant, or mother or
22 daughter ... it seems as if we have no option but to
23 reject her application. Is this correct, as far as
24 you see it?
25 "Until this change was made, she would have

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1 "Spouse or civil partner; other cohabitant;
2 mother, son or daughter of the mother."
3 Then we see the second part of this:
4 "And the infection occurred as a result of:
5 sexual transmission; transmission from a mother to her
6 baby; accidental needle stick injury (but limited to
7 the relationships described above and excluding the
8 sharing of needles by injecting drug users); or some
9 other route, verified by a qualified medical
10 practitioner but limited to the relationships
11 described above and excluding the sharing of needles
12 by injecting drug users)."
13 Then if we go to the next page, paragraphs 4
14 and 5:
15 "Persons who qualify for and receive a stage 1
16 payment will be eligible for the stage 2 payment if
17 they develop cirrhosis or primary liver cancer or
18 receive or are the waiting list to receive a liver
19 transplant."
20 Then 5:
21 "No payments are made in respect of those who
22 died before 29 August 2003."
23 So that's the original agency agreement signed,
24 as I say, nearly three years after the fund itself
25 began operating.

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1 been eligible for a payment and it is possible that
2 similar cases may have gone through (albeit a very
3 small number) before this alteration was made. It
4 seems to me that this lady deserves a payment but is
5 excluded by the wording of the agreement."
6 I may want to ask Mr Fish about that tomorrow,
7 but you'll see it would appear from this that prior to
8 the agency agreement being finalised and signed, the
9 Skipton Fund had been taking a slightly different
10 approach to needle stick injuries where someone was
11 infected through that route as a result of contact
12 with someone who was themselves a qualifying person.
13 The Skipton Fund was determining that they were
14 eligible without requiring them to be within one of
15 those qualifying relationships, but that changed, it
16 would appear, once the agency agreement was
17 formalised.
18 The Skipton Fund, or the way in which it was
19 set up, attracted criticisms from a number of
20 quarters. I am just going to invite your attention to
21 one document in that regard. It is SKIP0000034_010.
22 This was a submission from the Scottish Haemophilia
23 Forum in March 2005. And you will see in the first
24 paragraph:
25 "The Skipton Fund arose only as a result of the

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1 campaigning in Scotland by the Scottish Haemophilia
2 Forum, the motion supported by 80 MSPs from all
3 parties, the unanimous support of the 1999-2003 health
4 committee of the Scottish Parliament and the decision
5 of the then health Minister Malcolm Chisholm."

6 And reference to an announcement he made in
7 January 2003. Then the perspective of the Haemophilia
8 Forum then set out in the next paragraph:

9 "Sadly since then, the work of the Scottish
10 Parliament appears to have been hijacked by
11 Westminster."

12 And reference then made to the simultaneous
13 announcements about what was going to be set up.

14 And then you will see in the third
15 paragraph reference to the meetings being held in
16 London at Department of Health offices in Skipton
17 House, thus the funding has been named after
18 a building, and so on.

19 If we look over the page, we see the heading
20 "Issues of concern". Then there are some particular
21 concerns set out regarding the appeals panel process.
22 I am not going to go through the details of all of the
23 concerns that are expressed, but there are a couple of
24 more general concerns that merit attention at this
25 stage.

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1 were not permitted to attend.

2 "15. Will the appellant be able to have legal
3 representation and who will meet the cost?"

4 To which the answer is: if an appellant sought
5 any form of representation, they would have to meet
6 the cost. Then at 17:

7 "How will appellants obtain expert opinion to
8 challenge the decision of the medical panel?"

9 Again, we will look at the practicalities of
10 that when we look at some of the case studies.

11 Then if we go a little further down the page,
12 the paragraph beginning:

13 "We would urge the committee to amend the bill
14 and remove the discrimination refusing payments to the
15 dependants of those who have died prior to
16 29 August 2003."

17 So concern being expressed by the Scottish
18 Haemophilia Forum about the exclusion of those who had
19 died.

20 So that's just one example of concerns
21 expressed about the arrangements that were made.

22 Over the years of its operation, the scheme
23 underwent several revisions. Initially, there -- as
24 well as the requirement that the people be alive on
25 29 August, there was provision that a person who died

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1 So paragraph 1:

2 "1. Why is there a need to set up a private
3 company limited by guarantee, given that its function
4 will only be to administer the fund by sending out
5 application forms, making payments based on a set
6 criteria and rejecting others.

7 "2. Given that Skipton will be funded by
8 public finance, why is it not part of a Government
9 department, thus ensuring that a Minister be
10 politically responsible and answerable to elected
11 members?"

12 "4. Why has the money provided as an *ex gratia*
13 payment to people infected with hepatitis C ... being
14 used to pay the staff of Skipton?"

15 Then a series of questions about the appeals
16 panel and how that will work. A number of concerns
17 there expressed. Again, we may be able to explore
18 some of these with Professor Mildred.

19 If we go to the next page and we pick up at
20 paragraph 12:

21 "Where will hearings take place?"

22 "13. Will the appellant be able to attend?"

23 So that is all about how the Appeal Panel might
24 operate, and we know there were no oral hearings as
25 such. There was no attendance by appellants; they

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1 after 5 July 2004 had to have applied to the

2 Skipton Fund before their death. That was amended in
3 around 2006, but the restriction on making payments to
4 those who died prior to 29 August remained in place at
5 that stage.

6 It wasn't until 2011 that there were more
7 substantive amendments to the scheme. So the stage 2
8 payments were then -- this is in the post-Archer
9 period -- increased to £50,000. Provision was made
10 for a regular payment, and the scheme was finally
11 opened to the estates of people who died prior to
12 August 2003. I am not going to go through the various
13 revisions to the agency agreement, but the various
14 iterations of the agreement have been disclosed to
15 Core Participants.

16 Then there were further changes in
17 November 2016. It might be worth just looking at
18 that. It is at SKIP0000031_042. These were revisions
19 made by way of directions from the Secretary of State.
20 We can see:

21 "The Secretary of State makes these directions
22 by virtue of clause 1.1 of the agency and services
23 agreement made between the Secretary of State for
24 Health and Skipton Fund Limited."

25 The reference there to 24 March 2011 is to one

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of the later agency agreements.
 We can see at paragraph 1:
 "Skipton shall, in accordance with the agreement, pay:
 "Each qualifying person the annual sum ..."
 It was an uplift, an increase in the annual sums introduced in 2011 or thereabouts, and:
 "A bereaved spouse or partner a one-off sum of £10,000."
 So that was the introduction of one-off payments to bereaved spouses.
 Then we can see what the annual sums were. We see here differences between the four administrations.
 1.(2) (a) deals with the English provision:
 "In relation to a qualifying person for whom the Department of Health for England is liable to contribute funding ... [the annual sum] is:
 "(i) £3,500 (of which £500 is designated a winter fuel payment where that person is eligible for a stage 1 payment.
 "(ii) £15,500 where that person is eligible for a stage 2 payment."
 So this, as of 2016, was the sum contemplated by way of annual payments in England.
 In relation to Scotland, we see at

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for something called the special category mechanism, but those proposals weren't, in fact, implemented during the operation of the Skipton Fund. It was incorporated into the English Infected Blood Support Scheme, and we will no doubt explore that with an appropriate witness in due course.
 So, as it were, that was the architecture of the Skipton Fund and how it came into existence.
 In terms then of how decisions on eligibility were made, there are three documents I'm just going to draw attention to. The first is SKIP000031_248.
SIR BRIAN LANGSTAFF: You are missing a nought somewhere.
MS RICHARDS: SKIP000031_248. So this is a document which it would appear would be available to or might be provided to potential applicants. This is one that postdates the 2011 revisions to the scheme. But we can just see it gives broad information about the process. So if we look at the bottom half of the page "How does the scheme work", we can see there, again, the basic architecture of the scheme, the £20,000 lump sum payment. That's at (a). Then at (d) we can see the additional £50,000 payment for stage 2. So we can see it is after the increase from £25,000 to £50,000.
 (f) tells us:
 "It will be assumed that people who have

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paragraph (b):
 "In relation to a qualifying person for whom the Scottish ministers are liable to contribute ...
 "(i) £27,000 where that person is alive and has received a stage 2 payment or a stage 2 top up and is not infected with HIV.
 "£18,500 where that person is alive, and also infected with HIV and in receipt of an annual payment from MFET and has received a stage 1 payment."
 So a different level from the English payments.
 Then if we go over the page, we can see the provision next in relation to Wales which is the same figures as in relation to England, so:
 "£3,500 where the person is eligible for a stage 1 payment; £15,500 where the person is eligible for a stage 2 payment.
 Then at (d) in relation to Northern Ireland:
 "A qualifying person eligible for a stage 2 payment, a sum of £14,749."
 Which seems a rather oddly specific sum.
 So those are the changes made in 2016, and we see there the divergence between the four administrations.
 There had then been proposals in the course of 2017 by way of the issuing of a consultation document

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developed hepatitis C after being treated with Factor VIII or Factor IX clotting concentrates were infected as a result of that treatment. Virtually all haemophiliacs will fall into this category.
 "(g) No payments will be made in respect of those who have cleared the virus spontaneously in the acute phase of the disease.
 "(h) The scheme will not pay any legal costs that people incur in preparing a claim from the Skipton Fund."
 So there is the answer to one of the questions raised by the Scottish Haemophilia Forum.
 Then we go over the page. We can see here the mechanics of the application process:
 "1. How do I apply?
 "(a) If you want to apply for payment, you can do so by completing the online registration form or by applying direct to the Skipton Fund.
 "(b) The Skipton Fund will send you an application form containing comprehensive guidance on how to use the form. After answering a few questions concerning your application and signing the form, you should then pass it to your doctor who will answer the questions that relate to your illness and how you might have been infected."

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1 That's an important feature of the process.
 2 Most of the work was expected to be done by a doctor,
 3 and it was the clinical opinion that was sought, with
 4 there being very little scope at the first stage, the
 5 application stage, for an individual to provide any
 6 form of additional supporting information.
 7 Then if we go a little further down the page,
 8 what happens once the form has been completed:
 9 "When the form is completed, your doctor will
 10 send it to the Skipton Fund."
 11 So that was the process: the applicant would
 12 put in their details, they'd then provide it to their
 13 doctor, their doctor was supposed to complete the rest
 14 and send it off.
 15 "(b) The Skipton Fund will then check the
 16 information on your form. If further information is
 17 required, the Skipton Fund will write to inform you or
 18 the doctor who completed the form."
 19 Then:
 20 "3. What happens if my doctor is unable to
 21 provide the information required?
 22 "If your doctor is unable to provide the
 23 necessary information e.g. because some or all of your
 24 medical records are missing, they'll send the form to
 25 the Skipton Fund anyway with an explanatory note. The

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1 the completed application form, of having their own
 2 copy of the completed form. There was no provision
 3 for the doctor to complete it and then give it back to
 4 the applicant, who would then send it off. The route
 5 was set up to be via the clinician, which raises
 6 obviously potential difficulties when it comes not
 7 least to questions of appealing.
 8 Then if we go towards the bottom of the page,
 9 the penultimate bold question:
 10 "Do I need the help of a lawyer when applying
 11 for a payment from the Skipton Fund?"
 12 It says:
 13 "The Skipton Fund application process is
 14 designed to allow people to take forward their
 15 application themselves. The forms only require you to
 16 provide very basic information and your doctor will
 17 supply the necessary medical input. Therefore, there
 18 is no need for you to consult a lawyer. However, you
 19 are free to seek legal advice, if you wish. For
 20 example, if you are considering appealing ... the
 21 decision is yours, but please note that the Skipton
 22 Fund will not pay any legal costs that you may incur."
 23 So that's one document about the process
 24 relating to stage 1 applications.
 25 In relation to stage 2 applications, if we go

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1 Skipton Fund will then write to you explaining what
 2 action should be taken."
 3 Then:
 4 "4. What do I do if I disagree with a Skipton
 5 Fund decision?
 6 "(a) If you disagree with a decision of the
 7 Skipton Fund, you can appeal."
 8 Then if we go to the next page, "The Skipton
 9 Fund -- additional information". If we go towards the
 10 bottom of the screen, we can see the question:
 11 "Will I have to prove that it was NHS treatment
 12 that caused me to have hepatitis C?
 13 "The Skipton Fund will consider applications on
 14 the balance of probabilities where there is evidence
 15 of an applicant receiving blood or blood products,
 16 including Factor VIII or Factor IX blood clotting
 17 concentrates.
 18 "Can I see what my doctor has written about me
 19 on the application form?
 20 "You are entitled to see the answers your
 21 doctor has made to the questions in the application
 22 form. If you want this information, you should ask
 23 your doctor."
 24 So an applicant would not even be in
 25 a position, unless their doctor gave them a copy of

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1 to CVHB0000009_118, please. So this is a guide to
 2 applications for stage 2. If we look at the second
 3 main question:
 4 "How do I know if I qualify for the additional
 5 payment?
 6 "In order to qualify, you must first have
 7 received the basic £20,000 payment from the
 8 Skipton Fund. Provided this is the case, you should
 9 then automatically qualify for the additional payment
 10 if ..."
 11 Then we see the reference to liver transplant,
 12 or waiting list, or liver cancer:
 13 "Alternatively, if you and your specialist
 14 doctor suspect or have confirmation that you have an
 15 advanced stage of liver damage called cirrhosis, you
 16 may also qualify."
 17 So not there put as an automatic qualification
 18 in the way in which this document expresses itself.
 19 Again, that's a matter that we will need to explore
 20 with witnesses this week.
 21 Then:
 22 "I think I qualify for payment. How do
 23 I apply?"
 24 Reference is made to application form:
 25 "If you have advanced liver disease, you will

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almost certainly be under the care of a specialist doctor or consultant. You should take the application form to that specialist and discuss whether that your present condition is likely to qualify you for the payment."

Bottom of the page:

"How do I get the evidence that I need to apply for the additional payment?"

Again, reference is made to the specialist doctor who will be asked to complete the application form by providing evidence based on tests or medical history.

Over the page, under the heading "The application form", we can see after the first question, it says:

"The medical questions in the application form are not designed to be completed by you personally ... they should be completed by the specialist doctor looking after your liver condition."

Then the next question:

"My specialist doctor and I agree that I am likely to qualify for the additional payment. What do I do now?"

Then reference is made to the doctor in many cases being able to:

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application form gives your specialist the opportunity to provide other supporting evidence (such as that obtained from a physical examination, other blood tests or any scans et cetera you may have had) that might be helpful in deciding whether you are likely to qualify for the additional payment."

Then under the heading "When the application form is completed", if we go a little further down the page, you will see there is an italicised paragraph:

"The Skipton Fund can't make a payment with the information your specialist doctor can provide."

The next paragraph says:

"If you wish to see the information that's been supplied about you, you should ask your specialist doctor for a copy of the completed form."

Again, the route is: the doctor completes the key parts of the form, sends it off to the Skipton Fund, and the applicant only has a copy if their doctor provides it to them.

So that's the information about stage 2.

Then there is one set of internal guidance which I would like to look at before we take a break. SKIP0000030_045. "Guidance on assessing an application for the £20,000 payment":

"Evidence is defined as information supplied on

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"... complete the form simply using information from your medical records."

The next paragraph says this:

"If you do not automatically qualify for payment and do not have the necessary medical information or tests results in your medical history, your specialist will need to arrange for further non-invasive tests to determine whether you are likely to have cirrhosis."

Then further information is set out about that:

"What tests might I need to have?"

Reference to a liver biopsy, but that being an invasive procedure which carries an element of risk. It says:

"Your specialist doctor will not carry out a biopsy just to support your claim."

In the last paragraph, references to various blood test results which may be sufficient.

Then if we go over to the next page, again there is more information about the process of testing. And if we look just above the big heading "When the application form is completed", we can see it says:

"The results of the blood tests may not always provide a clear-cut answer. In such cases, the

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an application form ..."

And we have seen the application form insofar as the applicant is concerned is a few basic questions. So the bit of the application form which makes provision for substantive information to be provided is that completed by the doctor:

"Authentic documentation, e.g. from any NHS establishment, the National Blood Service, et cetera. Opinion, confirmation, or signed authority from the a clinician, or attestation by an authorising signatory that the Claimant has no history of intravenous drug misuse."

So no provision there, for example, for personal statement by the applicant or the applicant's parents or the applicant's spouse or sibling setting out recollections of receipt of a blood transfusion. That's not included in this list or definition of what's said to amount to evidence.

Then we see a series of questions, and we can see this is relatively early guidance because it predates any of the changes.

"1. Is there evidence that the Claimant is alive or died between 29 August and 5 July and has been/was chronically infected with hepatitis C for a period of more than six months?

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1 "Yes -- continue with the section.
 2 "No -- reject application."
 3 So that's the initial assessment of whether it
 4 is a qualifying person:
 5 "Is the Claimant a primary infectee?
 6 "Yes -- continue with this section.
 7 No -- go to section 4.
 8 "Is the Claimant a haemophiliac?
 9 "Yes -- go to section 2.
 10 "No -- go to section 3."
 11 We then need to follow through the
 12 decision-making process.
 13 Section 2 is for haemophiliacs, which I think
 14 is a shorthand for all those with an inherited
 15 bleeding disorder:
 16 "Is there evidence of NHS treatment with
 17 Factor VIII or Factor IX blood products before
 18 September 1991?
 19 "Yes -- approve application."
 20 So that effectively is all that's required:
 21 "No -- continue with this section.
 22 "Is there evidence of NHS treatment with other
 23 blood or blood products before September 1991?
 24 "Yes -- continue with this section.
 25 "No -- go to section 2."

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1 Claimant's infection occurred because of exposure to
 2 NHS blood or blood products before September 1991?
 3 "Yes -- continue with this section.
 4 "No -- reject application."
 5 Over the page:
 6 "Is there evidence that a particular incident
 7 or course of treatment ... was responsible for the
 8 Claimant's infection?
 9 "Yes -- continue with this section.
 10 "No -- reject application."
 11 So the Claimant has to pinpoint a particular
 12 incident or course of treatment, otherwise their
 13 application gets rejected, according to this.
 14 The next question we see framed in the same way
 15 as in relation to haemophiliacs:
 16 "Is there evidence that a source of infection
 17 other than NHS blood or blood products could be
 18 responsible for the Claimant's infection?
 19 "Yes -- reject application."
 20 Only if no, there is no evidence of a possible
 21 other source, does the application get approved.
 22 **SIR BRIAN LANGSTAFF:** So what is the position, applying
 23 this guidance strictly, to someone who comes to have
 24 hepatitis C identified in the early 1990s who has in
 25 the 1970s had one transfusion, 1980s two more? They

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1 This is section 2. Quite how that's meant to
 2 work is unclear.
 3 Next question:
 4 "Is there evidence that a source of infection
 5 other than NHS blood or blood products could be
 6 responsible for the Claimant's infection?
 7 "Yes -- reject application."
 8 So you will see that that question is repeated
 9 in the other sections of this guidance. So this would
 10 seem to suggest that the existence of any evidence
 11 that there's a possible source of infection other than
 12 NHS or blood or blood products was supposed to lead to
 13 the application being rejected, rather than
 14 an approach of assessing on the balance of
 15 probabilities which was the likeliest cause of
 16 infection.
 17 **SIR BRIAN LANGSTAFF:** Yes. It looks very much like proof
 18 beyond reasonable doubt.
 19 **MS RICHARDS:** Yes. And, again, it is an issue we will
 20 want to explore with relevant witnesses.
 21 **SIR BRIAN LANGSTAFF:** Indeed. It isn't necessarily
 22 reasonable. It could be.
 23 **MS RICHARDS:** Yes, absolutely. So that's section 2,
 24 haemophiliacs. Section 3 is non-haemophiliacs:
 25 "Is there any evidence to suggest that the

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1 can't necessarily say which particular incident or
 2 course of treatment caused it.
 3 **MS RICHARDS:** No, they can't. Whether that would have led
 4 in practice to a rejection is unclear. I don't think
 5 we have seen any individual files that would suggest
 6 that approach being taken, but we may not have seen
 7 any individual files on those particular facts.
 8 The practical impediment that seems to have
 9 been faced by many applicants really is either the
 10 absence of what was regarded as acceptable evidence,
 11 i.e. almost always records, medical records, or
 12 a suspicion being raised that there might be another
 13 cause, in which case applications, according to this,
 14 fell to be rejected. We have seen some support for
 15 that in the individual files that we have examined.
 16 I am not going to go through the series of
 17 questions for section 4, indirectly affected
 18 Claimants, but again there are a series of questions
 19 there set out, and there is a similarly phrased
 20 question, the fourth question:
 21 "Is there evidence that a source of infection
 22 other than that of exposure to the blood of the
 23 primary infectee in a domestic environment could be
 24 responsible for the Claimant's infection?
 25 "Yes -- reject application."

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1 Sir, I note the time. I am going to move now
 2 to a slightly different topic and just look briefly at
 3 the appeals process. Is this a convenient moment for
 4 a break?
 5 **SIR BRIAN LANGSTAFF:** Yes. We will take a break until
 6 11.45. So 11.45, please.
 7 **(11.15 am)**
 8 **(Short break)**
 9 **(11.45 am)**
 10 **MS RICHARDS:** Sir, before I move to the appeal process we
 11 were looking at the guidance in relation to the
 12 application forms. Once the application form was
 13 received by the Skipton Fund, in some cases if the
 14 fund administrator thought that further information
 15 was required, the form would be returned either to the
 16 applicant or the completing clinician. Once the form
 17 was completed to a level which seemed to the
 18 administrator, as far as we can tell, to contain
 19 adequate information for the purpose of making the
 20 decision, a decision on eligibility would be taken by
 21 the administrator, so by Mr Foster and then about
 22 Mr Fish, but would require, as it were, a sign-off
 23 from one of the directors. Again, no doubt Mr Fish
 24 will be able to tell us a little more about how that
 25 works in practice when he gives evidence tomorrow.

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1 itself, but only to examine the process to determine
 2 the claims within the terms of the scheme.
 3 "Appeals may be made against both stage 1 and
 4 stage 2 payments."
 5 Decisions -- if we go over the page, we can see
 6 the details of the Appeal Panels members. The chair
 7 was Professor Mildred, who we are hearing from this
 8 week. If we look down the page, we will see there was
 9 a lay member, a hepatology member, and if we go to the
 10 bottom of the page, a haematologist, Dr Patricia
 11 Hewitt, from the NHS Blood and Transplant and, over
 12 the page, also a GP.
 13 In terms of the Appeal Panel guidance notes
 14 provided to applicants whose claims had been rejected,
 15 we can see those at NHBT0090738. These guidance notes
 16 are not dated, so it is not clear at what point in the
 17 Appeal Panel's life they began to be provided to
 18 applicants.
 19 We can see at the top of the page:
 20 "The following notes are for your guidance to
 21 help you provide the information the Appeal Panel is
 22 likely to need in order to fully consider your
 23 appeal."
 24 Then the next paragraph refers to balance of
 25 probabilities. The last sentence of that paragraph:

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1 Then in terms of appeal if we go to -- let me
 2 find the reference -- SKIP000030_023, you will see
 3 there that the Skipton Fund Appeal Panel members were
 4 appointed by the NHS Appointments Commission. I think
 5 the written note suggests that the appointment was
 6 made by the Department of Health. It is actually by
 7 the Appointments Commission but the Appointments
 8 Commission was an arm's length public body and not the
 9 Department of Health, but associated with the
 10 Department of Health.
 11 We can see that the appointments were finally
 12 made with effect from 1st September 2006. If we look
 13 down to the bottom of the page, we can see the "Terms
 14 of Reference" of the Appeal Panel:
 15 "The role of the Appeal Panel is to reconsider
 16 the cases of any claimants who appeal against
 17 individual decisions made by the Skipton Fund. The
 18 Panel will look at how the decision was reached and
 19 examine all available evidence, or seek further
 20 written evidence where necessary, in order to either
 21 confirm or change the Skipton Fund's decision. In
 22 considering the evidence the Appeal Panel will look
 23 solely at the written evidence and will not seek
 24 personal attendance. The Panel will not be able to
 25 consider appeals against the ex-gratia payment scheme

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1 "... it has to have been a probability and not
 2 just a possibility that your infection with
 3 hepatitis C occurred in this way."
 4 Then we can see there is a discussion of
 5 missing records:
 6 "The most common reason for an initial refusal
 7 by the Fund is the absence of documented records of
 8 eligible exposure ... This may be because:
 9 "the records exist but do not mention
 10 a transfusion or other exposure
 11 "the records are lost or destroyed.
 12 "2. Make every effort to obtain and produce
 13 for the Panel as much as you can in the way of
 14 hospital records ..."
 15 Paragraph 3 suggests that they ask the GP to
 16 look through GP records.
 17 "4. If the records are not available, obtain
 18 and produce a letter to that effect from the hospital
 19 records department and/or GP.
 20 "5. Provide a personal statement for the
 21 Appeals Panel giving, in as much detail as you can,
 22 what operation, procedure, accident or illness led to
 23 the procedure ... when it occurred and why, in your
 24 recollection, a transfusion (or other exposure) was
 25 needed or occurred.

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1 "If you have any witnesses to the alleged
2 exposure (for example relatives or hospital visitors)
3 you should get a statement from them and include it
4 with your appeal.

5 "With any written evidence of the treatment you
6 believe led to your infection with hepatitis C, please
7 provide a photograph of your operation or injury scar.

8 "In the absence of complete records the Panel
9 will make a judgement on the likelihood of your
10 exposure to hepatitis C given the type of treatment,
11 the circumstances and the outcome that you describe."

12 So the Appeal Panel looked at a wider range of
13 evidence than the initial application process
14 permitted or contemplated. How the Appeal Panel then
15 dealt with that wider range of evidence we will have
16 a look at some examples and we will no doubt wish to
17 explore with Professor Mildred.

18 Why it was that the same invitation was not
19 issued to applicants at the outset is unclear,
20 because, of course, there may have been applicants who
21 could have provided personal statements, witness
22 testimony and the like at the first stage, didn't
23 because there was no opportunity for them to do so,
24 and effectively they gave up. It would only be
25 through going through the appeal process that you

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1 "other recreational drug use including snorting
2 cocaine ..."

3 Quite why that is thought to be relevant is
4 unclear:

5 "... sexual activity involving the exchange of
6 bodily fluids with a person infected with
7 hepatitis C."

8 Then "Other Reasons for Refusal". There are
9 set out a number of potential other reasons for
10 refusal: one is the cut-off date of September 1991;
11 another example at (c) is treatment abroad; (d)
12 discrepancies in the application form; (e) natural
13 clearance.

14 If we go to the next page, we can see
15 paragraph 4. This is at advice given to those
16 appealing:

17 "Obtain a copy of your original application
18 form ..."

19 We have seen the process did not provide for
20 the applicant to have that, so they have to make the
21 effort to get that:

22 "... and make sure that you agree with what
23 [has been said]."

24 Then paragraph 5 deals with the position of
25 natural clearers in some detail. Then bottom of the

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1 would receive these notes suggesting that a wider
2 range of evidence be considered. As I say, it is not
3 clear why that approach was taken.

4 If we go over the page:

5 "Intravenous Drug Use.

6 "Applicants who have had a history of exposure
7 to recreational intravenous drug use (such as heroin)
8 are unlikely to succeed in their appeal. This is
9 because expert advice shows that the chance of getting
10 hepatitis C from even the smallest degree of IVDU is
11 many times greater than the risk of getting
12 hepatitis C from a transfusion. However, because the
13 panel considers each case individually, you should
14 document all your intravenous drug use in as much
15 detail as you can.

16 "The Panel will make a judgement on the
17 relative likelihood of your having obtained hepatitis
18 C from intravenous drug usage or from NHS treatment."

19 We will look at what the expert advice was in
20 a few minutes:

21 "Other Risk Factors."

22 So we will see that the panel asks applicants
23 to identify other factors that might have contributed
24 to the risk of infection:

25 "... tattoos

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1 page:

2 "Please note that the Appeals Panel does not
3 have any power to consider cases that fall outside the
4 Skipton Fund scheme."

5 Applicants were not able to make
6 representations in person, as I have indicated, and it
7 appears from the Inquiry's investigations that the
8 Panel's view was that it didn't have the power to do
9 so, but the basis for that can no doubt be explored
10 with Professor Mildred.

11 The Inquiry's analysis so far of the
12 information it has received in terms of applications
13 and what happened to them suggests that the Appeal
14 Panel overturned 49.6% of the rejections that were
15 referred to it. We can take that down. Thank you.

16 In terms of the burden and standard of proof,
17 we have seen that the burden was regarded as being on
18 the applicant, the standard of proof was expressed to
19 be on the balance of probabilities. There is some
20 evidence, which I will be exploring with Mr Fish
21 tomorrow, to suggest that additional measures put in
22 place following the discovery that the scheme
23 administrator had defrauded the Skipton Fund may have
24 led to a stricter approach to applications. It
25 became, for example, a requirement that a copy of

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1 medical records should be provided to the Skipton
2 Fund. As I say, we will look at some documentation
3 relating to that with Mr Fish tomorrow.

4 There is evidence to suggest that that in turn
5 caused or might have caused financial difficulties for
6 individual applicants. You will recall, sir, during
7 the evidence of Dr Giangrande that we explored the
8 charge that was imposed by the Oxford University
9 Hospital's NHS Foundation Trust for completing the
10 stage 2 forms, and we have seen in various
11 documents -- or the Inquiry has seen in various
12 documents -- potential costs to the applicant in
13 trying to get copies of medical records. They would
14 be charged for that.

15 Just to complete the picture in relation to
16 what happened in Oxford, if we go to WITN5573001,
17 please, the Inquiry, following the evidence of
18 Dr Giangrande, asked the Oxford University Hospital's
19 NHS Foundation Trust to explain why charges were
20 imposed for the completion of the stage 2 application
21 forms and received a statement from Dr Susie Shapiro
22 on behalf of the Trust.

23 If we go to the second page, we pick it up in
24 paragraph 5. She did not have any information beyond
25 that stated in the letter from Dr Giangrande to the

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1 I mention that, sir, because we set the hare
2 running, as it were, during the evidence of
3 Dr Giangrande and those familiar with that evidence
4 may wish to know what happened in terms of the
5 Inquiry's further investigation of that issue. The
6 extent to which that was a course taken by other
7 Trusts is currently unclear, but certainly applicants
8 to Skipton having to pay for copies of records is
9 highly likely to have occurred across the country.

10 **SIR BRIAN LANGSTAFF:** The hurdles in terms of making
11 an application and then making an appeal would be
12 these, if it is a hurdle, in the first place knowing
13 there is a Skipton Fund. You have shown me this
14 morning considerable detail in a document plainly
15 intended to be read by a patient rather than a doctor
16 and intended to inform them about Skipton, but how did
17 they know where to go to get that document and how did
18 they get hold of it?

19 **MS RICHARDS:** There is a document that was made available
20 to by the Skipton Fund to those who had some knowledge
21 of the Skipton Fund and therefore needed to make some
22 form of contact. In terms of what steps were taken by
23 the Skipton Fund to promote its existence, that's
24 a question we are going to need to ask Mr Fish about
25 tomorrow.

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1 Skipton Fund, which we looked at during his evidence.
2 Then if we go to the bottom of the page, the Inquiry
3 asked if the fee was levied against patients directly.
4 She answered:

5 "It appears from the records that the ... fee
6 was levied against ... patients' relatives directly."

7 Then if we go to the next page, paragraph 8, we
8 will see she was asked about whether other forms were
9 charged for:

10 "The Trust has found no evidence of a separate
11 fee being charged by clinicians for completion of
12 other forms."

13 But she recorded that:

14 "... the Trust has historically charged for
15 photocopying medical records centrally."

16 That appears to have been the position until
17 July 2017, according to paragraph 8.

18 Then if we go over the page, paragraph 12, she
19 says:

20 "The Trust wishes to apologise that patients
21 were charged for the completion of Skipton Forms. As
22 this is not representative of the supportive approach
23 that we strive for, the Trust is taking steps to
24 refund the relatives of patients for any fee incurred
25 for completion of the Skipton Fund forms."

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1 **SIR BRIAN LANGSTAFF:** So we have no documents about it?

2 **MS RICHARDS:** There are no documents I can call to mind,
3 immediately at least, that tell us the answer to that
4 and it's a question we will also want to direct to the
5 Department of Health because the Skipton Fund was the
6 agent of the Department of Health, delivering services
7 on its behalf. So there's a bigger question of what
8 steps were taken by the Department of Health or indeed
9 the Health Departments of the devolved
10 administrations, as it were, to broadcast or advertise
11 the existence of the Skipton Fund more widely.

12 We do know -- again, this is something Mr Fish
13 may be able to assist with but we know applications
14 continued to be received by the Skipton Fund
15 throughout its life. So applications were still being
16 made in 2016, 2017 in circumstances where obviously
17 the infection had to have occurred before
18 September 1991. So some of those may, of course, be
19 the result of the diagnosis of hepatitis C itself only
20 being made at a later stage, but some may be due to
21 a lack of knowledge about the Skipton Fund.

22 **SIR BRIAN LANGSTAFF:** The knowledge about appeal seemed to
23 depend upon the individual first deciding that they
24 wanted to appeal or at least investigate the
25 possibility of it and either contacting Skipton or

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1 obtaining it through their doctor.

2 **MS RICHARDS:** Again, Mr Fish may be able to assist, but it

3 looks from the refusal letters that we have seen as

4 though it was routine in the refusal letters to refer

5 to the right of appeal.

6 **SIR BRIAN LANGSTAFF:** But to contain -- to include the

7 document or not, the guidance notes?

8 **MS RICHARDS:** The document itself suggests that it should

9 have been sent routinely. Whether as a matter of fact

10 it was I think we will have to wait until we hear from

11 Mr Fish tomorrow.

12 **SIR BRIAN LANGSTAFF:** Yes. Thank you.

13 **MS RICHARDS:** We can take that statement down, thank you.

14 Sir, the Inquiry has been analysing hard-copy

15 applicant files held by the Skipton Fund, with, I hope

16 for obvious reasons, a focus on applications which

17 were rejected at the first stage to examine the

18 decision-making process in that regard. Sir, the

19 Inquiry requested from Russell-Cooke solicitors, who

20 effectively administer what's left of the Skipton

21 Fund -- its no longer operational in terms of

22 decision-making -- copies of all Skipton Fund files

23 relating to applicants whose application was declined

24 or appealed. It has become apparent to the Inquiry on

25 reviewing the material that not all applicant files

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1 "Number of applications declined by the Skipton

2 Fund where no appeal was heard -- 622."

3 So that's the number that didn't proceed to

4 an appeal.

5 Number of applications declined by the Skipton

6 Fund and that refusal is upheld by the Skipton Fund

7 Appeal Panel: 223.

8 Total applications reviewed by the Appeal

9 Panel: 443.

10 Applications submitted on behalf of a deceased

11 infected person: 785.

12 So that gives some parameters in terms of the

13 work that was undertaken by the Skipton Fund and the

14 Appeal Panel.

15 Can we go to page 19, please, Soumik? You will

16 see there a table that sets out reasons for refusing

17 the application.

18 **SIR BRIAN LANGSTAFF:** Sorry. Could you just go back to

19 the page before the last one?

20 **MS RICHARDS:** Page 15.

21 **SIR BRIAN LANGSTAFF:** Please. Then page 16. Yes. Thank

22 you.

23 **MS RICHARDS:** If you go on to page 19 again, Soumik. So

24 this sets out the reasons given by the Skipton Fund

25 for refusing an application. The Inquiry hasn't --

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1 still exist, and that of those that do many are

2 incomplete. Some don't have a completed application

3 form.

4 The Inquiry is making further enquiries as to

5 why that is the case. If we could have up on screen,

6 Soumik, our written note about the Inquiry's analysis

7 of these files. It is INQY0000245, I think. If we go

8 to page 15, we can see some statistics. So we have

9 got classifications: "Declined", application

10 unsuccessful, either at first stage or on appeal;

11 "Unresolved", applications in respect of which there

12 was a registered application but the fund considered

13 it wasn't a sufficiently complete application form for

14 the purpose of making a decision; and then "Approved"

15 either at the first stage or on appeal.

16 So those are the terms that are used and then

17 under the heading "Statistics" we have some hard data.

18 This is taken from a spreadsheet that has been

19 provided to the Inquiry by the Skipton Fund. 6712

20 applications, 338 unresolved, 5529 approved, of those

21 5309 approved by the Skipton Fund itself, 220 declined

22 by the Skipton Fund but then approved by the Appeal

23 Panel. Then:

24 "Total applications declined -- 845."

25 If we go over the page:

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1 **SIR BRIAN LANGSTAFF:** I am sorry. Could you just go back

2 again?

3 **MS RICHARDS:** Yes, of course.

4 **SIR BRIAN LANGSTAFF:** There is something troubling about

5 the figures.

6 **MS RICHARDS:** Is the maths not adding up?

7 **SIR BRIAN LANGSTAFF:** Let's have a look at 15 again, if

8 you please? The number declined: 845. Then you can

9 go over the page: 622, no appeal. So that leaves 200

10 odd, but 443 applications reviewed by the Appeal

11 Panel. How does that figure?

12 **MS RICHARDS:** Some of the applications were allowed.

13 **SIR BRIAN LANGSTAFF:** Yes, I follow that. Go back to the

14 previous page.

15 **MS RICHARDS:** 63.2 --

16 **SIR BRIAN LANGSTAFF:** So this is the whole -- I follow,

17 but the total applications declined is the overall

18 picture. I have got it now.

19 **MS RICHARDS:** Yes.

20 **SIR BRIAN LANGSTAFF:** What was troubling me, I think, was

21 the idea that this is looking at the administrators'

22 figure rather than the appeal figure. I understand

23 now how it fits. Just in case my concern was shared

24 by anyone else watching, that's the answer. Thank

25 you.

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1 **MS RICHARDS:** So this table looks at 307 files. So these
 2 are all files that fall into that category of the 622
 3 applications declined by the Skipton Fund where there
 4 was no appeal. The Inquiry doesn't have the files for
 5 all of those. It obtained 314 of those files and 307
 6 of them were sufficiently complete for review. That's
 7 why the figure adds up to 307. These are files the
 8 Inquiry has looked at to try to identify from the file
 9 what the primary reason was for refusing the
 10 application. Sometimes more than one reason is given,
 11 but this is what seems to be the primary reason.

12 We can see there Anti-D Immunoglobulin
 13 injection a reason in 12 cases. We will come back to
 14 what is meant by "Application Form" but essentially
 15 insufficient information on the application forms led
 16 to the application being declined in two cases. 68
 17 cases where intravenous drug use was the basis for
 18 rejecting the application. The largest number are the
 19 next two categories: lack of evidence of NHS
 20 transfusion/blood product, medical records
 21 destroyed/unavailable, 72 and 76 cases respectively.
 22 There is an overlap between the two, the terms are not
 23 used in discrete terms of art in the materials that
 24 the Inquiry has looked at. This takes the way in
 25 which the refusal letters have characterised the

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1 applications were declined altogether. If we go back
 2 to the page before this, and again -- sorry, wrong
 3 page. It is page 15. What you were telling me, the
 4 figures which came out about the breakdown of reasons
 5 given before appeal.

6 **MS RICHARDS:** Page 19. This is where there is no appeal.

7 **SIR BRIAN LANGSTAFF:** That comes to 307.

8 **MS RICHARDS:** That's because not all the files have been
 9 provided to the Inquiry or are available.

10 **SIR BRIAN LANGSTAFF:** That is the Russell-Cooke problem --
 11 I didn't mean to imply it was their fault but it is
 12 the problem that has emerged.

13 **MS RICHARDS:** A problem that has emerged where we have
 14 asked for all files where applications have been
 15 refused, either at the first stage or on appeal, but
 16 not all files still exist in what Russell-Cooke appear
 17 to have been provided with, and again it is an issue
 18 we want to explore with Mr Fish tomorrow as to whether
 19 there is any reason why that might be the case.

20 We have only been able to examine a proportion
 21 of the files as a result. That's why the figures when
 22 we look at the examined files are lower than the total
 23 numbers.

24 **SIR BRIAN LANGSTAFF:** So these figures may change if other
 25 files come to light?

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1 reason for refusal. But in reality those may not be
 2 two discrete areas.

3 Then we have further examples. We can see 27
 4 cases, for example, which are post the screening date,
 5 the September 1991 screening date. Some refused on
 6 the basis that the transfusion probably took place
 7 overseas, two on the basis of sexual intercourse being
 8 the likely route, one on the basis of tattoos.

9 So those are all cases that went no further,
 10 because there was, for whatever reason, no appeal.

11 If we then go on to page 21, here the Inquiry
 12 has set out the position in relation to applications
 13 that were refused by the Fund and did go to appeal,
 14 but were also refused on appeal, slightly different
 15 reasons sometimes given. So if we go over the page,
 16 again we have sought to look at the appeal refusal
 17 letter to try and work out what the primary reason is.
 18 We can see again intravenous drug use is a relatively
 19 sizeable number of cases and then the biggest category
 20 is lack of evidence of NHS transfusion/blood product.
 21 A smaller number in the category of medical records
 22 destroyed or unavailable, but again the two
 23 effectively interrelate and overlap.

24 Then if we go to --

25 **SIR BRIAN LANGSTAFF:** Just pausing there for a moment, 845

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1 **MS RICHARDS:** Yes, that's right.

2 I am just going to -- we have set out in the
 3 report from page 25 onwards, if we just go to that --
 4 I am not going to go through the detail of all of
 5 it -- we have set out our understanding of the
 6 categorisations that were used by the Skipton Fund and
 7 the evidence upon which the Skipton Fund relied in
 8 relation to certain categories. Issues such as lack
 9 of evidence, medical records being destroyed or
 10 unavailable, natural clearers are probably
 11 self-evident as to what's meant by that. The question
 12 of whether the right approach was taken is obviously
 13 a different one.

14 But there are two areas where I just want to
 15 look at the underlying evidence that the Skipton Fund
 16 considered as a matter of generality in relation to
 17 certain cohorts of cases.

18 The first is in relation to anti-D
 19 immunoglobulin injection cases.

20 So if we go, please, Soumik, to SKIP000031_071,
 21 this is a letter, and if you go over the page, it is
 22 from Dr Hewitt of the National Blood Service, who of
 23 course was then appointed the following year to the
 24 Appeal Panel. If we go back to the first page, it is
 25 a letter dated 24th February 2005 and it sets out

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Dr Hewitt's view in response to an invitation from the then administrator, Mr Foster, about the risks of infection transmission from anti-D immunoglobulin. She says in terms, in the second paragraph:

"Anti-D immunoglobulin produced within the UK, either by [BPL or the SNBTS] has ... an unparalleled safety record ... There are no established reports of infection transmission by the intramuscular product produced within the UK since treatment began."

Then she contrasts that with there being:

"... well documented transmission episodes from anti-D immunoglobulin preparations produced outside the UK."

Examples given are that produced by the Irish Blood Transfusion Board and a well-documented episode relating to anti-D immunoglobulin used in Germany. She says:

"[Those preparations] involved a completely different method of manufacture from that used within the UK ..."

The Irish one was an intravenous rather than intramuscular product.

She says she is aware that some Irish anti-D immunoglobulin was imported into the UK and used on a named-patient basis on a very small number of women

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of the applicant files that the Inquiry has undertaken that this effectively then formed the basis for the Skipton Fund's rejection of cases where an individual believed that they had been infected with hepatitis C as a result of the receipt of an anti-D immunoglobulin injection. If time permits we will look at a couple of the case summaries in that regard that we have referred to in this note.

It doesn't appear as though at least as a matter of routine applicants were provided with a copy of Dr Hewitt's letter and so all that applicants in general received was a refusal letter which would state, typically in fairly short terms, that the fund or the Appeal Panel were satisfied that the product they received was safe in terms of viral transmission.

So there is evidence to suggest that if an applicant asked to see the basis of the Skipton Fund or Appeal Panel's view, this might then after the event be provided to them. We've seen one file that suggests that was the case but it was not routinely shared with applicants so they could make submissions or representations or indeed obtain contrary medical evidence or expert opinion about the issue.

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and suggests there was a recall and notification exercise in the course of the 1990s. She says towards the bottom of that paragraph:

"I am not aware of any UK recipients, traced through this process, who were found to be infected with hepatitis C as a result of this exercise. It is possible, however, that there may be cases which have only subsequently come to light. I am not aware that the product used in Germany was ever imported into the UK."

Over the page:

"In general, therefore, women who have been treated with anti-D immunoglobulin within the UK will have received UK product which is considered safe from the point of view of viral transmission. There may be a few women who received product manufactured outside the UK, which might have presented a risk of hepatitis C infection. In order to totally exclude this scenario, it would be necessary to know whether there are any reasons to believe that non-UK product was used. This would only have been in exceptional circumstances and not for routine treatment during and after pregnancy."

That was Dr Hewitt's view expressed to the Skipton Fund, and it would appear from the examination

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SIR BRIAN LANGSTAFF: Do we know of anyone to whom this reason applied and was given a copy of this information who said "How do you know it has been unparalleled safety record, because I believe I am someone that got it? Have you not taken my case into account? What is the evidence to show it has had an unparalleled safety record, whatever that means?"

MS RICHARDS: There is certainly one of the individual cases we have referred to in our case studies where -- we can go to page 40 of the note. So go back to INQY0000245. It was on the screen a few minutes ago, page 40. This is one of the examples of someone whose application was rejected and we can see the terms of the rejection in paragraph 142:

"The Skipton Fund noted that they had been informed by the National Blood Service that the immunoglobulin blood product the applicant had been treated with in 1984 was safe, and therefore not a possible route of hepatitis C infection. This advice was not provided to her."

There is actually an e-mail exchange between the Fund and Dr Hewitt, in which Dr Hewitt, having been asked to, expresses an opinion and that's not provided to the applicant. She made submissions in support of an appeal and we have sought to summarise

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1 them very briefly in paragraph 143 of the note. She
2 did, I think, from recollection query "What is the
3 basis upon which you say this is safe? How does one
4 know it was safe?" The appeal was unsuccessful and we
5 can see the terms of the refusal in paragraph 144:

6 "Our expert members [who by then included
7 Dr Hewitt] accepted the universally held opinion that
8 a transfusion with anti-D would have been without any
9 risk of infection with hepatitis C."

10 There is an assertion that only British anti-D
11 would have been used:

12 "... there has never been any evidence that
13 this product carried any risk of transmitting
14 Hepatitis C. Other imported anti-D products are known
15 to have carried such a risk but would not have been
16 used in your case."

17 That's the approach taken in her individual
18 case, but from what the Inquiry has looked at it is
19 fairly typical of the approach taken by the Skipton
20 Fund to anti-D immunoglobulin injection cases.

21 The second example probably worth mentioning at
22 this stage, if we just go to the bottom of the page,
23 we have the case reference there. So this is someone,
24 again, whose application was declined, who appealed
25 and appeal was rejected. If we go over the page and

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1 not GD57, in any event.

2 Perhaps most notably is paragraph 155, the
3 applicant supported using the same information has
4 succeeded in an application to the English Infected
5 Blood Support Scheme.

6 I should just for the sake of completeness
7 invite you to note, sir, if we look at SKIP000031-070,
8 that further advice or updating advice was provided in
9 2010 to the Skipton Fund on the issue of
10 immunoglobulin. If we go to the third page, we can
11 see this was from Dr Hewitt again in conjunction with
12 Dr Dash ^ (spelling?) and essentially it set out the
13 same view as Dr Hewitt.

14 **SIR BRIAN LANGSTAFF:** Just go back to the first page of
15 that letter, it says -- this is the second sentence,
16 second paragraph:

17 "... there have been no documented reports of
18 hepatitis C transmission through intramuscular
19 immunoglobulin ..."

20 Assuming for the moment that anti-D of British
21 origin is intramuscularly injected, where does the
22 complaint to the Skipton Fund sit as a documented
23 report?

24 **MS RICHARDS:** You mean the appeals?

25 **SIR BRIAN LANGSTAFF:** The appeal, because the appellant is

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1 pick it up at paragraph 146, again we can see the
2 application being declined:

3 "The ... Fund stated that recent guidance had
4 been obtained from the [National Blood Service]
5 regarding anti-D immunoglobulin ..."

6 So that's the letter from Dr Hewitt. That
7 wasn't provided to the applicant. The applicant
8 appealed. We can see from paragraph 147 she provided
9 a personal statement. A hepatologist who supported
10 her appeal thought her only risk for hepatitis C was
11 the injection received. The appeal was refused. She
12 made a second application.

13 If we go down the page, we can see the second
14 application fails, that's paragraph 150. The matter
15 goes to the Appeal Panel for a second time.

16 Then if we go over the page, we can see she had
17 clinical evidence supporting her application, which we
18 have set out at the top of the page. We can see the
19 GP's view set out in paragraph 152, but then the
20 Appeal Panel refused it again. This is paragraph 153.

21 I should say quo said in paragraph 154 that it
22 was unclear how the panel concluded that the anti-D
23 was intramuscular and from BPL. There is a reference
24 to a batch number in the documents that the Appeal
25 Panel has, although the batch number is given at SD57,

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1 saying "I had this, I got it", in one case "My GP
2 thinks that's a high possibility" that's the
3 expression he uses, "it came from anti-D, there is no
4 other obvious source".

5 **MS RICHARDS:** I anticipate, although this is a question we
6 will no doubt want to ask Dr Hewitt herself about,
7 that document and reports probably refers to medical
8 literature, but whether that is the case Dr Hewitt or
9 Dr Dash will be able to confirm, but it may be that's
10 what they are referring to. Dr Hewitt herself would
11 have been aware of the applications that were being
12 made and that were coming to the Appeal Panel because
13 of her involvement with the Appeal Panel. In any
14 event that's the updating evidence obtained by the
15 Skipton Fund in July 2010.

16 So the second category of cases where the
17 Skipton Fund had and relied upon expert evidence is in
18 relation to intravenous drug use. If we could go to,
19 please, to SKIP0000031_217, this is a document
20 provided in response to a request from the Skipton
21 Fund. It is from Dr Mary Ramsay of the Health
22 Protection Agency, 19th March 2007. You will see
23 what's set out under the introduction:

24 "The question we have been asked is whether the
25 Panel [which is presumably the Appeal Panel] can be

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1 more precise in its quantification of the chance that
2 injecting drug use for less than two years has been
3 the cause of the HCV infection in someone who also has
4 a history of blood transfusion."

5 Then she sets out three issues:

6 "Estimating the risk of acquiring HCV through
7 short term drug use in the UK

8 "Additional factors that may influence the
9 estimates of risk of short term drug use in the UK

10 "Estimation of the risk of acquiring HCV
11 infection through the receipt of unscreened blood in
12 the UK."

13 I am not, in the interests of time, going to go
14 through what she says in relation to each of those
15 matters, but if we just go to the summary on page 4,
16 we can see what's said is this:

17 "Overall, the risk of hepatitis C infection
18 with short-term injecting in the UK is poorly
19 documented, and is likely to have varied
20 geographically and over time. Although data on
21 one-off or casual injectors is absent, evidence from
22 many countries supports the belief that the risk of
23 acquiring hepatitis C in the early period of injecting
24 is high. The estimated probability of transmission
25 from single episodes of needle and syringe sharing

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1 to the spreadsheet data we have received. The stage 1
2 payments declined by the Skipton Fund overturned on
3 appeal. The Inquiry has got 211 of those files and
4 208 are sufficiently complete in order to be able to
5 understand what the basis was of the decision. We can
6 see, of these 208 cases, the vast majority of them
7 were refused by the fund, the administrator, because
8 of lack of evidence or destroyed medical records.

9 What's difficult to ascertain from the
10 documentation is how the Appeal Panel approached the
11 cases and what the basis was for the Appeal Panel, as
12 it were, overturning the decision. Where the Appeal
13 Panel was disagreeing with the fund and overturning
14 the decision, its letters communicating its decision
15 really just said that the panel were satisfied that
16 the person was eligible on the balance of
17 probabilities, rather than going into detail about the
18 reasoning. We have again set out in the note -- I am
19 not going to go through the details of it -- tried to
20 identify cases where we can see what the basis was for
21 the Appeal Panel's decision. There are certainly some
22 cases in which there is additional evidence and it may
23 be that that's why the Appeal Panel had taken
24 a different view but there are other cases where there
25 hasn't been additional evidence but the Appeal Panel

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1 also appears to be substantially higher than the risks
2 associated with a single transfusion of unscreened
3 blood. On an individual basis it will be difficult to
4 assess the risks associated with single episodes of
5 injecting where sharing is denied, but recent studies
6 suggest that the incidence of hepatitis C in injectors
7 who deny sharing is around half of that observed in
8 those that do report such behaviour."

9 So it might be said somewhat equivocal
10 conclusions. I don't mean that necessarily
11 pejoratively but that's the way the summary is
12 expressed.

13 In terms of what we see the Skipton's approach
14 being to IV drug use, I can really only say this: the
15 Inquiry has not yet seen any applications where
16 someone who reported intravenous drug use succeeded in
17 their application to the Skipton Fund. So it appears
18 to have been regarded effectively as an exclusionary
19 condition. Again, we will be asking relevant
20 witnesses this week more about that.

21 If we go back to the Inquiry's note,
22 INQY0000245, and we go to page 32, this is the
23 Inquiry's analysis of the applications declined by the
24 Skipton Fund but overturned on appeal. You will see
25 in paragraph 109 there were 220 applications according

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1 has taken a different view. It had actually not been
2 possible to understand from the documents alone why
3 that might have been the case.

4 If we then can go to page 38 of this document,
5 what we have done in this section of the note is just
6 set out some summaries of applications. They are
7 inevitably selective, because we have not sought to
8 summarise the contents of the hundreds of files, but
9 we tried to select applications which illuminate
10 aspects of the decision-making process to try to get
11 some understanding as to the approach taken either by
12 the Fund or the Appeal Panel or both. So there are,
13 I think, some 23 anonymised summaries that we have set
14 out in our note.

15 I have already drawn attention to the two cases
16 that were anti-D immunoglobulin injection cases.

17 If we could go, please, next in this document
18 to page 42, you will see at the bottom of the page:

19 "Case suffers lack of evidence."

20 The majority of the cases we have referred to
21 in this note are cases which failed, were rejected or
22 declined on the basis there was insufficient evidence
23 and/or medical records destroyed. A theme of the
24 documentation is the difficulty that has caused
25 applicants in terms of making successful applications.

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1 I am just going to refer to a handful of them in the
2 time available.

3 So start with, case 3, set out in paragraph 156
4 onwards of the note. I will do it by reference to the
5 underlying documents, if I may. So, Soumik, it is
6 SKIP0000079_017.

7 If we go, first of all, to page 12 of this
8 document, sir, it is not terribly easy to read, but
9 essentially this is the completed application form.
10 If we look at the bottom half of the page, we can see
11 that the doctor completing this has confirmed
12 infection most probably arose through NHS treatment.
13 The hospital is identified; the procedure is
14 identified. In terms of do any records exist the
15 answer is "unknown".

16 "Do you believe infection occurred before 1st
17 September 1991?"

18 "Yes."

19 If we look at the right-hand side:

20 "Other possible sources of infection", the
21 doctor has suggested no in terms of other possible
22 sources of infection.

23 Then the bottom of the page:

24 "In your view is it probable that the infected
25 person's HCV infection was acquired in consequence of

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1 been it was transfusion acquired. There are no
2 records relating to the transfusion itself.

3 If we go to page 3, you will see there is
4 an unsuccessful application, so this is a letter from
5 Mr Fish, April 2009. Paragraph 2:

6 "It is with regret I must advise you your
7 application has been declined. This is due to the
8 lack of supporting confirmation."

9 So, as it were, it seems as though it is
10 looking for confirmatory or corroboratory evidence:

11 "... that you were treated with NHS blood or
12 blood products prior to September 1991 but on two of
13 the letters we have received 2000 and 2001 it mentions
14 a past transfusion but in the absence of medical
15 records this was presumably as a result of
16 consultation between you and your doctor."

17 Then it says:

18 "If you do obtain any other supporting medical
19 records please return these along with your
20 application form."

21 In answer to a question you asked earlier about
22 the Appeal Panel, you will see this is a fairly
23 standard form paragraph in these letters. Mr Fish
24 refers to the right of appeal and he says in the last
25 sentence of this letter:

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1 NHS treatment received before 1st September 1991?"

2 Answer: yes."

3 This was an applicant who believed that the
4 source of his hepatitis C infection was a blood
5 transfusion received in 1986. There were no relevant
6 records, but the applicant was able to provide some
7 medical -- some letters from his records, nothing that
8 directly related to the transfusion itself, but if we
9 go to page 6, please, you will see here a letter from
10 a surgeon. Second paragraph:

11 "I note that he has hepatitis C as a result of
12 his blood transfusion when he fractured his ankle."

13 If we go to the top of that page, we will see
14 the date of this letter was August 2001. So that's
15 a view being set out at a time when the Skipton Fund
16 did not exist, had not been announced, so it cannot
17 possibly be thought this was somehow some form of
18 contrived state of affairs.

19 Then if we go to page 8, please, again one
20 doctor to another set out their view in December 2000,
21 so again before the Skipton Fund ever came into
22 existence. First paragraph of the letter:

23 "I note that he has a history of transfusion
24 acquired hepatitis C virus ..."

25 So the view of treating doctors appears to have

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1 "I enclose a copy of the Appeal Panel
2 guidelines for your reference."

3 The evidence the Inquiry has in relation to
4 this applicant is he felt unable to appeal because of
5 his dyslexia, so his was an unsuccessful application.

6 Soumik, if we go back to INQY0000245, please,
7 and we go to page 43, I am going to take some of these
8 just by reference just to the notes rather than going
9 to the underlying documents. Case 4 again is a case
10 in which the applicant believed their hepatitis C
11 infection was caused by a particular operation,
12 transfusion in 1991. It is before the cut-off date of
13 September 1991. There's no clear evidence in the
14 medical records one way or another but there is a note
15 that you will see we have set out in paragraph 161.
16 Declined on the basis of lack of supporting medical
17 records.

18 Case 5, just go further down the page. This is
19 someone who made an application in May 2016, believed
20 that the source of his hepatitis C infection was
21 a blood transfusion received in the '70s, following
22 surgery for a ruptured Achilles' tendon as a child
23 when he put his foot through a broken window on
24 a landfill site.

25 If we go over the page, we will see the

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1 application was unsuccessful. That's paragraph 165.
 2 Sorry, I should just pick up the previous paragraph,
 3 top of the page. In accordance with the Appeal Panel
 4 guidelines this applicant obtained confirmation that
 5 his medical records had been destroyed. So he
 6 couldn't produce any further evidence.

7 If we go to the documents themselves,
 8 SKIP0000044_008 and if we go to what I hope is
 9 page 17. Yes. So we will see here the refusal
 10 letter, July 2006. We see in paragraph 2 it is due to
 11 the lack of supporting medical records.

12 He couldn't have any medical records because
 13 they had been destroyed. There was a handful of
 14 documents that the applicant did have and you will see
 15 reference made to that. No reference to treatment
 16 with blood or blood products. This is not a procedure
 17 where blood transfusion would probably be required, so
 18 this application was rejected.

19 Now, this applicant did appeal. If we go to
 20 page 11, he put in a letter from his mother, who
 21 confirmed that -- this is the last sentence:

22 "He lost a lot of blood and had to have
 23 a transfusion, an operation and 32 stitches."

24 So his mother says he had had a transfusion.

25 If we go to a few pages before that, the

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1 identical form for the most part, apart from one or
 2 two paragraphs. So what's set out on this
 3 page appears in almost all of the Appeal Panel's
 4 refusals. The first paragraph says:

5 "You will be disappointed to hear that the
 6 Panel has refused your appeal. To help you understand
 7 our decision, I would like to explain to you the
 8 clearly defined role and powers of the Appeal Panel."

9 Then what are set out are a number of
 10 paragraphs which are not particularly material to this
 11 particular individual case. Bottom of the page you
 12 will see reference there to the burden on the
 13 appellant to satisfy the Panel on the basis of balance
 14 of probabilities. Then the last sentence says:

15 "In order to be satisfied that this is the case
 16 the Panel will pay particular attention to the
 17 treatment records of the person concerned."

18 Of course, he had none. Next page, the next
 19 two paragraphs are where we get the substance of the
 20 decision:

21 "We reviewed the entire panel of papers along
 22 with the additional information supplied for the
 23 appeal. We noted that there was no record of any
 24 transfusion in your notes."

25 Well, most of the notes aren't there.

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1 applicant himself gave his own account. He refers in
 2 the first paragraph, last sentence, to the application
 3 form and his own consultant confirming her view as to
 4 the probable route of injection. Paragraph 2 refers
 5 to the destruction of the records. If we go a little
 6 further down we can see numbered paragraph 1, he
 7 refers to his accident and the treatment being in 1978
 8 and his consultant -- his liver consultant having said
 9 that the damage already caused to his liver was
 10 consistent with having the disease for 30 years or
 11 more, which would place it in all likelihood as
 12 a childhood event.

13 In paragraph 2 he sets out further detail about
 14 the circumstances of the accident. He talks about how
 15 he had to be carried by a friend and his leg was
 16 bleeding profusely. He had a three-week stay in
 17 hospital. He refers to his mother providing
 18 a statement. It is also right to note that the person
 19 who carried him from the accident site to get help
 20 also talks about him having been bleeding badly.
 21 That's page 4. Penultimate sentence of paragraph 4:

22 "His leg was bleeding badly, so badly he
 23 couldn't walk", et cetera, et cetera.

24 Then if we go to the Appeal Panel's decision,
 25 that's page 2, these decision letters are largely in

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1 "The Panel, including our expert members, was
 2 of the view supported by the clinical records we have
 3 seen that there is insufficient evidence to show you
 4 were treated by a blood transfusion."

5 There is reference to the severed Achilles
 6 tendon:

7 "... delay in receiving treatment. It is said
 8 that part of the leg was lacking in blood vessels and
 9 the bleeding was restricted so that there was little
 10 likelihood of your needing a transfusion as a fit
 11 10 year old.

12 "As a result of these considerations we were
 13 not satisfied it is probable that the infection
 14 resulted from qualifying NHS treatment and accordingly
 15 regret we must refuse your appeal."

16 You see there is no engagement with the actual
 17 evidence provided by the appellant, not least from his
 18 mother who has provided a statement saying he received
 19 a transfusion. That's a pattern we see in a number of
 20 these cases where there is supporting evidence from
 21 either the individual saying "I remember receiving
 22 something" or from a family member saying "I remember
 23 being told that my brother/husband, father" etc, "had
 24 received a transfusion" or "my wife during child birth
 25 had received a transfusion" of the refusals don't

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engage for the most part with that evidence and don't assist us in understanding what the panel made of it.

So that's an example of a case refused where there was precisely the kind of supporting evidence that the Appeal Panel guidelines invited applicants to submit to it.

If we go back to INQY0000245, please, and we go to page 44, bottom of the page, this is an example of a successful appeal. We can see from paragraph 168 this was an individual who pointed to surgery they had received in 1974 and said they thought they had a blood transfusion then. If we go over the page, there were records which confirmed the procedure that the applicant underwent but there were no records of a transfusion as such. The clinicians supporting the application expressed their opinion that a blood transfusion would have been required. The application was again refused.

The applicant appealed, and this applicant was able to consult and obtain a report from a private clinician, which, of course, will not be something that many applicants can do, and I will just look at the documentation in relation to that. It is SKIP000088. I think I have not got a full reference there. Oh, that's right. SKIP000088.

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"As a result of these considerations, we were satisfied that it is more likely than not that your infection resulted from qualifying NHS treatment."

So, that's why I said a few moments ago, sir, we can't tell from the successful applications how material was considered by the panel, because it is really just a communication of the decision rather than any detailed assessment of the evidence, but this application succeeded on appeal it might be thought probably because this applicant was in the position of getting a private report that he was able to submit to the Appeal Panel, which would be beyond the abilities of many applicants.

Going to perhaps just one or possibly two more examples to see how this issue of lack of medical records or lack of supporting evidence affected applications, if we go back to INQY0000245 and go to page 45, we can see here case 7, bottom half of the page. This was an individual who had had treatment for a range of injuries, broken nose, broken teeth and blood loss. Most records were unavailable. Paragraph 174, the applicant obtained confirmation that records would have been destroyed in line with the relevant document destruction policy. We can see from paragraph 175 the application was declined by the

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If we go to I hope it will be page 31 -- no.

Sorry. Can you go on a couple of pages, Soumik? If we go on about another ten pages. Next page. We will get there in the end. The problem is that my pagination does not match this. I am just going to read aloud the relevant paragraph.

This applicant obtained a report from a consultant ENT surgeon, who expressed the view that it was:

"... very highly probable indeed that the applicant would have required at least one or more blood transfusions at or around the time of the operations he described."

So we can take that document down. That doesn't help. Sorry. Actually, if you go to page 20 perhaps. So that was the additional evidence or part of the additional evidence the applicant put in on appeal, and we can see the Appeal Panel decision here. If we go to the bottom of the page, we can see it says:

"The panel reviewed the entire file of papers held by the Skipton Fund and has also reviewed the additional information."

Again, that is a standard form of wording. Go to the next page:

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Skipton Fund, reference being made to the lack of supporting medical records.

The applicant appealed. We can see from paragraph 176 reference to the applicant having referred to his mother's diary as evidence he developed jaundice in December 1970. He was asked to get those pages certified by a solicitor and submitted, which he did. He also supplied school attendance records which showed that in 1969, the year he stated he was infected with hepatitis C, his school attendance was problematic, but then you will see in paragraph 178:

"The panel refused the appeal, asserting that the jaundice suffered in April 1970 couldn't have been connected with a transfusion in August 1969, as the gap in time was too long", and then said it was not clinically plausible that the injuries suffered would have necessitated a transfusion.

I am just going to show you a couple of underlying documents relating to this particular file. It is SKIP000027_006. If we go to I think it is page 15. Yes. So the applicant provided here a fairly detailed account of what had happened to him. Towards the bottom of the page he refers to significant blood loss and he says:

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"I know I spent one night and possibly two at the hospital. I lost a lot of blood and they gave me some to top it up."

This had been an injury sustained on holiday. If we go to page 8, we can see the Appeal Panel rejected the application. If we go to the second page, paragraph 1 refers to no record of transfusion in the notes. There is little by way of notes. Paragraph 2 is the reference to there being too big a gap in time. They apparently accepted he suffered jaundice in late 1970, but asserted it couldn't have been connected with a transfusion in August 1969 as the gap in time was too long.

If we then go to page 6, the applicant provided further medical evidence in the form of a clinician's opinion. So this was in July 2012. Bottom of the page, last two paragraphs, the doctor refers to the Skipton Appeal Panel's reasoning and then says this:

"On balance, as an expert in the area of clinical microbiology and as a clinical practitioner, I would have some concerns around these findings.

"As to whether or not you had a blood transfusion, my view is that it would be difficult to conclude that it was not clinically plausible given that your injury was severe enough that you had to be

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hurdles in the way of applicants who were unable to point to actual medical records detailing the transfusion. We have further examples that we have set out in the material and, of course, you, sir, in the statements you have read will have seen still further examples from those who have provided the Inquiry with witness accounts.

So that then I think completes the Skipton presentation. This afternoon we will hear from Ann Lloyd.

SIR BRIAN LANGSTAFF: Very well. Thank you very much.

2 o'clock then. 2 o'clock.

(1.00 pm)

(Luncheon adjournment)

(2.00 pm)

(Proceedings delayed)

SIR BRIAN LANGSTAFF: Ms Lloyd, can you now hear me?

THE WITNESS: I can, thank you.

SIR BRIAN LANGSTAFF: You can see me?

THE WITNESS: I can.

SIR BRIAN LANGSTAFF: That's an improvement. I am sorry to have kept you waiting so long. There has been one positive outcome that I have made a mental note to be more forgiving when I watch the news on TV and they have a breakdown in the link between somebody remote

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hospitalised and the need for a blood transfusion would have been determined by the amount of blood loss rather than the specific injuries. In addition, significant blood loss associated with facial injuries is well recognised."

Then the next page:

"In terms of the issue of hepatitis C, the accepted incubation period for hepatitis C is up to 26 weeks. However, longer incubation periods are described in the literature and it is therefore in my opinion possible that the jaundice you developed in 1970 could have been due to hepatitis C acquired from a blood transfusion in August 1969, especially given your lack of other risk factors for this condition."

So that was submitted to the Skipton Fund, but the Appeal Panel maintained its refusal and the appeal was unsuccessful. We can take that down.

Sir, those are just some of the examples from the case summaries we have looked at and have referred to in our written note. Those summaries in turn are just some of the examples of applications that were unsuccessful in particular because of lack of medical records or other contemporaneous medical documentation demonstrating that a transfusion was undertaken, and would appear to suggest that there were significant

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and in the studio. I am sorry it had to happen to you.

THE WITNESS: Well, it was a little disconcerting but I thought as long as I have not cursed the equipment, that's okay.

SIR BRIAN LANGSTAFF: These things come with social distancing, don't they, but anyway we are now ready to start. Let me just explain where you are. You can tell us, actually, where you are at the moment. You are in your office, are you?

THE WITNESS: I am in my office, yes.

SIR BRIAN LANGSTAFF: Elsewhere in the office, who is there?

THE WITNESS: Nobody in my office.

SIR BRIAN LANGSTAFF: Outside there are members of staff?

THE WITNESS: Well, most of them are having an executive Team at the moment. So most of them are not in the corridor.

SIR BRIAN LANGSTAFF: You are talking to a room which has some eight members of the Inquiry staff, one of whom is Soumik, whose job is to let you see documents. Another is Mary, who will ask you to take the oath in a moment or two, but the audience you are really talking to are the audience beyond Fleetbank House, which is remote. It will be about 200 or so people

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1 who will be watching. Can I apologise to them too for
2 having kept them waiting because they will have been
3 cursing the screen. I am very sorry. I hope it
4 doesn't happen again. We do what we can.

5 Anyway, with that introduction, Mary, would you

6 ...

7 **ANN JUDITH LLOYD (sworn)**

8 **Questions from COUNSEL TO THE INQUIRY**

9 **MS SCOTT:** Mrs Lloyd, can you see and hear me?

10 **A.** I can.

11 **Q.** You were the chair of the Caxton Foundation between
12 February 2013 and March 2015; is that right?

13 **A.** That's true.

14 **Q.** You have provided us with your employment history that
15 shows since 1982 you have held increasingly senior
16 roles in the NHS, including between 1992 and 2001 as
17 Chief Executive of a healthcare trust --

18 **A.** Yes.

19 **Q.** -- and between 2001 and 2009 you were the Director
20 General of Health and Social Care and the Chief
21 Executive of NHS Wales; is that correct?

22 **A.** That is true, but that latter employment was via the
23 Civil Service rather than the NHS.

24 **Q.** Mrs Lloyd, can you still hear me?

25 **A.** I can.

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1 right?

2 **A.** Yes.

3 **Q.** I am not going to ask you today any questions about
4 your role as director general or chief executive of
5 NHS Wales. Some Core Participants have suggested
6 questions and those will be the focus of a request for
7 a separate witness statement from you in due course.
8 Today I am going to be asking you questions about your
9 role as chair of the Caxton Foundation.

10 In 2013 what experience did you have of being
11 on a charity board and of chairing a Board of
12 Trustees?

13 **A.** I had been a charity trustee at the Shaw Trust by then
14 for some six years. I was also on the Board of the
15 Patients Association. I had never been the chair, but
16 in the Patients Association I acted as the vice chair.

17 **Q.** You carried out your role as chair of the Caxton
18 Foundation until March 2015, when you stood down --

19 **A.** Yes.

20 **Q.** -- because of other commitments causing a conflict of
21 interest.

22 **A.** Yes.

23 **Q.** How did that arise?

24 **A.** I was asked whether or not I would apply for the Welsh
25 Health Specialist Services Committee, which dealt with

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1 **Q.** Good. Something has just popped up on my screen. You
2 retired from the -- you retired in 2009; is that
3 right? Mrs Lloyd, can you hear me?

4 **A.** (Shakes head).

5 **SIR BRIAN LANGSTAFF:** No. We have lost it. I am sorry.
6 Let's try again. I will take a break. Try and get it
7 right.

8 **MS SCOTT:** Mrs Lloyd, if you can hear me, we are going to
9 take a break.

10 **SIR BRIAN LANGSTAFF:** You had better use the text or other
11 communication.

12 **MS SCOTT:** Yes.

13 **(Pause)**

14 **SIR BRIAN LANGSTAFF:** I am very sorry yet again for
15 testing your patience. Let's hope we don't have to
16 have a third time lucky. Ms Scott?

17 **MS SCOTT:** So, Mrs Lloyd, we know from your witness
18 statement that you retired in 2009, but since then you
19 have held a number of posts.

20 **A.** Yes.

21 **Q.** You have been the Appointments Commissioner for Health
22 and Social Care in London between 2009 and 2012. You
23 have been the Chair of the Welsh Health Specialist
24 Service Committee and you have been the Chair of the
25 an Aneurin Bevan University Health Board; is that

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1 specialist services, and I will define those, if you
2 wish, but it is the very rare treatments that are
3 undertaken within the Health Service, and because
4 I wished to contribute more to Wales, I applied for it
5 in open competition and was given the position by the
6 Minister.

7 As part of the role of the Specialist Services
8 Commission we have to consider very rare treatments
9 and very rare drugs and there was much discussion at
10 the time when I was in Caxton latterly that there were
11 new treatments coming on course and you will have seen
12 that in our minutes, and, therefore, I considered that
13 there would be a potential conflict if the Welsh
14 Health Specialist Services Commission were asked to
15 consider new treatments with my role on Caxton, which
16 would not be to the benefit of Caxton and its
17 beneficiaries at the time.

18 **Q.** What drew you to the Caxton Foundation and applying to
19 become trustee and chair?

20 **A.** I saw the advertisement and was contacted by the head
21 hunter, Veredus. I was very interested in
22 health-related charities, as you can see from the
23 Patients Association contact, and I was aware of the
24 organisation being established to provide grants to
25 potential beneficiaries caused through the infected

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NHS blood investigations of the '70s and '80s. That was of interest to me, in that it was a grant-giving organisation connected with health and would fit with some of the works that we were doing at the Patients Association, in terms of ensuring we could get a wide grip of issues coming through patients' groups to inform our future work there as well.

Q. What did you -- sorry.

A. Sorry. So that is how it is in that position. Sorry for interrupting you.

Q. What did you know about people becoming infected with by hepatitis C via blood and blood products during the 1970s and 1980s, when you first came to Caxton?

A. Well, there are two slightly different questions I think, aren't there? What did I know about infected blood in the '70s and '80s and then what did I know as I was coming to Caxton; is that a true definition?

Q. No. What did you know about people becoming infected in the 1970s and 1980s in 2013 when you came to Caxton?

A. Well, obviously I knew that the Skipton Fund had been specifically established to ensure that there could be a recognition of the challenge of people who had been infected by the NHS through infected blood, because I was at the Welsh Government when the UK Government

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Q. We will come on and look at the priorities that you set yourself at the start of your time there a little bit later on.

Is this correct, that by the time you arrived at Caxton, a company, the Caxton Trustee Limited, had been established to act as the corporate trustee of the Caxton Foundation? So, in fact, while I have been calling you and your fellow trustees "trustees", in fact, you were directors of the company that was the corporate trustee of the Caxton Foundation?

A. When I applied for this position I wasn't aware of the technicalities of the legality of Caxton, but Mr Lister advised me of that and that, because of the liabilities, the potential liabilities, that could be borne by the individual trustees, that they had decided to become a company, and that the Board and the organisation would thereby become the corporate trustee.

Q. But did you understand -- were your powers and obligations to act in accordance with the Trust Deed in the same way that they would have been if you were a trustee rather than a director of the corporate trustee?

A. I considered that that would be the case. We still had to undertake the charitable function for which the

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announced that being brought into view and that, as a consequence of -- I think it was the Archer and the Penrose Inquiries, that charitable organisations were to be set up in order to provide grants, et cetera, to people who would be potential beneficiaries. The actual policy making in Wales on this particular issue; in other words, the Skipton Foundation, was undertaken in the CMO's, the Chief Medical Officer's, office and not in my department but, nevertheless, I knew exactly why it was being established and when.

Q. What kind of information or induction were you giving at the time of your appointment to the Caxton Foundation, and in particular about the challenges facing the Caxton Foundation as at 2013?

A. I was given very little induction except conversations, very helpful conversations, that I had with the vice chair, who outlined the rationale behind establishing the charity in the first place, the difficulties that were being faced in trying to ensure that those who could be beneficiaries actually made representation to us for grants, because we were very concerned and remained very concerned about the numbers of people who were coming forward, and that there were concerns about how effective the organisation was to date.

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organisation had been established and would be bound by those rules.

Q. I am going to continue during the course of this afternoon to refer to you as "trustees", although technically that's not correct and you are directors. Your statement tells us that you initially had a concern that there may be a conflict of interest in having one Chief Executive for both Macfarlane Trust and the Caxton Foundation. What did you consider -- how did you consider that that conflict may or did arise?

A. I believed that it was quite difficult as Chief Executive for two organisations to actually adjudicate over your time and the priorities that were being followed by the organisation. We did have a sound relationship with Macfarlane, but there could be confidential issues that would arise within each Trust that would make it very difficult on occasions.

Now, these would be rare, I am sure, for the Chief Executive. However, my main concern was if one of the organisations believed it had a greater command over the time of the Chief Executive, they could get into conflict with each other.

Q. Can we just look at a document on that point? It is CAXT0000110_094.

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1 My screen doesn't seem to be working. I don't
 2 know if you have the document up, Mrs Lloyd. Has
 3 anything come up for you?
 4 **A.** Is this a transcript?
 5 **Q.** Yes, it's a transcript taken from a recording of the
 6 partnership meeting. Have you got that on your
 7 screen, because both my screens are now blank?
 8 **A.** I have, yes. Thank you.
 9 **MS SCOTT:** Sir, do you have that on your screen?
 10 **SIR BRIAN LANGSTAFF:** I have lost my picture of the
 11 witness but -- she is back -- but I do have the
 12 screen, the document.
 13 **MS SCOTT:** I have a printed copy.
 14 **SIR BRIAN LANGSTAFF:** You were going to say something,
 15 Mrs Lloyd?
 16 **A.** No. I just questioned what it was we were looking at,
 17 because I couldn't see it very well at first. It is
 18 now clear. Thank you.
 19 **MS SCOTT:** This is a document -- it says at the top:
 20 "The following transcript is taken from a
 21 recording of the Caxton Foundation Partnership Group
 22 meeting. It has been approved by the campaign group
 23 members that attended. It is a genuine attempt to
 24 reflect accurately the discussions which took place at
 25 the meeting."

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1 information that we can use -- fully provide through
 2 more organisations on hepatitis C in our own website
 3 in terms of the sort of scope of what we are going at
 4 the moment. The expectation of our beneficiaries,
 5 et cetera."
 6 This is the bit I want to draw your attention
 7 to:
 8 "We have been trying very hard to improve
 9 communications. We are hugely handicapped by the fact
 10 we actually have lost staff or just haven't got
 11 anybody at the moment to do it with the challenges of
 12 MFT and its distribution of the reserves which took
 13 everybody's time for the last few months but it is our
 14 aim to be much more clear about what we are able and
 15 not able to do and to help the beneficiaries obtain
 16 the benefit from a charitable resource", et cetera.
 17 Soumik, you can take that down.
 18 Is this the sort of concern that you had about
 19 there being one Chief Executive for two organisations?
 20 There was a fight over resource and sometimes the
 21 Caxton Foundation may come off worse?
 22 **A.** Yes, that was the type of the concern about which
 23 I expressed my concerns. As it happened with this
 24 particular issue, it was additional work required by
 25 Caxton that couldn't be undertaken rather than the

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1 Then it gives the date 28th November 2013.
 2 Was this document a document you saw shortly
 3 after the meeting took place or around that time?
 4 **A.** I cannot recall accurately when I received a copy of
 5 this document, I am afraid.
 6 **Q.** We can see that you, second name down, were
 7 an attendee, along with Jan Barlow and Charles Lister,
 8 the vice chair.
 9 **A.** Yes.
 10 **Q.** It is a discussion about staffing that I want to draw
 11 your attention to. So we can see the beginning of
 12 that discussion starts at page 5?
 13 **A.** Oh, yes.
 14 **Q.** Then I don't want to look at the first few pages.
 15 Just to go over to page 8, please. Sorry, just to go
 16 over to page 9.
 17 **A.** Thank you.
 18 **Q.** Have you got that up on the screen?
 19 **A.** I have got page 9.
 20 **Q.** So if we look -- the first paragraph there, about
 21 halfway down, a few lines up from -- I have two sort
 22 of hole punch marks on mine. Halfway along that
 23 line it says:
 24 "AL said:
 25 "Let us take back the whole issue of the

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1 general facilitation of grants by the staff. That
 2 would always have had to have continued, because that
 3 was fair and equal, but it was the additional work
 4 that was required, and that sometimes was in conflict
 5 with what we might have wished the staff to do as
 6 a first priority.
 7 **Q.** And there, that additional work you are referring to
 8 there, was trying hard to improve the communications
 9 with the beneficiaries to let them know what they
 10 could apply for and so on?
 11 **A.** Yes.
 12 **Q.** So in your witness statement you suggest that you put
 13 in place a communications protocol between the two
 14 organisations to try and deal with this potential
 15 conflict.
 16 Was that a success?
 17 **A.** In the whole, yes. We did used to discuss what our
 18 priorities were, but in this instance, because of the
 19 combination of losing staff and the fact that the
 20 distribution of reserves in MFT would have taken first
 21 priority, that was in the interests of their part of
 22 the organisation's beneficiaries, then we could not
 23 proceed as quickly as we wished with the work we
 24 wanted to undertake.
 25 **Q.** Did you consider that there might be a conflict to the

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1 extent that both the Macfarlane Trust and the Caxton
2 Foundation were pursuing the same pot of Department of
3 Health money?

4 **A.** No.

5 **Q.** Why not?

6 **A.** Because the requests that we made were quite separate
7 and not shared with each other. The budget within the
8 blood team was unknown to either of us. We didn't
9 know the full extent of that and, of course, it was
10 used for many other things, but I never had any
11 evidence that we were bidding against each other.

12 **Q.** Did you consider that there may be a conflict arising
13 from the fact that the Caxton Foundation was providing
14 staffing services to the Macfarlane Trust, pursuant to
15 a service level agreement?

16 **A.** No, because that had to be operated absolutely
17 equally, given the balance of work that had to be
18 undertaken and that was overseen by the Chief
19 Executive.

20 **Q.** But how could the Chief Executive of the Macfarlane
21 Trust effectively challenge the Chief Executive of the
22 Caxton Foundation, if they were the same person?

23 **A.** Exactly, but I think that one has to rely on the
24 professionalism of individuals, because if Caxton had
25 believed that to be the case, then she would have been

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1 evaluate them and take a view prior to going to the
2 Department of Health. I really would in my own mind
3 have preferred to have taken any bid for additional
4 funding to the Department of Health on the basis of
5 benefits to our beneficiaries rather than staffing.
6 **Q.** Can we look now at a minute of a board meeting from
7 2nd May 2013. Soumik, it is CAXT0000110_034. We can
8 see at the top there minutes dated 2nd May. You are
9 present as Chair. If we go to the bottom of that
10 first page to "Chair's statement", it says:

11 "AL advised the board that she had spent her
12 first few months as Chair getting to know the
13 organisation and understanding priorities. She
14 advised that she intended the board to be able to hold
15 her to account through the Chair's statement."

16 Then if we go over the page, there's
17 a discussion then about strategy.

18 Mrs Lloyd, can you still hear me?

19 **A.** I can.

20 **Q.** Good. It is at (iii):

21 "AL briefed the board regarding the meeting
22 with the health Minister, Anna Soubry, on
23 25 March 2013. At the meeting Caxton had acknowledged
24 that a number of areas required further work and
25 improvement, but plans were now in place to take this

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1 challenged.

2 **Q.** Were you -- the Inquiry heard evidence from Mr Roger
3 Evans that he was unhappy when he was chair of the
4 Macfarlane Trust about the services that were being
5 provided to the Macfarlane Trust by the Caxton
6 Foundation.

7 Was that anything that was brought to your
8 attention?

9 **A.** No.

10 **Q.** You say in your witness statement that you considered
11 pursuing the appointment of separate Chief Executives
12 for the Macfarlane Trust and the Caxton Foundation.

13 Can you tell us what happened to that idea and
14 why you didn't pursue?

15 **A.** I believed that ideally it would have been
16 a reasonable way through the potential conflicts of
17 interest. However, in the light of (a) getting two
18 people of sufficient seniority at a price we could
19 afford I believed would detract some of the money from
20 the beneficiaries because it would be from a pot.

21 **Q.** Did you think that was something you could raise with
22 the Department of Health with a view to trying to
23 increase the budget, the allocation?

24 **A.** The balance of risk I decided was such that we could
25 run with the arrangements for the next 12 months and

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1 forward, including ..."

2 Then you set out a number of your priorities:

3 "... developing a strategy for Caxton; work to
4 identify additional clients; recruitment of a board
5 member with experience of living with HCV; creation of
6 a partnership group with stakeholders; improvements to
7 customer care; further work to establish how best to
8 support clients and not create a dependency culture."

9 Now we will come on to look at all of those in
10 a little more detail in a moment, but was it your
11 impression after those first few months that there
12 were areas that could be improved at the Caxton
13 Foundation?

14 **A.** Very much so.

15 **Q.** These were your priorities. In particular there we
16 see:

17 "Creation of a partnership group with
18 stakeholders."

19 Was it the case that there was no formal method
20 of communicating with beneficiaries by the time you
21 arrived in February 2013?

22 **A.** Not as a collective.

23 **Q.** And is this also correct, that you set up
24 a partnership group that had its first meeting in
25 June 2013?

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1 A. Yes.

2 Q. Just before we leave this page can I just draw your

3 attention to what's said at (i)? Just go up this

4 page, "strategy". It is the second paragraph there:

5 "Following AL's concern regarding the use of

6 the term beneficiary to describe those people Caxton

7 enlisted to support, the board agreed that in future

8 all references would be to 'clients'."

9 We have heard some evidence from Miss Barlow

10 about this.

11 A. Yes.

12 SIR BRIAN LANGSTAFF: May I just ask, if that is so, why

13 on the previous page -- can we go back to the previous

14 page? No.

15 MS SCOTT: Is it below at (iii)?

16 SIR BRIAN LANGSTAFF: We were looking at strategy.

17 MS SCOTT: It may be the bottom of page 2.

18 SIR BRIAN LANGSTAFF: Possibly. Yes. Those bullet

19 points:

20 "Improvements to customer care."

21 Does that mean client care?

22 A. Yes.

23 SIR BRIAN LANGSTAFF: Thank you.

24 MS SCOTT: We heard some evidence from Miss Barlow about

25 this, that this was a decision that she said wasn't

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1 within our Trust deed of what we would and would not

2 do and what we would and would not prioritise.

3 Q. So --

4 A. Sorry. Can I just -- which I actually think is far

5 more logical than having a strategy.

6 Q. In fact, I think we have given you a couple of

7 documents early this morning, for which I apologise,

8 setting that out.

9 A. Yes.

10 Q. I think the fullest one is probably in the annual

11 report, which is CAXT0000034_008. It's the

12 31st March 2013 annual report, so you can see that on

13 the first page. Then if we turn to page 7 of that

14 document under "Future plans" at the bottom of that

15 page 7 -- do you have that, Mrs Lloyd?

16 A. I do. Thank you.

17 Q. It says:

18 "Following the appointment of a new Chair and

19 Chief Executive and four other new board members, the

20 board held a strategy day to begin the process of

21 setting out the priorities and direction for the next

22 five years. It established a vision, mission, and

23 values for the organisation for the first time."

24 The vision is:

25 "Caxton wants everyone who has been affected by

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1 very popular with the beneficiary community and was

2 one that was reversed. Is that correct?

3 A. That's true.

4 Q. Is there a reason why you are still using the word

5 "clients" in your witness statement?

6 A. I didn't realise I was. I am sorry.

7 Q. That's just an oversight on your part, is it?

8 A. Yes. I wasn't aware of it.

9 Q. Soumik, you can take that down. I am going to look at

10 some of those priorities you identified in that

11 meeting in May 2013 and first of all look at the

12 development of a strategy for Caxton?

13 A. Yes.

14 Q. Why was that a priority for you? Why is it that

15 a charity that has a Trust deed should have

16 a strategy? Can you explain that to us?

17 A. The development of this strategy commenced before

18 I became the Chair. So I cannot apprise you of the

19 rationale behind the original decision, but there was

20 a strategy day developed in March just after -- it had

21 been established before I got there, but the board had

22 a strategy day, and I would say from reading -- being

23 part of that discussion and reading the notes of that

24 strategy meeting which you kindly sent me, this isn't

25 a strategy. This is a determination of the objectives

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1 hepatitis C derived from the NHS to be able to live

2 a positive, fulfilling and independent life."

3 The mission:

4 "We will reach ... all those affected by

5 hepatitis C derived from the NHS and work with them to

6 improve the quality of their lives."

7 The values:

8 "Respect.

9 Fairness.

10 Sound stewardship.

11 Confidentiality.

12 Caring and responsiveness.

13 Empowerment.

14 Engaging."

15 Then the board sets out the key strategic

16 principles that will govern its work and be priorities

17 in the coming year:

18 "Effective identification of clients and

19 effective communication and awareness raising."

20 That's what you have already told us, the

21 importance of identifying potential clients as they

22 are there called:

23 "Effective intervention -- using the experience

24 of the first 18 months of operation, we will examine

25 what further support can be offered to clients with

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a view to developing new partnerships to enhance the range of services ... understanding the external environment ... a greater capacity to understand what impact changes, eg in the benefits system, will have on our clients and how best to respond. Ensuring that the Caxton Foundation is appropriately resourced. We will ensure that we continue to have regular discussions with our funder, the Department of Health, regarding appropriate levels of funding to meet the needs of our clients and we will also look at our staffing needs to ensure we have the right skill set to deliver our work."

What impact do you think having this kind of strategic principles and objectives had for the Caxton Foundation?

A. Well, I believe it allows us to focus our work and test it out with the partnerships that surrounded us to ensure that arising from the comments that we were having with the beneficiaries and others, other partners, that this was the right type of suite of objectives that we should be pursuing, and I think for the board to have a common focus based on that knowledge was important.

Q. Is this right: in your statement -- and you told us this afternoon that you had the strategy day in March,

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Then it says:

"Estimates have been made of the possible numbers of primary beneficiaries. Factors taken into account when making these estimates, based on Skipton's stage 1 payments, are the rate of mortality, the prevalence of asymptomatic hepatitis C, and the success rate of antiviral treatments, all of which have to be estimated, but the best estimates so far suggest that the potential total number of primary beneficiaries might be in the region of 1,600, with potentially 400 dependent families."

So is this correct, that when you arrived at the Caxton Foundation, there was a thought that they only had registered with them a quarter of the beneficiaries who may, in fact, be eligible for support?

A. Yes.

Q. And what did you understand to be the impact of that on the way that the Caxton Foundation had operated thus far?

A. Well, I don't think that I put it down to what the Caxton Foundation had or had not done because I was unsighted on what action they had taken, both to identify what we felt was a shortfall, or to take action to improve the situation. However, as we had

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and then these principles were adopted in May.

Is it right to understand that there hadn't been any formal -- at least formal consultation with the beneficiary community before these principles and objectives were finalised?

A. That is correct.

Q. If we just stick with this document then and look at the issue of identifying beneficiaries --

A. Yes.

Q. -- can we look at page 6, please? At the bottom there:

"Caxton's client community."

It says:

"By the end of March 2013 [so this is very early on in your chairmanship], 555 primary beneficiaries and widows had been registered with Caxton following receipt of a stage 1 Skipton payment. This was much lower than the number that had been expected, and it remain a key task for Caxton to identify all those whom it could be helping. It is not known whether the shortfall in numbers results from a lack of awareness of Caxton or reluctance to seek charitable help, or whether it signifies that many fewer people than anticipated are, in practice, in need of Caxton's support."

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identified a shortfall, then one of our first priorities actually was to make sure that we took action to try and ensure that people did know what we were there to do and how to get hold of us.

Q. I am going to come back to that in a moment, but did you get any sense that the Caxton Foundation had been cautious about disbursement of its allocation because it was expecting this huge increase in the beneficiary population?

A. No, that is not the impression I gained.

Q. Soumik, you can take that down.

I think you described yourself as being unsighted as to what had been done prior to your arrival to try and improve beneficiary numbers. Does that remain the case? You don't know what was done before you arrived? Sorry, did you say yes?

A. Yes, sorry.

SIR BRIAN LANGSTAFF: She still remains unsighted.

A. The Internet connection is unstable it is telling me.

No, I remain unsighted, and you have frozen.

MS SCOTT: Can you hear me now?

A. There you go.

Q. Good.

A. I can now. Thank you.

Q. Is this right? I can take you to the document if it

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1 assists. At the first Board meeting you attended as
 2 chair in February 2013 there was a discussion about
 3 approaching those who had received Skipton Fund stage
 4 1 payments to tell them about the Caxton Foundation
 5 and it was considered that carried significant data
 6 protection problems. Do you want me to take you to
 7 the document? Would that assist? It is CAXT --
 8 A. No, it is okay. I remember that.
 9 Q. Is that correct, that there was a discussion --
 10 A. No, it's okay. Honestly.
 11 Q. My question is: is that correct, in February --
 12 A. That is what was recorded.
 13 Q. That is what was recorded. Do you recall whether or
 14 not --
 15 A. Yes, that is what was recorded.
 16 Q. Sorry. Right. Do you recall or not an approach was
 17 actually made to Skipton in order to ask them whether
 18 or not they would approach their beneficiaries or was
 19 the decision made that actually there was no point in
 20 even asking?
 21 A. Well, I can't recall. I wasn't chairman until the end
 22 of this meeting and I cannot recall the finite detail
 23 of exactly what was discussed, but I -- the importance
 24 of this for me was that it alerted me to the fact that
 25 there was this problem and we had some indication of

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1 for which I am grateful, and I have never seen this
 2 document before, but certainly I do not believe that
 3 the Caxton Foundation trustees really appreciated
 4 this, which -- well, the chairman -- the outgoing
 5 chairman was part of this agreement. So whether or
 6 not a codicil to this had been produced prior to --
 7 when was it -- 7th February '13, I don't know because,
 8 as I said, I have never seen this document before.
 9 Q. Soumik, you can take that down. Just to understand
 10 then, you were never given, when you joined the Caxton
 11 Foundation as chair or at any other time, a copy of
 12 the Trust Deed?
 13 A. No.
 14 Q. Can you recall -- we know from your statement in
 15 August/September 2014 a look-back exercise was
 16 undertaken by Skipton to identify beneficiaries for
 17 the Caxton Foundation. I will come on and ask you
 18 questions about that in a moment, but can you recall
 19 what steps, if any other steps, were taken by the
 20 Caxton Foundation to advertise its existence to
 21 potential beneficiaries?
 22 A. Yes. We had extensive talks with the Haemophilia
 23 Society and the Hepatitis Society to ask them to
 24 publicise our work and they were very accommodating in
 25 that respect, and we continued discussions with

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1 direction to improve the situation if we did work with
 2 Skipton.
 3 Q. Is this right: you don't have any recollection of
 4 whether or not direct requests from made of Skipton by
 5 the Caxton Foundation?
 6 A. No.
 7 Q. Do you recall whether the Caxton Foundation sought and
 8 obtained any legal advice about the data protection
 9 issue?
 10 A. I do not know.
 11 Q. I am going to show you a provision in the Trust Deed
 12 now. It is CAXT0000095_006. It is page 15 of that
 13 document. It is schedule 5, which deals with the
 14 background to the establishment of the Caxton
 15 Foundation and it is clause 7 of that at the bottom:
 16 "Under the Skipton Fund Agreement ... and at
 17 the request of the Trustees, the Skipton Fund is
 18 (subject to compliance with data protection laws)
 19 required to notify the Trustees of the identity of the
 20 Primary Beneficiaries."
 21 Do you remember whether that was something that
 22 the trustees were aware of when these considerations
 23 and discussions were taking place, that there was that
 24 obligation on the Skipton Fund?
 25 A. Well, you kindly sent me this document this morning,

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1 Skipton about what was possible from their point of
 2 view and I know you are coming to that.
 3 Q. Am I to understand that you do recall discussions with
 4 Skipton about what they could and could not do in
 5 terms of getting in touch with their beneficiary
 6 population?
 7 A. Yes. The Chief Executive had those discussions on our
 8 behalf.
 9 Q. Skipton was saying to you "No, we can't do it"?
 10 A. They could not do it because of staffing.
 11 Q. They weren't raising data protection issues; they were
 12 raising staffing issues?
 13 A. At that time they weren't raising data protection
 14 issues, correct.
 15 Q. So just to try to understand, the Caxton Foundation
 16 were concerned there were data protection issues but,
 17 in fact, when they went to Skipton, Skipton were
 18 saying "No, that's not the issue, the issue is
 19 staffing"?
 20 A. Yes.
 21 Q. How then did that resolve itself and end up in
 22 a look-back exercise being carried out in August and
 23 September 2014?
 24 A. We made an application to the Department of Health to
 25 fund Skipton to undertake this work on our behalf.

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1 Q. The Caxton Foundation made that application, did they?
 2 A. Yes, yes.
 3 Q. What was the result of that, can you recall?
 4 A. Yes. The Department of Health gave the money
 5 requested to the Skipton Foundation to conduct the
 6 look-back on our behalf, and that is why -- and to
 7 make contact with their clients, really, so that we
 8 again did not hold the records of those individuals,
 9 but Skipton acted on our behalf and, as a consequence,
 10 the numbers of potential beneficiaries increased
 11 rapidly.
 12 Q. Looking back now, do you think more could have been
 13 done by the Caxton Foundation to get this work done
 14 before it was in August/September 2014?
 15 A. I think we probably could have pushed harder, but then
 16 I am always a bit impatient to get things done.
 17 Q. Another element of this strategy that we looked at in
 18 the annual report was the appointment of a user
 19 trustee with experience of hepatitis. When did you
 20 become aware that it was important for at least some
 21 members of the beneficiary community to have a user
 22 trustee on the Board?
 23 A. Pretty early on. There had, I understand from
 24 Mr Lister, been some discussions about this latterly
 25 before I came on board, and having been a trustee of

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1 consideration?
 2 A. No, it wasn't part of that consideration. It was more
 3 that we wanted to have a greater understanding of the
 4 conditions and its consequences.
 5 Q. Is this right, that while user trustees -- while
 6 beneficiaries -- shall I put it that way -- of Caxton
 7 were not excluded from applying to become the user
 8 trustee, the Board felt that it would be preferable
 9 not to have a beneficiary, because of potential
 10 conflicts of interest?
 11 A. That is true.
 12 Q. What were the Board's concerns about conflict of
 13 interest?
 14 A. I think that if we are discussing the details of
 15 either applications or the rates at which we were
 16 paying grants or the comprehensive nature of the
 17 grants, then it could be an issue of a conflict of
 18 interest if a user who was a beneficiary was also
 19 party to that. They might have to exclude themselves,
 20 you have got to be quite careful about declarations of
 21 interest, and we thought it would probably be
 22 preferable if the individual was not a beneficiary
 23 but, as you have pointed out, we didn't rule that out.
 24 Q. Were you aware at the time of the Charity Commission's
 25 guidance on user trustees, users on boards and

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1 the Patients Association I did find it unusual for
 2 a grant-making organisation that was focused on
 3 beneficiaries not to have anybody on the Board who at
 4 least had a limited experience of the condition. So
 5 I believed it was -- as part of our trying to get
 6 a better, more comprehensive relationship with the
 7 partners with whom we were working and the
 8 beneficiaries, it would be a good addition to our
 9 Board.
 10 Q. Did you understand there to be a concern about the
 11 ability of the Board to challenge the Department of
 12 Health effectively because there were members of the
 13 Board who had had senior roles at the Department of
 14 Health or in the NHS?
 15 A. No.
 16 Q. You weren't aware of that?
 17 A. I never even considered it. It certainly did not
 18 alter any behaviour.
 19 Q. But did you become aware that there was a concern
 20 amongst some in the beneficiary community that that
 21 was the case?
 22 A. Yes, I did become aware of that but did -- could, by
 23 our actions, reassure them that that was not the case.
 24 Q. So did you consider recruiting a user trustee would
 25 address those concerns or was that not part of the

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1 beneficiaries who become trustees?
 2 A. No.
 3 Q. Would you accept that, at the time that this was under
 4 consideration, the Caxton Fund had already put in
 5 place some measures to deal with perceived conflicts
 6 of interests from other trustees? For example,
 7 Mr Lister tells us in his witness statement that he
 8 recused himself from having direct meetings with the
 9 Department of Health because of his previous role in
 10 the Department of Health?
 11 A. Yes.
 12 Q. Could that approach not have been taken for
 13 a beneficiary user trustee?
 14 A. Well, as I said, we did not rule out definitively that
 15 a user trustee, a beneficiary, could not become
 16 a trustee but we were concerned about the conflicts of
 17 interest, which is what we tested.
 18 Q. You appointed Mrs Margaret Kennedy --
 19 A. Yes.
 20 Q. -- as a -- she was termed a user trustee but, if fact,
 21 she wasn't a user trustee, was she? She wasn't
 22 a registrant of the Caxton Foundation?
 23 A. No.
 24 Q. But she had been infected with hepatitis C through
 25 contaminated blood, is that right?

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1 A. That's right.
 2 Q. So she was there to fulfil the role on the Board, if
 3 I can put it that way, of someone with lived
 4 experience of hepatitis C?
 5 A. Yes.
 6 Q. Was any consideration given by the Board to appointing
 7 another trustee from the beneficiary community?
 8 A. Not at that time. We were going to evaluate the
 9 consequences of having a trustee with lived experience
 10 on the sort of quality of our decision-making in 2015
 11 before considering further appointments.
 12 Q. Then you left your -- you left the Caxton
 13 Foundation --
 14 A. Yes.
 15 Q. -- before that could take place?
 16 A. Yes. Might I just add something?
 17 Q. Yes.
 18 A. What we also had in mind is that we had a number of
 19 really good applicants, some of whom were
 20 beneficiaries and that, as a consequence, we wanted to
 21 invite them to the Partnership Group, but also
 22 I thought it would be a good idea to increase the
 23 participation of the beneficiaries by trying to
 24 establish regional fora in which we could gather more
 25 extensively the views and wishes of our beneficiaries

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1 improved relationships with the beneficiary community?
 2 A. I'm not sure. I'm not sure.
 3 Q. Why?
 4 A. Well, I'm just not sure. I did not have the
 5 opportunity to evaluate the advantages and
 6 disadvantages of that recommendation. And had
 7 I stayed, I would have discussed with the Chair of MFT
 8 what the advantages and disadvantages might be, and
 9 I left before I had the opportunity to have that
 10 conversation.
 11 Q. Sir, I am conscious of the time. I don't know what
 12 you want to do about breaks and so on, given the late
 13 start that we have had. I anticipate that I have
 14 probably got 45 minutes to an hour left with
 15 Mrs Lloyd.
 16 **SIR BRIAN LANGSTAFF:** Yes. Shall we just go on for
 17 another quarter of an hour, if you can, and take
 18 a break then because I am sure both Ms Lloyd and those
 19 at home could do with a break at that stage. Then we
 20 will come back and see how we go.
 21 I am sorry, it is going to be a rather longer
 22 afternoon than we anticipated, but for the reasons
 23 which are all too obvious from the way we started.
 24 **MS SCOTT:** So, Mrs Lloyd, you were telling us about the
 25 changes that you wanted to make to the partnership

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1 but that again didn't commence -- well, I don't think
 2 it ever commenced but if I had stayed it would have,
 3 because I was very keen that we should use the people
 4 who had applied who were very, very good and met the
 5 criteria more extensively, and they seemed keen to do
 6 that.
 7 Q. I will come on to ask you a few more questions about
 8 that a little bit later on.
 9 The APPG in its report --
 10 A. Yes.
 11 Q. -- made a recommendation that, in order to improve
 12 relationships with the beneficiary community a portion
 13 of trustees should be recruited from the beneficiary
 14 population and that the Haemophilia Society should
 15 appoint three beneficiaries to the Caxton Foundation,
 16 as they do for the Macfarlane Trust.
 17 Can you recall whether or not you had
 18 a response to that recommendation as a Board? It was
 19 shortly before you left the Caxton Foundation?
 20 A. Yes, it was before. Well, because it was shortly
 21 before, I did not discuss that, but I understand that
 22 the Board did consider the whole of the Parliamentary
 23 Inquiry's recommendations subsequently.
 24 Q. You, personally, do you think that that kind of
 25 recruitment from the beneficiary population could have

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1 group as a result of interviewing and meeting with the
 2 beneficiaries who had applied to become the user
 3 trustee.
 4 Is this right, that you did, in fact, make some
 5 changes to the partnership group in about
 6 November 2014?
 7 A. Yes.
 8 Q. What were those changes, and why did you make them?
 9 A. Well, we made them to increase the range and spread of
 10 the advice and guidance we could be given from the
 11 beneficiary and partnership communities. And they
 12 were invited to attend, but that's not as far as we
 13 wanted to go.
 14 We undertook -- I don't know whether you are
 15 going to come to this, the survey that we undertook,
 16 or is that a separate question?
 17 Q. No. Do talk about that now.
 18 A. Shall I carry on?
 19 Q. Yes. Please do.
 20 A. Okay. We undertook a survey with our beneficiaries to
 21 ask them how they would like us to engage with them
 22 more effectively. We were thinking of regional
 23 meetings at that time, but there was little uptake for
 24 that. They weren't very keen on that, which was
 25 a surprise, but, you know, you've got to respect

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1 people's views. We were reviewing the outcome of that
 2 survey to ensure that we could put into practice the
 3 suggestions that they had largely made.
 4 **Q.** Did you consider as a matter of general principle that
 5 having a partnership group was an effective way of
 6 communicating with the beneficiary population
 7 community?
 8 **A.** It was a way of communicating. And when I looked
 9 through the information that you sent me last Thursday
 10 and the partnership group meetings, it was clear to me
 11 that a number of things that they raised, particularly
 12 at the first two meetings, were really important to
 13 us. And we were able to action their concerns and put
 14 them right, or at least make sure that they were
 15 discussed either by the board or the National Welfare
 16 Committee to alleviate concerns that were being
 17 expressed by the community.
 18 So in looking at and evaluating what was said
 19 and what was done, I felt that we were getting
 20 a better view of what the trustees -- not the
 21 trustees -- sorry -- the beneficiaries believed would
 22 be an improvement than we would have without that
 23 partnership group.
 24 **Q.** Why was it that it took until December 2014 to produce
 25 a newsletter?

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1 beneficiaries or certain categories of beneficiary.
 2 Did the Caxton Foundation have any events of that
 3 nature?
 4 **A.** Yes, we had one whilst I was there which we initiated.
 5 **Q.** What did that entail?
 6 **A.** There were some seminars, and there was general
 7 discussion on things that the beneficiaries wished to
 8 raise.
 9 **Q.** Was it well attended?
 10 **A.** Yes, quite well attended, although not as well
 11 attended as I expected.
 12 **Q.** Did you find it a useful forum for meeting
 13 beneficiaries and discussing issues they were
 14 concerned with?
 15 **A.** Yes.
 16 **Q.** And was that a forum in which you got to meet
 17 beneficiaries that you hadn't got to meet through the
 18 partnership group?
 19 **A.** Yes.
 20 **Q.** And were there plans for further such events?
 21 **A.** Yes.
 22 **Q.** And did those not happen in your time because you had
 23 left by then?
 24 **A.** Yes.
 25 **Q.** Can you recall when that event was?

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1 **A.** I don't know. There were instructions that it should
 2 be done long before that.
 3 **Q.** So that was something that you were disappointed with,
 4 was it?
 5 **A.** Yes.
 6 **Q.** Was there consideration given to whether a forum
 7 should be created on the website to allow
 8 beneficiaries to communicate either with each other,
 9 or with members of the staff, or trustees?
 10 **A.** That came up latterly, I understand, because I wasn't
 11 unfortunately at the last of the partnership meetings
 12 before I left. That would have been a sensible way
 13 forward as well. It is not an unusual technique.
 14 **Q.** So not something you were averse to, but just
 15 something that didn't happen during your time there?
 16 **A.** No.
 17 **Q.** And I think you have said that you were keen on
 18 regional meetings, but they didn't, in fact, take
 19 place during your time at the Caxton; is that right?
 20 **A.** There was no enthusiasm for them from the returnees of
 21 our survey.
 22 **Q.** Equally, did the Caxton have any sort of larger
 23 conferences and so on? We have heard evidence from
 24 the Macfarlane Trust and the Eileen Trust that they
 25 ran fairly regular events, either to all of the

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1 **A.** Gosh! I can't, I'm afraid. I am awfully sorry.
 2 I can't remember when it was.
 3 **Q.** I'm going to ask you some questions now about an event
 4 that took place on 17 April 2013 when a group of
 5 beneficiaries came into the offices at the Alliance
 6 House organisation.
 7 Is it right that you weren't present at the
 8 Alliance House offices on that day?
 9 **A.** That's true, and the beneficiaries knew that would be
 10 the case.
 11 **Q.** And the Inquiry has heard evidence from Ms Barlow that
 12 she was present in the office having a meeting but
 13 didn't witness the events themselves. Is that also
 14 your understanding?
 15 **A.** No.
 16 **Q.** Did you come to hear about the event from Ms Barlow?
 17 **A.** Yes.
 18 **Q.** And you understood, did you, that she'd actually seen
 19 what had gone on?
 20 **A.** Yes.
 21 **Q.** Was she the sole source of your information about the
 22 events --
 23 **A.** No.
 24 **Q.** -- initially?
 25 **A.** Well, initially, yes.

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1 Q. I am just going to take to you a letter you wrote on
 2 I think it is 26 April. It is WITN2050107.
 3 So if we go to the second page of that
 4 document, it is 26 April 2013. It is a letter to
 5 Mr Wilkinson, and it says at paragraph 2:
 6 "I was most disturbed to hear that, despite
 7 being informed that we were not available, you and
 8 a number of your colleagues took it upon yourselves to
 9 barge, unannounced and uninvited, into the office on
 10 17 April, causing real concern to the staff. Such
 11 behaviour is not acceptable, and I was particularly
 12 concerned to learn that one of your number has
 13 publicised the fact that your group thought the effect
 14 of your 'visit' on our staff was amusing.
 15 "I can understand the frustrations of potential
 16 beneficiaries, and we do wish to work constructively
 17 with you and other representatives from the HCV
 18 community to deliver our services well. But I have to
 19 advise you that neither I nor my board will tolerate
 20 such behaviour in the future."
 21 You can take that down now, Soumik. Does that
 22 account that you set out there reflect what you were
 23 told by Ms Barlow had occurred?
 24 A. Yes, and it was corroborated by our external auditor.
 25 Q. And who was the -- was the external auditor present in

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1 A. No.
 2 Q. Do you think, with the benefit of hindsight, it would
 3 have been a good idea to do so?
 4 A. Yes, and I have already apologised to Mr Wilkinson.
 5 Q. When you spoke to him about this event, did his
 6 version of the event differ to the version that you
 7 had been given by Ms Barlow and the auditor?
 8 A. Yes. He said he popped in to say hello.
 9 Q. Can you look now at another document? It is
 10 CAXT0000110_034. This is a document we have already
 11 looked at. It is the minutes of 2nd May 2013 board
 12 meeting. If we turn to page 3 of those minutes, under
 13 (v) at the top there:
 14 "The board noted a report from JB regarding the
 15 intrusion into Caxton's offices by members of the
 16 Contaminated Blood Campaign on 17th April. It was
 17 noted that AL had written to the chair of the CBC, and
 18 Roger Evans had also written to the Macfarlane Trust
 19 beneficiary who had been involved. It was noted that
 20 following the visit, increased security measures had
 21 been put in place. It was also noted that the
 22 Department of Health had been briefed."
 23 Just pausing there, why was the Department of
 24 Health briefed? Can you recall?
 25 A. I cannot recall why they were briefed.

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1 the office?
 2 A. Yes.
 3 Q. And the external auditor spoke to you, did he or she?
 4 A. Spoke to -- corroborated Jan Barlow's understanding of
 5 what had happened.
 6 Q. And you spoke to the auditor, did you?
 7 A. I spoke to the auditor.
 8 Q. And they told you --
 9 A. Yes.
 10 Q. -- what had happened was in similar terms to what's
 11 set out in this letter?
 12 A. Yes.
 13 Q. The Inquiry has seen a leaflet that was published by
 14 the Caxton Foundation inviting beneficiaries to pop in
 15 to attend the office if they wished to. Is that
 16 a leaflet that you were familiar with at the time?
 17 A. No.
 18 Q. Have you seen it subsequently?
 19 A. No.
 20 Q. And so presumably you weren't aware of the existence
 21 of that leaflet when you wrote this letter?
 22 A. No.
 23 Q. Did you take any steps before writing this letter to
 24 find out what Mr Wilkinson's account of the incident
 25 was?

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1 Q. And then going back to the note:
 2 "JB advised that whilst it had been
 3 an unpleasant experience for staff, their main concern
 4 had been to ensure no confidential client information
 5 could be accessed by CBC members whilst they were in
 6 the offices. The board thanked the staff for their
 7 calm handling of the situation."
 8 Is it right to understand that these -- Soumik,
 9 you can take that down -- minutes were published on
 10 the website?
 11 A. Yes. All minutes are published on the website.
 12 Q. Did you consider the impact that publishing minutes in
 13 that form with that description of the incident might
 14 have on official communications -- on official
 15 relations? Sorry.
 16 A. No, not explicitly.
 17 Q. Is this right, that at a partnership group meeting
 18 subsequently a request was made for those minutes to
 19 be removed from the website because of the impression
 20 that they gave?
 21 A. Yes.
 22 Q. Yes, and were any steps taken to either tone down the
 23 language or put that part of the minute into the
 24 confidential section of the minutes that weren't
 25 published on the website or any steps taken at all to

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1 deal with those concerns?

2 **A.** Oh, gosh! I can't actually remember, but I believe

3 that action was taken. We had a long conversation at

4 the partnership group about this at the end.

5 **Q.** So you think action was taken to --

6 **A.** I think so, but I am not precise about it. I am

7 really sorry.

8 **Q.** And that presumably was for the sake of good

9 beneficiary relations, was it?

10 **A.** Yes, and because I had already apologised to

11 Mr Wilkinson for not consulting him prior to writing

12 the letter.

13 **Q.** Sir, I am going to go on to another topic. I hope

14 I will only be about thirty to forty minutes.

15 **SIR BRIAN LANGSTAFF:** Right. Well, let's take a break now

16 then. You no doubt will be fielding some questions

17 which the core participants may have during the break.

18 Is 4.10 too early for you?

19 **MS SCOTT:** No, I think that will be fine, and then if we

20 need another short break, then we could have another

21 short break perhaps after Mrs Lloyd has completed her

22 evidence.

23 **SIR BRIAN LANGSTAFF:** Yes. I am concerned not to keep

24 Mrs Lloyd here any longer than is necessary --

25 **MS SCOTT:** Right.

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1 holding the CEO and the trustees to account for the

2 effective management and administration of the charity

3 in accordance with the charitable aims."

4 Can you tell us in what way you considered

5 yourself to be responsible to the Government?

6 **A.** I felt I was -- well, I know I was responsible to the

7 Government for the proper distribution of the funds

8 they provided to us, as any organisation who is in

9 that position is.

10 **Q.** As the chair of a charity, did you consider that you

11 had a duty to the charity itself and to act in the

12 interests of the charity and to be independent of the

13 Government?

14 **A.** I think that I always felt I was independent of the

15 Government, but when you come to the public account

16 and the receipt of Government money, you have to deal

17 with it appropriately and in line with their rules.

18 You could see from the action I took as Chair

19 that we did act independently because we acted in the

20 best interests of the beneficiaries, as we said we

21 would, and in line with the information we were

22 acquiring in terms of needs.

23 **Q.** Did you see the annual reviews with the Department of

24 Health as meetings in which you had to account to them

25 for the ways in which the Trust was spending its

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1 **SIR BRIAN LANGSTAFF:** -- but yes, let's do that.

2 **A.** I am happy to stay, chair.

3 **SIR BRIAN LANGSTAFF:** Thank you very much indeed. That's

4 very kind of you. Thank you. 4.10 in any event and

5 there will probably be another break before we finish.

6 So 4.10.

7 **A.** Thank you.

8 (3.43 pm)

9 (Short break)

10 (4.10 pm)

11 **MS SCOTT:** Mrs Lloyd was there a minute ago.

12 **A.** I am here. I was just dealing with a query on breast

13 cancer, so sorry about that.

14 **SIR BRIAN LANGSTAFF:** Are you ready?

15 **A.** I am. Breathless but ready.

16 **SIR BRIAN LANGSTAFF:** Ms Scott.

17 **MS SCOTT:** I just want to ask you a question about

18 something you said in your statement. Can we go to

19 WITN5257001. So that's your statement. It is the

20 second page. It is paragraph 4. You were asked a

21 question by the Inquiry -- you were asked to describe

22 your role and responsibilities as Chair of Caxton, and

23 you say this:

24 "I was responsible to the Government for

25 overseeing the governance of the organisation and in

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1 allocation?

2 **A.** I had to account -- well, the Chief Executive is the

3 accounting -- accountable officer, obviously, but we

4 had to account for the regularity and probity of the

5 use of the resources against the deed against which we

6 were established and the use of the money that they

7 required of us.

8 **Q.** Is an arrangement where the Department of Health

9 provides all the funds for the Caxton and then holds

10 them to account as to how they spend it -- is that

11 arrangement, do you think, consistent with Caxton

12 operating as an independent charity?

13 **A.** No, but it was a fact of life. I did not feel

14 beholden to the Department of Health. I just knew

15 that we had to account effectively for the use of

16 their resources for the purposes intended.

17 **Q.** So do you think that the Caxton Foundation's

18 independence was impugned by that arrangement?

19 **A.** No.

20 **Q.** What steps were in place, or what procedures or

21 protocols were in place to ensure that that was the

22 case, that the Caxton's Foundation's independence

23 wasn't impugned by that arrangement?

24 **A.** We had no interference in determining the vision, in

25 determining our priorities. We were not instructed to

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1 undertake certain pieces of work, and we would have
 2 made sure that as we were established to work in the
 3 best interests of the potential beneficiaries that
 4 that is what we did. And I don't think it was the
 5 intention of the Department of Health to prevent us
 6 from doing that.

7 **Q.** During the annual meetings with the Department of
 8 Health that you attended with the Chief Executive, was
 9 there an opportunity to raise concerns about the
 10 allocation, about underfunding and matters of that
 11 nature?

12 **A.** Yes, there was every opportunity to do that.

13 **Q.** And were those opportunities taken during your chair?

14 **A.** The issue of the underfunding was a difficult one
 15 until latterly to raise with them because we always
 16 underspent. So asking for additional money when you
 17 hadn't spent the money you were given wasn't a very
 18 strong starting point. However, when we had our
 19 request for the funding of the regular payment scheme
 20 refused, then in the next round of discussions, we --
 21 and the numbers of potential beneficiaries had risen,
 22 we then had the lever to argue for additional
 23 resources.

24 **Q.** I will come on to ask you about that in a bit more
 25 detail and perhaps show you some documents. But just

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1 discovered when they were looking at the regular
 2 payment scheme, in terms of the levels of poverty that
 3 many beneficiaries were living in?

4 **A.** Yes.

5 **Q.** Do you have any understanding as to how that could
 6 have arisen, that there were many beneficiaries in
 7 those years, where the Caxton was underfunding, were
 8 living in poverty but Caxton were underspending. Were
 9 those beneficiaries simply not coming forward and
 10 asking for money?

11 **A.** That is true, and when they were coming forward to ask
 12 for grants, really they were very prudent in the way
 13 in which they asked for a number of grants, and that
 14 is why we started to take the discussion forward on
 15 trying to support those in the greatest poverty in
 16 a better way than relying on them applying for grants,
 17 et cetera.

18 **Q.** You are talking there about implementing a regular
 19 payment scheme, are you?

20 **A.** Yes. Yes.

21 **Q.** Just to be clear to you and to those that are watching
 22 that I am not going to be asking you questions about
 23 ways that decisions were made by the NWC about grant
 24 applications and so on because you didn't sit on the
 25 NWC, did you?

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1 on that point you raise that the Caxton Foundation had
 2 underspent --

3 **A.** Yes.

4 **Q.** -- in the years preceding your Chairmanship --

5 **A.** Yes.

6 **Q.** -- what did you understand the reason for that to have
 7 been?

8 **A.** My understanding was that the Department of Health had
 9 provided us with their estimate of the amount of money
 10 we would require, given the potential number of
 11 beneficiaries, but we didn't get all those
 12 beneficiaries coming forward.

13 **Q.** So the trustees at that stage were taking a cautious
 14 approach, given the fact that they may meet a huge
 15 rise in beneficiary numbers and have to meet need out
 16 of the same amount of money?

17 **A.** That is not my understanding of the situation. My
 18 understanding was that we were just not getting
 19 sufficient beneficiaries coming to us, rather than us
 20 being too cautious.

21 **Q.** So --

22 **A.** The only time we started being cautious was when we
 23 had to reconsider the level at which we funded the
 24 regular payment scheme.

25 **Q.** Does that surprise you, given what the Board

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1 **A.** No. No.

2 **Q.** And we have Mr Lister, who was the chair of the NWC
 3 and indeed vice chair of Caxton coming to give
 4 evidence towards the end of the week, so those
 5 questions will be directed towards him. But I will be
 6 asking you questions about the regular payment scheme
 7 because you were involved in that, and you were
 8 involved in presenting that to the Department of
 9 Health, as I understand it; is that right?

10 **A.** Yes, indeed.

11 **Q.** Just sticking then with generally about -- generally
 12 on meetings with the Department of Health, were those
 13 meetings minuted by the Caxton Foundation?

14 **A.** No.

15 **Q.** Why was that?

16 **A.** They were meetings convened by the Department of
 17 Health.

18 **Q.** So you would expect the Department of Health to minute
 19 them, would you?

20 **A.** Yes.

21 **Q.** And would you receive copies of those minutes? When I
 22 mean "you", I mean the Caxton Foundation.

23 **A.** Yes. Yes.

24 **Q.** Again, as a matter of sort of general principle what
 25 was the Caxton Foundation's strategy with respect to

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1 the Department of Health during your Chairmanship?

2 **A.** They were our funders. We needed to keep them

3 apprised of our policies going forward and what we

4 considered to be the main issues facing ourselves as

5 an organisation in terms of meeting the requirements

6 of our objectives, and to start to discuss with them

7 things like the rationale behind the regular payment

8 scheme. So to warn them in advance that there would

9 be additional bids coming in to enable us to do this

10 and why we were doing it. It was a discussion about

11 our priorities and our objectives.

12 **Q.** Did you consider that you had a campaign or lobbying

13 role with the Department of Health? Did you consider

14 that was part of the role of the Caxton Foundation?

15 **A.** I didn't consider that we were campaigning, because

16 that was not part of our responsibility, but I did

17 think that we could act as advocates, particularly in

18 terms of what we were finding in evidence from our

19 beneficiaries to produce a better result for them,

20 which was the basis of the charity in the first place.

21 **Q.** Why did you take the view that campaigning was not

22 part of the responsibility of Caxton?

23 **A.** There were campaign groups that were most effective.

24 **Q.** Were you aware that the Trust Deed would have allowed

25 the Caxton Foundation to campaign had they wanted to?

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1 **Q.** Was your personal style, if I can put it that way, as

2 the leader the Caxton Foundation, to push the

3 Department of Health or were you more of a sort of

4 don't upset them approach and try to keep them on

5 side? Would you be able to describe your style to us?

6 **A.** My style in general is not the latter. If I feel

7 seriously about something then people will know what

8 my views are and my views will be supported by

9 evidence.

10 **Q.** Did you ever get the impression that if you took that

11 forceful approach, the Department might withdraw

12 funding or even close Caxton down?

13 **A.** I never, never imagined that they would withdraw

14 funding.

15 **Q.** So a --

16 **A.** Because that would require a huge justification,

17 wouldn't it, which I don't think they would wish to

18 handle.

19 **Q.** I think you have just told us that you don't think

20 Caxton was at the bottom of the Department of Health's

21 priority list. What was your impression of how the

22 Department of Health viewed Caxton and the important

23 of Caxton?

24 **A.** Certainly from the discussions they thought that we

25 were fulfilling an important role amongst a group of

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1 **A.** As I advised you, I am afraid I have never seen that

2 Trust Deed before.

3 **Q.** That wasn't -- and that wasn't a conversation you had

4 with any of your fellow trustees or the Chief

5 Executive?

6 **A.** No.

7 **Q.** I think I interrupted you saying something. Did you

8 want to complete what you were saying?

9 **A.** Sorry. Just to reinforce the point that I did believe

10 and the Board considered that they were advocates for

11 the people they were serving.

12 **Q.** Did you think it would be helpful in terms of trying

13 to advocate for the Caxton Foundation to take steps to

14 increase -- what has been called in other -- in

15 documentation by other witnesses "increase Caxton's

16 political capital", ie sort of push it up the

17 Department of Health's agenda?

18 **A.** Well, I didn't consider it was at the bottom of the

19 Department of Health's agenda. Certainly, I don't

20 think it's every charity that's brought in for

21 a discussion with the Minister every year and that

22 certainly gave us a platform on which to advocate and

23 to advise the Minister of precisely what we were doing

24 and why we were doing it and the needs of the people

25 that we were serving.

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1 beneficiaries who did have quite a high profile as

2 denoted really by the fact that the APPG were

3 undertaking an investigation, an Inquiry into what was

4 going on. So that ensures that that has a high

5 profile. So that was my view, that we were treated

6 equably and listened to.

7 **Q.** Turning more specifically and in a bit more detail

8 then to the funding, is this right, that because of

9 the way money was provided by the Department of Health

10 to the Caxton Foundation, any underspend effectively

11 meant that the Caxton Foundation lost the money, ie it

12 couldn't be rolled over as a reserve to the following

13 year?

14 **A.** Yes, and that's what I wanted to correct in my answer

15 to question 62, thanks to the helpful information --

16 63, because that is an incorrect answer. I am afraid

17 I have got the Patients Association and Caxton mixed

18 up for one moment in that, and so -- 62 it is, sorry.

19 We had to -- we didn't have reserves. We had to

20 return unspent monies.

21 **Q.** So if -- I'm plucking figures out of the air here but

22 if in a particular year the Department of Health

23 allocation is 2 million and you only spend 1.5,

24 actually you only get 1.5, because the half a million

25 will go back to the Department of Health --

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1 A. Yes.

2 Q. -- and can't be used the following year?

3 A. No, it couldn't, but it didn't affect the amount of

4 money we got the next year. They didn't reduce the

5 allocation as a consequence of that.

6 Q. Can we come then on to the funding bid made at the end

7 of 2013 to fund the regular payments scheme?

8 A. Yes.

9 Q. What did you understand to be the reason why a regular

10 payment scheme had not been implemented before you

11 arrived at Caxton?

12 A. I don't know why a regular payment scheme had not been

13 implemented before I came to Caxton.

14 Q. Can we look at a document then? AHOH0000001. We can

15 see at the top there:

16 "Business case for increased funding for the

17 Caxton Foundation from 2014/15 for a regular payments

18 scheme."

19 Then if we go over to page 2, we can see the

20 table at the bottom, "Income benchmarks". It has

21 various different household compositions along the

22 left-hand column going from "Single with no children"

23 up to "Partner with 4 children" and then various

24 income benchmarks, Joseph Rowntree being the most

25 generous, somewhere between 16 and 45. Then 60%

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1 differentiating between the different communities, ie

2 the infected the community and the bereaved community

3 and felt uncomfortable about doing that and so haven't

4 differentiated between the two communities.

5 A. Yes.

6 Q. Can I just ask you about this idea that the

7 Joseph Rowntree level of regular pay could act as

8 a disincentive to independent living and could

9 encourage dependency? A concern about encouraging

10 dependency is something we see frequently in Caxton

11 Foundation documentation and indeed it is something

12 you mention in your witness statement. What was meant

13 by that?

14 A. Ours was a grant-giving organisation primarily and the

15 founders of the Foundation were concerned about the

16 prevalence of a dependency culture. On what basis

17 they were, I don't know, because I didn't see that

18 information because, as you can tell from at that

19 first strategy overview, the same issue was raised.

20 I think the problem we were trying to solve here was

21 a problem of people who really were below the poverty

22 line. The Trust Board did not consider that it would

23 be sufficient just to raise people, if we could, to

24 the poverty line, because of the reasons stated in the

25 business case, and wished to do better than that.

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1 median income from 8,900 down to £23,900. Then 80%

2 median income from 11,900 to 31,900.

3 Is this correct, initially you had requested

4 funding so you could put in place a regular payments

5 scheme that would mean that anyone who had an income

6 of less than the 80% median income would being

7 eligible for a regular payment and that regular

8 payment would bring them up to the 80% median income

9 level?

10 A. Yes.

11 Q. Can we go then on to page 3 of that document, please?

12 At the bottom of that page is set out the reasons why

13 that particular scheme was put forward:

14 "As expected, the financing modelling showed

15 that the Joseph Rowntree model would be extremely

16 expensive, as well as being at a level which could act

17 as a disincentive to independent living and encourage

18 dependency amongst Caxton's client community."

19 The 60% of median income, Caxton feels is only

20 to raise people to the poverty line and that is not

21 sufficient, and does not reflect the additional costs

22 of with living with hepatitis C and consider that they

23 should in fact receive higher levels at the 80% of

24 median income.

25 Then it says you then thought about

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1 Plus, of course, whatever we did did not preclude the

2 delivery of grants to the same people because that

3 would continue.

4 I have asked that we should look at what the

5 poverty levels were described as being at the time and

6 what the Joseph Rowntree Foundation would recommend.

7 I think our ideal in the longer run was the Rowntree

8 Foundation levels, because by then we would have been

9 able to have judged whether any levels of dependency

10 were rising and to have debated further whether

11 dependency was something that would be endorsed, if

12 you can use that word, by the Board for the future.

13 So we, I think, had moderated our view about

14 dependency in even considering having a regular

15 payment scheme. But we still wanted people to be

16 encouraged to try to lead, with support, a more

17 fulfilled and independent life. If that wasn't

18 possible, then what could we do?

19 Q. Is one of the concerns about dependency that if you

20 set regular payment too high, people that could work

21 wouldn't work. Was that a concern?

22 A. That was a concern, which is why we wanted to evaluate

23 the consequences of a regular payment scheme, but our

24 primary issue was that we felt very, very strongly

25 that we had to do something to support better those

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1 who were in a parlous situation.

2 **Q.** Do you recall how this business case was presented to

3 the Department of Health? Was it done in a meeting or

4 was it simply submitted as a written document?

5 **A.** There was a discussion about it with the Department.

6 **Q.** If we just turn on to page 5 of that document, at the

7 bottom there?

8 **A.** Yes.

9 **Q.** The last paragraph there:

10 "Caxton is therefore submitting this proposal

11 to the DH for consideration. Caxton has set out its

12 preferred option for a scheme based on 80% of median

13 income which it believes will best meet its clients'

14 need without engendering dependency. However, Caxton

15 understands that the DH may wish to discuss

16 modifications to this and look forward to having the

17 opportunity to discuss the proposal in more detail."

18 So was it your expectation that, even if the

19 Department of Health didn't say "yes", that there

20 would be some discussion about it?

21 **A.** Yes, and I understand there was discussion between the

22 blood team and the Chief Executive.

23 **Q.** After this business case had been submitted?

24 **A.** Yes. Yes. That would be a normal process.

25 **Q.** In discussions you had had with the Department of

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1 not?

2 **A.** No. No, I am sorry.

3 **Q.** Let me take you to the letter rejecting the business

4 case, it's CAXT0000110_089. It is a letter of 19th

5 February 2014?

6 **A.** Oh, dear. I can't find it. Oh, there we go. Thank

7 you.

8 **Q.** It is up on the screen. It says:

9 "Thank you for submitting a business case ..."

10 It simply says:

11 "Ministers have decided that this is not the

12 right time for an uplift in allocation, whilst they

13 continue to consider how best to address a range of

14 issues about the system of support available ..."

15 Then the last paragraph -- then it says:

16 "... I am not ... able to confirm the Caxton

17 ... allocation."

18 Then it says:

19 "I recognise that the decision not to increase

20 funding will be disappointing news ... However, I hope

21 that it does not come as a surprise to you, given our

22 discussion on a number of occasions of the continuing

23 downward pressure on Government spending."

24 So it doesn't look like this is a response in

25 which the Department of Health is willing to

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1 Health prior to submitting this business case, what

2 had they said to you about -- had they given you any

3 hints as to how the business case might be received?

4 **A.** No, but neither had they dissuaded us not to put it

5 in.

6 **Q.** Soumik, you can take that down.

7 Were you aware at the time that the business

8 case was submitted that the Macfarlane Trust was

9 providing top-up payments to their registrants who

10 were infected, who were receiving payments from the

11 MFET, and they were providing payments to the

12 non-infected community to guarantee their household

13 income at £19,000 per annum?

14 **A.** As part of the discussion when we started the

15 discussion on the regular payment scheme we were

16 advised of that.

17 **Q.** Is that something that featured in your discussions

18 with the Department of Health, "Look, this is -- you

19 are funding Macfarlane sufficiently to provide this to

20 their community, we need parity"?

21 **A.** I personally never had that conversation with them,

22 but the Chief Executive, who would have known what

23 both schemes were aspiring to would have had the

24 opportunity to say that.

25 **Q.** As a matter of fact, do you know whether she did or

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1 negotiate. Do you recall whether there were

2 negotiations about your business case or whether it

3 was just -- this looks like a straightforward

4 rejection?

5 **A.** Yes, it is.

6 **Q.** Do you recall any discussion or negotiation with them?

7 **A.** No.

8 **Q.** If that had taken place it, would have been through

9 Ms Barlow?

10 **A.** Yes, but I think that is a fairly firm rejection.

11 **Q.** You say in your witness statement that you asked

12 someone from the Department of Health to attend and

13 explain the position to the Board. There doesn't seem

14 to be a record of anyone from the Department of Health

15 attending a Board meeting after the writing of this

16 letter. Do you think they didn't take that

17 opportunity?

18 **A.** No, I think they did come, but I can't see the record

19 in the data that you have sent me because I thought it

20 was only reasonable for the Department's

21 representative to understand and allow us to re-state

22 our position and for us to gain a better insight into

23 the pressures on the Department and what we were going

24 to do next was something that we needed to discuss.

25 **Q.** What was again the strategy that the Board and you

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1 used following this rejection? Was it to push for
 2 more? Was it to accept the decision? What happened
 3 next?
 4 **A.** Well, the first thing we had to decide was, given the
 5 rejection, which was firm in Department of Health
 6 terms, what could we seek to achieve and what were we
 7 going to discuss in ongoing discussions with the
 8 Department of Health on the scheme we were trying to
 9 put in and where we would still wish to get to and
 10 over what period of time, to start to have a better
 11 understanding of the financial situation in which the
 12 Department found itself and the pressures with which
 13 they were juggling, to get almost a time-frame of when
 14 we would be able to commence a regular payment scheme
 15 and what opportunity there would be to re bid for
 16 an improvement, particularly based on evidence from
 17 our original scheme. So those were the sorts of
 18 discussions that would go on following a rejection.
 19 **Q.** Was any consideration given to saying to the
 20 Department "Look, we have underspent for the last few
 21 years and you have had that money back which was
 22 allocated to us, can we not at least have that to put
 23 into the pot for our regular payment scheme?"
 24 **A.** Unfortunately, we might understand how the Department
 25 of Health budget allocation works and what was given

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1 their household of between £3,000 and £4,500 per
 2 annum?
 3 **A.** Yes.
 4 **Q.** And is this -- sorry.
 5 **A.** Very disappointing.
 6 **Q.** Yes, very disappointing.
 7 **A.** It was very disappointing.
 8 **Q.** In addition to that, the other amendments that had to
 9 be made to the regular payment scheme was that the new
 10 proposal, the new scheme had to ignore the impact of
 11 a household of more than two children; in other words,
 12 the greatest payment one could get was as if you were
 13 two adults and two children?
 14 **A.** Yes.
 15 **Q.** And in addition, the scheme had to -- that the Caxton
 16 had to take into account when calculating household
 17 income the annual stage 2 Skipton Fund payments made
 18 to those beneficiaries who had received a Skipton
 19 stage 2 capital payment?
 20 **A.** Yes. All things we didn't want.
 21 **Q.** And so the effect particularly of that last alteration
 22 to the scheme meant that those who were the illest,
 23 the most unwell, would, in all likelihood, not obtain
 24 a regular payment from the Caxton Fund; is that right?
 25 **A.** Yes.

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1 back would no longer be available, because they have
 2 an annual (inaudible).
 3 **Q.** The answer to my question is "no" because, in your
 4 view, that wouldn't have got you anywhere?
 5 **A.** No.
 6 **Q.** And was any consideration given to lobbying or
 7 campaigning at that stage and doing something that
 8 might embarrass the Department of Health into changing
 9 their minds?
 10 **A.** I think embarrassing the Department of Health into
 11 changing their minds is a way of dealing with them,
 12 but we wanted a long-term positive relationship with
 13 them, not subservient but positive, and the tactics of
 14 embarrassing people into a corner frequently doesn't
 15 work.
 16 **Q.** Can we look then -- well, in fact, I can take you to
 17 the document if it assists, but is this right, that
 18 the scheme that the Caxton Foundation could afford, in
 19 terms of regular payments, was to identify those
 20 households whose income was less than 70% of median
 21 income as being eligible?
 22 **A.** Yes.
 23 **Q.** And then to make a payment to them but not to bring
 24 them up to the 70% median income level but to make
 25 a payment to them depending on the composition of

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1 **Q.** Was any discrepancy, or was there any difference in
 2 the way the Caxton Fund applied the regular payment
 3 scheme between the infected and the non-infected
 4 community?
 5 **A.** No. We still went for the bereaved community as well.
 6 **Q.** And you have mentioned in your oral evidence that
 7 following the increase in beneficiary numbers as
 8 a result of the Skipton look-back that discussions
 9 were undertaken with the Department of Health to see
 10 whether or not there was more funding available.
 11 Did you have those discussions with the
 12 Department of Health yourself, or were those conducted
 13 through Ms Barlow?
 14 **A.** Ms Barlow had those, but with the endorsement of the
 15 Board.
 16 **Q.** Do you have any particular recollection of how those
 17 discussions progressed or what was said and so on?
 18 **A.** No, but certainly it was reported back that there
 19 was -- we were concerned that -- we'd had the rise in
 20 numbers which we'd been looking for for a number of
 21 years, and we simply would not be able to maintain
 22 a regular payment scheme and all the additional
 23 beneficiaries within our allocation. I thought that
 24 actually we had a very strong case for an increase in
 25 the allocation as a consequence, but it did mean we

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1 had to take very difficult decisions at the latter end
 2 of '14 --
 3 **Q.** Are you --
 4 **A.** -- (inaudible) damage.
 5 **Q.** Are you there talking about making a decision to
 6 reduce the winter payment?
 7 **A.** Yes.
 8 **Q.** Was a formal business case or a more formal approach
 9 made to the Department of Health at that stage to try
 10 and increase the allocation as a result of the spike
 11 in beneficiary numbers, or was it done informally?
 12 **A.** I think it was done informally but a formal case was
 13 going to be produced. The trouble was timing, which
 14 is why the discussions went on with the department,
 15 because the numbers of additional beneficiaries were
 16 rising very much in the period when departments of
 17 health would normally expect business cases to come
 18 in, and we just could not be sure, which is why they
 19 had to be apprised of the fact that our numbers were
 20 rising, which is what we wanted, and the difficult
 21 decisions that were being taken.
 22 So we were looking to produce a business case
 23 which could be considered in the latter end of the
 24 year which would be more tangible and accurate than
 25 anything we could have produced before because of the

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1 result of the almost doubling of the numbers of the
 2 beneficiary community, did you seek to try and engage
 3 the APPG in this issue, see if you could garner some
 4 political capital?
 5 **A.** I don't think so. I know there was a meeting of the
 6 APPG, but unfortunately I couldn't attend that, and
 7 I think that was in November. But I am awfully sorry.
 8 I can't answer that question because I don't know.
 9 **Q.** And did you try and seek a meeting with the Minister
 10 or anything of that nature, try and escalate the issue
 11 to someone more senior?
 12 **A.** Not at that time because the Department is usually
 13 pretty late in allocating budgets, so we didn't know
 14 what their -- I still don't know what their decision
 15 was.
 16 **Q.** Then just lastly on dealings with Government, did you
 17 have any direct dealings with any of the devolved
 18 administrations, or was all of your communication with
 19 Government through the Department of Health?
 20 **A.** No. The health minister, the new health minister in
 21 the Welsh government asked to see me about a number of
 22 things, one of which was the work with Caxton. And
 23 I explained what we were trying to do and what the
 24 issues were, and he wanted me to speak to the Wales
 25 APPG chair, who was Julie Morgan. I agreed that, if

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1 levels of uncertainty at that time.
 2 **Q.** Just on the numbers of beneficiaries, just so that we
 3 have your evidence in relation to that, can we look,
 4 Soumik, at CAXT0000035_078. This is the annual report
 5 on 31 March 2015. So it's an annual report that's not
 6 signed by you because you have left as Chair by then.
 7 **A.** Yes.
 8 **Q.** But if we turn to page 8 of that document, we can see
 9 under "Caxton's beneficiary community", and the
 10 second -- it talks about the look-back in the first
 11 paragraph. The second paragraph gives us the number.
 12 Three lines down:
 13 "By 31 March, the number of Caxton
 14 beneficiaries had risen to 1,080 from 689 on
 15 1 April 2014, an increase of 57% for the year."
 16 Mrs Lloyd, you will recall that in the annual
 17 report that we looked at the year before, when you
 18 first arrived, the number there at that stage was 555.
 19 **A.** Yes.
 20 **Q.** Is that how you recall the rise in numbers?
 21 **A.** Yes, and then it continued to rise.
 22 **Q.** So the Department of Health, having turned down, first
 23 of all, your application for regular payment and then
 24 having turned down what you considered to be a very
 25 strong application for an increase in allocation as a

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1 invited, I certainly would do. So there was
 2 a separate discussion, but he actually wanted to talk
 3 to me about more than just Caxton at the time.
 4 **Q.** So a meeting with the Welsh administration. Any
 5 meetings with or communication with Scottish or
 6 Northern Irish administration?
 7 **A.** No. Well, we had the -- no, we didn't, no.
 8 **Q.** I am going to ask you now about the dispute between
 9 Macfarlane Trust and the Haemophilia Society --
 10 **A.** Oh, yes.
 11 **Q.** -- that occurred during your Chairmanship.
 12 **A.** Yes.
 13 **Q.** But before I do, can you just -- in your statement,
 14 you tell us that you and Jan Barlow met fairly
 15 regularly with the Haemophilia Society. What was the
 16 purpose of those meetings, and what was the
 17 relationship like before the allegations were made by
 18 Ms Carroll against Ms Barlow and Mr Evans?
 19 **A.** The purpose of the meetings was to share information
 20 about what we were doing and what our aspirations
 21 were, and for them and the Hepatitis C Trust to share
 22 information coming back from their candidates.
 23 Obviously, our relationship was closer with the
 24 Hepatitis C Trust, which you would expect, and they
 25 were very helpful in trying to promote our work to

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1 their clients. The relationship had been -- with the
 2 Haemophilia Society had been amicable and
 3 professional, as you would expect.
 4 **Q.** And helpful to the Caxton Foundation?
 5 **A.** Yes, where they could help us, they did.
 6 **Q.** Was the Caxton Foundation involved in any way in
 7 a dispute with the Haemophilia Society? Did it, for
 8 example, take part in the instruction of lawyers or
 9 pay anything for the lawyers?
 10 **A.** No.
 11 **Q.** Why was it necessary in your view to suspend relations
 12 with the Haemophilia Society in light of the
 13 allegations Ms Carroll made?
 14 **A.** I took that decision because the lawyers for MFT had
 15 advised the Chief Executive not to have any meetings
 16 with Ms Carroll whilst their dispute continued. We
 17 were just about to have a meeting with Ms Carroll and
 18 in the light of the lawyers' advice we decided to
 19 defer that meeting until the dispute was resolved or
 20 further clarification was available on the situation.
 21 **Q.** And this occurred right at the end of your time at the
 22 Caxton Foundation?
 23 **A.** Yes.
 24 **Q.** So you --
 25 **A.** Right at the end.

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1 from Core Participants -- one of them I have already
 2 asked -- the first of which is whether you know --
 3 were trustee appointments during your time at Caxton
 4 Foundation considered by the Commissioner for Public
 5 Appointments?
 6 **A.** No.
 7 **Q.** And the second question is whether you can recall how
 8 the Skipton Fund actually contacted beneficiaries when
 9 they were doing the look-back? Do you recall how that
 10 contact was made?
 11 **A.** No. I'm sorry.
 12 **Q.** There are other witnesses we can take that issue up
 13 with later on during the week.
 14 Sir, those are the questions that I had for
 15 Mrs Lloyd and the questions that I received during the
 16 break for Mrs Lloyd. I am going to suggest, Sir, that
 17 we have a short break for any further questions that
 18 have arisen as a result of the evidence that we have
 19 just heard.
 20 **SIR BRIAN LANGSTAFF:** Let's take a break until 5.10.
 21 **MS SCOTT:** Sir, Mrs Lloyd needs to be given the warning.
 22 **SIR BRIAN LANGSTAFF:** Yes, of course.
 23 What I should have told you at the last
 24 break -- I am sorry; it is my failing -- you are
 25 giving evidence. You must not discuss any matter

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1 **Q.** Right at the end?
 2 **A.** Yes.
 3 **Q.** In fact, it was the meeting at which you announced
 4 that you were stepping down?
 5 **A.** Yes.
 6 **Q.** Were you concerned nevertheless that the suspension of
 7 contact might have an impact on the beneficiary
 8 community?
 9 **A.** I wasn't at the time, because I did not expect the
 10 suspension of the relationship to be long-lasting, and
 11 if there had been -- my view at the time was if there
 12 had been an irreconcilable dispute between MFT and the
 13 Society, then the Board of Trustees of Caxton would
 14 have to act to restore a relationship with the
 15 Haemophilia Society.
 16 **Q.** And, of course, this came shortly afterwards, after
 17 the APPG had made a recommendation that the
 18 Haemophilia Society should have a larger role to play
 19 in the Caxton Foundation by appointing three trustees.
 20 So the relationship with the Haemophilia Society was
 21 presumably at that point quite important to the Caxton
 22 Foundation. Is that right? Is that fair?
 23 **A.** Yes, it was one of our important Trusts.

Questions from CORE PARTICIPANTS

24 **Q.** I have had a couple of questions over the break in
 25

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1 which you have already dealt with in evidence or
 2 anything which you think you may yet be asked to deal
 3 with with anyone, whoever that anyone is, although
 4 anything else is entirely a matter for you. It is
 5 plain from what you have already said that you may
 6 have various pressing issues to deal with. That is
 7 fine.

8 **A.** Thank you.

9 **(4.56 pm)**

10 **(Short break)**

11 **(5.10 pm)**

12 **MS SCOTT:** Mrs Lloyd, I just have a handful of questions.
 13 I was asking you -- you were giving some evidence
 14 about a seminar that Caxton held, and it is right to
 15 say in the Inquiry's consideration of documentation we
 16 have not seen any reference to a seminar.

17 **A.** Right. Okay.

18 **Q.** It looks instead like the beneficiary community were
 19 pressing for a seminar right up until the time you
 20 left, and indeed information that we've had over the
 21 break from some of the Core Participants was to the
 22 effect that they weren't aware that a seminar had
 23 taken place.

24 So can I just ask you to give us any more
 25 detail about when that could have been or where it

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1 could have been.

2 A. Well, I might have been mistaken. If that is the

3 case, I am really, really sorry, but I was sure that

4 we either had or were to have a seminar because I know

5 it had been raised by the partnership board and

6 others. So if I have got confused between this and

7 another trust, I really do apologise. I am sorry.

8 I have done my best to remember. Sometimes you can

9 get confused.

10 Q. So would this be fair to say: you had a recollection

11 of attending a seminar, but you can't be sure that it

12 was the Caxton Foundation; it may have been another

13 organisation?

14 A. It could have been, yes.

15 Q. You have said in your witness statement that you

16 carried out appraisals of trustees.

17 A. Yes.

18 Q. What was the nature of the annual appraisal you

19 conducted of trustees?

20 A. It was against their job description, which was not

21 extensive. But basically that they were able to and

22 felt confident in undertaking their responsibilities

23 along the lines of financial probity, objective

24 setting, and holding to account largely, and that we

25 had -- we were able to have a spread of talents and

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1 the need of the population was going to be for

2 a regular scheme. And as part of our sort of amending

3 the dependency requirement, we knew that even with our

4 support there were some people who would never be able

5 to be independent of a grant-making organisation, and

6 that had to be acknowledged.

7 So knowing better from Skipton the number of

8 beneficiaries that we were likely to receive requests

9 from, we tried to look at the median of the requests

10 we received to try and calculate what, if everybody --

11 who was entitled to receive a grant or regular

12 payments, how much would that require in the long run.

13 And that was the work we were doing when I left.

14 Q. And so that would -- it would be as a result of those

15 calculations and investigations, would it, that a case

16 would be put to the Department of Health as to what

17 the Caxton Foundation needed in order to --

18 A. Yes.

19 Q. -- meet the charitable need of the community?

20 A. Yes. It would be based on the evidence we had

21 collected, our analysis of the future size of the

22 community, including those who would require regular

23 payments at various levels, and then this would be the

24 overarching future bid for the organisation.

25 Q. So save for the bid for the regular payment which was

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1 understanding throughout the trustees which would

2 allow for good governance to take place.

3 Q. And so would the particular trustees have

4 responsibility for particular areas of governance?

5 A. Yes. Well, we had a collective responsibility, but

6 there were certain trustees who had particular

7 capabilities which were important to the governance of

8 the organisation, like an understanding of HR

9 practice, an understanding of communications,

10 an understanding of finance and audit in particular.

11 Q. And were there occasions during your tenure that you

12 had any cause for concern of individual trustees?

13 A. No.

14 Q. How was it possible for Caxton to create a realistic

15 assessment of the needs of the whole beneficiary

16 community when Caxton were under the impression that

17 many needy applicants were not making applications to

18 it, and there was an impression that large parts of

19 the beneficiary community had not been reached by

20 Caxton at all, and that Caxton had no independent way

21 of assessing the extent of charitable need within its

22 potential beneficiary community?

23 A. Well, that's part of the complication with which we

24 were faced. We did our utmost to try and calculate,

25 particularly given the regular payments scheme, what

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1 turned down, that work was in progress when you left?

2 A. Yes.

3 Q. Do you know how the Department of Health arrived at

4 the sum for the allocation? Was it based in any way

5 on what the needs of the Caxton Foundation were, or

6 was it based on what was available?

7 A. Oh, dear! I don't think I can give an accurate answer

8 to that because I wasn't part of the original

9 negotiation. But I would have assumed that the most

10 likely way they went about calculating it was based on

11 the numbers that they believed were likely to make

12 a claim and the numbers that -- and the sort of size

13 of the grant that we'd be able to give. It would be

14 something along those lines when the original

15 allocations were made, but I was never party to those

16 discussions. And that's why we needed to renew

17 discussions with them, given our increasing evidence

18 base of what was being requested by the beneficiaries.

19 Not easy when we were underspending, but once we

20 started to get the numbers that we expected

21 registering with us, then we would have a far more

22 credible set of arguments to place before the

23 Department.

24 Q. How were you able to assess during your time at the

25 Caxton Foundation whether it was successful in meeting

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1 its objectives using the powers available to it under
 2 the Trust Deed if you had not seen a copy of the Trust
 3 Deed?
 4 **A.** Well, that was almost impossible to do, but we did
 5 have our objectives. And what we had to do was review
 6 those, and based on whether or not we had made
 7 progress on them, then our business cases for the next
 8 year would be constructed. So we had our objectives,
 9 and we worked on those to try and ensure that they
 10 were met. There were trustees when I first started
 11 who had seen that Trust Deed because they had signed
 12 it, and that was our initial guide.

13 **MS SCOTT:** Sir, can I just take a moment to check that
 14 I have got all the questions that ...

15 **SIR BRIAN LANGSTAFF:** Yes.

16 **Q.** Sir, those are the questions I had from the Core
 17 Participants and their recognised legal
 18 representatives.

19 Questions from SIR BRIAN LANGSTAFF

20 **SIR BRIAN LANGSTAFF:** I just have a couple of questions.
 21 The first is this: at one stage in your evidence you
 22 described that the beneficiaries were in your words
 23 very prudent in applying for grants. That's why you
 24 were looking for a better way of getting money to
 25 them, money which you had and they were not asking for

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1 would be the case, no.
 2 **SIR BRIAN LANGSTAFF:** The reason I ask you that is there
 3 was a certain emphasis in some of the evidence we
 4 heard earlier about the Macfarlane Trust, which
 5 suggested that at the top there was a view that the
 6 beneficiaries of that Trust would take liberties. If
 7 they knew precisely what they could claim for, they
 8 would all claim the maximum, but that was not your
 9 view of the beneficiaries of Caxton?

10 **A.** No. I think it was probably the alternative view.

11 **SIR BRIAN LANGSTAFF:** Yes. Thank you very much. The
 12 second thing I want to ask you about was your
 13 description when you were appraising the trustees and
 14 the fairly light touch appraisal, as you called it,
 15 I think, you said you would "hold them to account".

16 **A.** Yes.

17 **SIR BRIAN LANGSTAFF:** Now, you didn't give me details of
 18 what holding to account actually involved. What do
 19 you mean by that? How would you hold a trustee to
 20 account?

21 **A.** What I meant was that the trustees had a variety of
 22 responsibilities, all of which could be assessed.
 23 I went through a suite of questions under each of
 24 those competencies to get -- well, I knew how I felt
 25 they had behaved and performed, but to have

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1 is, I think what you were saying.

2 Do you mean that, knowing they could get larger
 3 sums, they were nonetheless respectful of the fact you
 4 might not have all the money in the world to give them
 5 and therefore asked for fairly modest sums? Is that
 6 what you are saying?

7 **A.** No, Chairman. What I intend to convey is that we did
 8 an annual census of potential beneficiaries every
 9 year. When I got there it wasn't being used but we
 10 started to use it more in order to adjudge what the
 11 future needs of our beneficiaries would be and that,
 12 based on that evidence, we believed that they were
 13 applying for grants that actually, given their level
 14 of income, they could have applied for more, and
 15 therefore we tried to help them with information on
 16 the sorts of things that could possibly be available
 17 to them if they wished to apply. So I do not imagine
 18 that they were taking the initiative to help us with
 19 our management of our monies, rather that we believed
 20 there was a possibility that they were not accessing
 21 the support that they could have, given their level of
 22 income.

23 **SIR BRIAN LANGSTAFF:** So these were people who certainly
 24 weren't out for every penny they could get?

25 **A.** Well, given their applications I wouldn't think that

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1 a conversation with them about what the requirements
 2 were and additional training, if necessary, if I felt
 3 that they were scrutinising at, well, too low a level
 4 and they needed to start to think about a different
 5 range of questioning and to give them some coaching on
 6 that, and to ensure they felt comfortable that their
 7 skills were being used effectively by us and my
 8 responsibility was to maximise their skills. At that
 9 time, I was assessing Trust Boards for their
 10 competence -- well, it wasn't as hard nosed as that
 11 but I used the same basic framework that I would be
 12 using within the public sector to hold people to
 13 account.

14 **SIR BRIAN LANGSTAFF:** Yes. Thank you very much. Those
 15 are all the questions I have. Ms Scott?

16 **MS SCOTT:** Mrs Lloyd, do you wish to add anything to your
 17 evidence?

18 **A.** Only to say thank you very much for your courtesy and
 19 the helpful way in which you have asked the questions.
 20 My tenure at Caxton was two years only, which is
 21 actually quite a limited footprint in the life of the
 22 organisation, but I did work to make improvements to
 23 the lives that the beneficiaries could lead, although
 24 that sounds somewhat sanctimonious, and I have tried
 25 to recollect, as far as I can, to help this Inquiry,

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1 which I think is important, and thank you very much
2 for the evidence that you have provided to me, which
3 was appreciated.

4 **SIR BRIAN LANGSTAFF:** Well, I think really the thanks are
5 due from us to you. At a very early stage in your
6 evidence you described how you got things done because
7 you were impatient. I think you might have had every
8 right to have been impatient with this Inquiry in the
9 early stages, given the difficulties we had in
10 maintaining a connection, which surfaced more than
11 once, but --

12 **A.** No, not at all.

13 **SIR BRIAN LANGSTAFF:** The other thing which you might like
14 to know is that you might be surprised perhaps to know
15 by the number of witnesses that I have heard during
16 the course of my career who, faced with a "yes" or
17 "no" question never actually answer "yes" or "no" but
18 say something around it without ever really answering
19 the question. It is actually quite a relief to find
20 someone who is completely different, who does give
21 a "yes" or a "no" or even, on one occasion, a "don't
22 know". And on the one occasion that you perhaps
23 misremembered, you were absolutely straightforward in
24 saying that you might have done that. That is, I must
25 say, very welcome as to the precision and the clarity,

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1 the striving for accuracy which you have given and the
2 articulate way you have put it over has been most
3 welcome to the Inquiry.

4 Two years it may have been, but you have made
5 it a lot clearer with a certain definite clarity, if
6 I can put it that way, about it and I would just like
7 to thank you very much for that.

8 **A.** Thank you, Chairman. Thank you very much for that.

9 **SIR BRIAN LANGSTAFF:** Now, tomorrow we have Mr Fish, do
10 we?

11 **MS SCOTT:** Tomorrow we have Mr Fish at 10 o'clock.

12 **SIR BRIAN LANGSTAFF:** So ten o'clock tomorrow, Mr Fish.
13 Thank you very much.

14 **A.** Thank you.

15 **(5.28 pm)**

16 **(Adjourned until 10.00 am the following day)**
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