

Tuesday, 8 November 2022

(10.00 am)

SIR BRIAN LANGSTAFF: Mr O'Mahony.

THE WITNESS: Good morning.

SIR BRIAN LANGSTAFF: Welcome, to the Inquiry. Let me explain our arrangements, but, first of all, I understand that because your name, your surname, is mispronounced so often you prefer to be known as Brian.

THE WITNESS: Correct.

SIR BRIAN LANGSTAFF: Very good name. You're talking not just to the assembled company in front of you, who are a mixture of participants and Core Participants, and potentially in a room beyond this hearing room -- a breakout room -- but also online to those who are watching, either on YouTube or on live stream. So the audience for what you have to say will number in three figures, most probably. The questions will be asked by Ms Richards, in a moment, though first, Mary will invite you to take the oath.

Mary.

MR BRIAN O'MAHONY (sworn)

Questioned by MS RICHARDS

MS RICHARDS: Brian, I'm going to start with an overview of your career. You are the current chief executive

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Q. And that's the capacity in which you worked until 1994?
A. Correct.
Q. You've sat on multiple committees and boards relating to haemophilia including, for a period of time, the Irish Blood Transfusion Service board?
A. I still sit on that board, in fact.
Q. You've set those out in your witness statement in paragraph 3; I'm not going to go through them all but there is a significant number in terms of your involvement.

In relation to previous inquiries, you gave evidence at the Institute of Medicine Inquiry in the USA in 1994?

A. That's correct.

Q. And what, in very broad terms, was the nature of your evidence?

A. The nature of my evidence at the IoM Inquiry was related, entirely, to the response of governments outside the USA. So, they wanted some comparative statistics and data. So really, I was looking at the response in other countries --

Q. And then you gave information to the Royal Canadian Mounted Police in 1995 in the course of a --

A. That's correct.

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of the Irish Haemophilia Society.

A. That's correct.

Q. And you've held that position since 2006?

A. Correct.

Q. But your involvement with the Irish Haemophilia Society dates back to the early 1980s?

A. 1982.

Q. And you've been on the board since 1982 other than for a brief period in around 2003-04?

A. Yes.

Q. You were chairman of the Irish Haemophilia Society between 1987 and 2003?

A. Yes.

Q. Between 1994 and 2004 you were president of the World Federation of Haemophilia?

A. Yes.

Q. And between 2011 and 2019 you were president of the European Haemophilia Consortium?

A. Yes.

Q. You yourself have severe haemophilia B?

A. Yes.

Q. And you're a medical laboratory scientist by background and training?

A. Correct.

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Q. -- of a visit that was taking place in Canada not for that purpose?

A. That's correct.

Q. You were involved in the Finlay and the Lindsay Tribunals of Inquiry in Ireland. Just so that we understand the difference between the two: the Finlay Tribunal focused on infection through anti-D and also blood transfusion; the Lindsay Inquiry looked at the infection of people with haemophilia?

A. That's correct.

Q. And you gave evidence to the Lindsay Tribunal twice?

A. Yes.

Q. And you then gave evidence to the non-statutory inquiry, the Archer Inquiry, in this country?

A. Yes.

Q. I'm not going to ask you in any detail about your work in Ireland in the 1980s and '90s, but just so that we can understand the position of the Irish Haemophilia Society at that time, it was, as I understand it from your statement, a very small voluntary organisation and in the early '80s it didn't have an office or even a permanent address?

A. Yes, when I joined the board in 1982, the Society had a voluntary committee, no office, no staff, no headquarters. In fact, whoever the unfortunate

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1 individual was who happened to be honorary secretary,
 2 all of the mail arrived at their house. So the annual
 3 budget at the time was around £4,000.
 4 Q. And it was, I think, 1987 before there was any kind of
 5 staff member at all?
 6 A. We had a part-time member of staff, two mornings
 7 a week from 1987 and our first full-time staff member
 8 in 1989.
 9 Q. Then I just wanted to ask you briefly about your own
 10 knowledge of AIDS back in the 1980s and how you came
 11 to be aware of the possibility of a risk of
 12 transmission through blood or blood products.
 13 Your statement indicates that that came to the
 14 attention of the Haemophilia Society in Ireland in
 15 1983?
 16 A. Correct.
 17 Q. And you yourself learnt about it through reading an
 18 article in a laboratory magazine?
 19 A. Yes.
 20 Q. So through your own scientific work?
 21 A. Yes.
 22 Q. Do you have any recollection of roughly when in 1983
 23 that might have been?
 24 A. March or April of 1983.
 25 Q. Then it was, I think, following a newspaper article,

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1 head that if we were self-sufficient there would be
 2 a lower risk of transmission of potentially
 3 blood-borne viruses.
 4 Q. In your witness statement, if we just have it up on
 5 screen.
 6 WITN7418001, please, Lawrence, and if we could go
 7 to page 5.
 8 If we pick it up, top of the page, this is
 9 paragraph 7 of your statement, you've said --
 10 A. Yes.
 11 Q. "In his replies to us ..."
 12 And the context in the previous paragraph was the
 13 discussions you've referred to in 1983.
 14 "... the treating consultant pointed out that all
 15 blood products could potentially cause AIDS or non A
 16 non B Hepatitis, and that the risk of bleeding was
 17 much greater than the risk from any viral infection."
 18 Do you have any recollection of when in 1983 that
 19 was being said, roughly, by the treating consultant?
 20 A. That would have been around, I think, May or June
 21 of 1983, shortly after my meeting with the Blood
 22 Transfusion Service.
 23 Q. Then just one other request for clarification from
 24 your statement. If we go over the page to page 6,
 25 please. Paragraph 9, you report that:

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1 and you've referred, I think, in your statement to
 2 the "killer blood" article, which I think dates it,
 3 for our purposes, to the Mail on Sunday article at
 4 the beginning of May '83. You then had a meeting with
 5 the Irish Blood Transfusion Service?
 6 A. That's correct.
 7 Q. There was a suggestion that you discuss the issue with
 8 someone you've described in your witness statement as
 9 the "treating consultant". Would it be right to
 10 understand that's Professor Temperley that you were
 11 talking about there?
 12 A. Yes.
 13 Q. Again, just so that others can understand your
 14 statement, what was his role?
 15 A. Professor Temperley was the national haemophilia
 16 director, so he was the director of the main National
 17 Haemophilia Treatment Centre in Dublin at the time.
 18 The discussions I had were with Sean Hanratty, who was
 19 the chief scientific officer of the Blood Transfusion
 20 Service Board, and my meeting with him, which
 21 I actually took a handwritten minute of, was based on
 22 the fact that I was concerned that there seemed to be
 23 little or no progress being made in relation to
 24 self-sufficiency for factor concentrates from Irish
 25 plasma. And I was -- you know, I had this idea in my

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1 "In December 1984 we had the first diagnosis of
 2 AIDS in an Irish person with haemophilia."
 3 A. Yes.
 4 Q. And then this:
 5 "The indication from the treating consultant at
 6 that time was that this may be the only case of AIDS
 7 we would see in a person with haemophilia and that
 8 perhaps only 1% of those who were HIV positive would
 9 go on to develop AIDS."
 10 Do you know whether any reason was given for that
 11 rather optimistic prediction that it might be the only
 12 case of AIDS?
 13 A. I think it seemed to be very much the prevailing
 14 clinical opinion at the time. Professor Temperley
 15 would have had a close relationship with the UKHCDO,
 16 attended their meetings. If you look at similar --
 17 people like Dr Peter Jones in his book in 1985 he
 18 talked about 1, 1.5 per cent. So initially the advice
 19 was very much that, you know, to stop taking factor
 20 concentrates was much more dangerous, because there
 21 was risk of bleeding, than the potential risk of
 22 a potential blood-borne virus. By the end of 1984,
 23 when we had the first case, I remember
 24 Professor Temperley saying very clearly that he
 25 expected this would be the only case we would see,

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1 that the risk of people with -- who were HIV positive
 2 going on to develop AIDS was probably 1 per cent.
 3 Q. Can I then just ask you, in terms of the numbers of
 4 people with haemophilia in Ireland and numbers
 5 infected, if we look at a document you've exhibited to
 6 your statement -- it's WITN7418004 -- we can see it's
 7 entitled "AIDS, Haemophilia and the Government,
 8 A submission from the Irish Haemophilia Society
 9 calling for financial provision for people with
 10 haemophilia infected with the AIDS virus", and
 11 the date is April 1988.
 12 If we could go to page 3, please, Lawrence. We've
 13 just got some figures on the right-hand side of the
 14 page.
 15 A. Yes.
 16 Q. Third paragraph:
 17 "Of the 296 Haemophiliacs registered in Ireland.
 18 "- 265 have been tested for exposure to HIV.
 19 "- 106 have been infected with HIV ...
 20 "- 9 have developed 'full blown' AIDS.
 21 "- 4 [by that time] have died.
 22 "- 70% of severe Haemophilia A patients have been
 23 infected."
 24 So the 296 haemophiliacs registered in Ireland,
 25 did that encompass, as far as you understand it, those

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1 emerged following, first of all, a survey that
 2 the Irish Haemophilia Society undertook of its members
 3 in 1987; is that right?
 4 A. Yes, I became Chairman of the Society in 1987, and my
 5 top priority was helping our members who had been
 6 exposed to HIV and who had developed AIDS. So, in
 7 order to understand what their real requirements and
 8 needs were, a dental surgeon and I -- who sat on our
 9 board as well -- we did a survey of as many people as
 10 possible who had HIV and AIDS, so I think we got
 11 58 responses out of 70 surveys sent out and that
 12 allowed us to draft up this proposal for Government,
 13 based on a real understanding of what their needs
 14 were.
 15 Q. That resulted in the submission that we looked at
 16 briefly --
 17 A. Yes.
 18 Q. -- a couple of minutes ago?
 19 A. Correct.
 20 Q. The argument that was being made at that point in
 21 time, as I understand it, was that there was a moral
 22 responsibility on the Government to respond to
 23 the situation of those who had been infected, through
 24 no fault of their own, with HIV?
 25 A. Yes.

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1 who were mild, moderate and severe?
 2 A. No, looking at the numbers, that would probably have
 3 been moderate and severe.
 4 Q. Then we have the figures there, 106 infected with HIV,
 5 so 40 per cent. Does that remain the figure, as far
 6 as you know, of the numbers infected with HIV?
 7 A. Yes, yes.
 8 Q. Then in terms of the numbers infected with
 9 hepatitis C, do you have any knowledge of what
 10 proportion were infected with hepatitis C?
 11 A. We're talking about 240, 245 people.
 12 Q. Okay. So a very significant proportion?
 13 A. Yes, but also that would have encompassed a number of
 14 people with mild haemophilia as well.
 15 Q. Understood. We can take that down, thank you.
 16 I want to ask you now, Brian, about some of
 17 the measures that have been put in place, over
 18 the decades in Ireland, to address the needs and
 19 the circumstances of those who were infected through
 20 contaminated blood and blood products. The purpose,
 21 as I know you understand, being for us to understand
 22 whether there is anything that can be learnt from how
 23 Ireland has responded to the plight of those infected.
 24 So I wanted to start with the Haemophilia HIV
 25 Trust. As I understand your statement, Brian, this

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1 Q. That wasn't accepted by the Government to start with
 2 and the Society embarked upon a public and political
 3 campaign?
 4 A. I mean, when you say it wasn't accepted, all we
 5 received, actually, was an acknowledgement of receipt
 6 of the document and then five months of silence. And
 7 despite the fact I was naive enough to think, at
 8 the time, that if you sent in a well reasoned,
 9 well argued case that it would receive a fair response
 10 from the Department of Health, that didn't happen. So
 11 at the end of that year people were getting sicker and
 12 they were dying, so we realised we had no option
 13 really but to try and put political and media pressure
 14 on the Government to respond to this.
 15 Q. Now, that resulted, eventually, in an agreement which
 16 led to the establishment of the Haemophilia HIV Trust?
 17 A. Yes.
 18 Q. Did you -- what was your understanding of what
 19 ultimately persuaded the Government to accede to that?
 20 A. Well, the fact that the political media campaign was
 21 very successful, we got a lot of traction, a lot of
 22 media coverage, we had some of our members with HIV
 23 who spoke publicly and very bravely to highlight
 24 the issue. And then it went all of the way to -- we
 25 had a minority Government at the time -- it went all

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1 of the way to a vote in Parliament.
 2 The week before the vote I had assumed that
 3 the Government would offer some sort of compromise.
 4 We spent the week in discussions, the Government
 5 didn't move whatsoever on this. They made it an issue
 6 of financial management so that when -- they then
 7 threatened that if they lost that vote in
 8 the Parliament they would call for an election. So
 9 the Prime Minister lost the vote in Parliament, called
 10 a general election, lost seats in the election, and
 11 fortunately, in the course of the election campaign,
 12 we had received written commitments from the leaders
 13 of all of the other parties to implement a trust fund
 14 if they got into office. The outgoing Prime Minister
 15 then had to go into a coalition with another party
 16 and, as part of the negotiations for the programme for
 17 Government, the trust fund was established.
 18 Q. Now, initially, that trust paid regular payments, so
 19 from about 1987 to 1991 there was some regular
 20 payments?
 21 A. 1989 to 1991, it was established in '89. We made
 22 regular payments to some individuals, not to all
 23 individuals. It was very much based on an assessment
 24 of individual need and people's individual
 25 circumstances, and people really were struggling, some

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1 to be done as quickly as possible; is that right?
 2 A. Yes, it was very non-complicated. I think the Society
 3 had people on the board of trustees with independent
 4 trustees. So a request would come in for funding, it
 5 may be based on a phone call, it may be based on
 6 a letter and then that would be discussed very, very
 7 quickly and a decision made. In some cases where it
 8 was a very urgent situation and the request came in
 9 directly to the Irish Haemophilia Society, we would
 10 pay the item ourselves and then seek to recoup the
 11 money later from the HHT.
 12 If you look at our audited accounts for all
 13 the years from 1989 to now, there is always an in and
 14 out from the HHT and they never match up because,
 15 typically, there can be a couple of months' delay
 16 before recouping the money back. But it's always been
 17 our view that the trust fund should be non-complex, it
 18 should be easy to administer and that payments should
 19 be made quickly where they're required. In fact
 20 the procedures were set up following meetings with
 21 the beneficiaries, so that was very important. They
 22 were consulted on how they wanted the trust fund to
 23 operate.
 24 Q. Now, in 2002 there were further payments made, we'll
 25 come on to that, but the Tribunal that had been set up

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1 people were really struggling. So regular payments
 2 were made to those who needed them until 1991 when, in
 3 fact, a further tranche of compensation was paid.
 4 Q. Those are the *ex gratia* payments, essentially, from
 5 1991?
 6 A. Yes, yes.
 7 Q. We'll pick up those in a moment. If we then -- just
 8 staying with the Haemophilia HIV Trust, from 1991
 9 onwards it was one-off payments?
 10 A. Yes.
 11 Q. So it might be for funeral grants or equipment, those
 12 kinds of --
 13 A. Yes. Hospital beds, wheelchairs, any -- special
 14 mattresses, anything that would be required by
 15 the person with HIV or AIDS to help them to deal with
 16 the condition or -- and certainly one-off items which
 17 would not easily be provided, in any sort of timely
 18 manner, by the Health Service.
 19 Q. And what you've told us in your statement is that
 20 the way it was designed to operate was that it didn't
 21 have overly complex procedures, or requirements for
 22 lots of different types of proof. The individual
 23 would communicate with the trust, it might be by
 24 letter or by telephone, and a decision would be made
 25 as to whether to make the payment, and it was designed

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1 in relation to hepatitis C was extended to cover HIV?
 2 A. Yes.
 3 Q. And as a result there was a decision that needed to be
 4 made about the future of the Haemophilia HIV Trust?
 5 A. Yes.
 6 Q. As I understand it, the decision was taken through
 7 consultation with those who had been infected; is that
 8 right -- with a range of beneficiaries?
 9 A. Yes, we organised a meeting with as many of those as
 10 possible who survived with HIV and we asked them --
 11 you know, at that point there wasn't an enormous
 12 amount of money left in the trust fund so we offered
 13 them the option of closing down the trust fund and
 14 dividing the remaining funds equally between
 15 the participants, or keep it going as sort of an
 16 emergency fund, and they were very adamant they wanted
 17 it kept going.
 18 Q. That's the way in which it has continued to operate,
 19 again, through -- it continues, is this right, to make
 20 one-off --
 21 A. Yes, yes.
 22 Q. -- payments? Again, it might be for equipment or --
 23 you refer to Christmas payments?
 24 A. Yes, we also look very carefully at, you know,
 25 the people's individual circumstances, and we make

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1 a number of payments at Christmas each year to
 2 individuals who we believe are still in particular
 3 financial need.
 4 Q. And there was a top-up of the amount that the trust
 5 had in 2006?
 6 A. Yes, yes.
 7 Q. EUR 300,000?
 8 A. Yes, that's right.
 9 Q. The trust was chaired initially by one High Court
 10 judge and then since then has been chaired by another
 11 High Court judge?
 12 A. Yes.
 13 Q. You tell us in your statement that they had met with
 14 a lot of those who were infected, but, you know, they
 15 also made themselves known to the community?
 16 A. Yes.
 17 Q. Is that right?
 18 A. Yes.
 19 Q. And how important has that been?
 20 A. Both Judge Carroll and latterly Judge Murphy, we had
 21 several meetings with the members who had HIV to hear
 22 about their concerns and their issues, and also both
 23 chairs of the trust would usually attend our annual
 24 conference for the full weekend and meet members and
 25 just have conversations with them. So they really

17

1 A. Yes.
 2 Q. -- in the United Kingdom, which was settled in 1991;
 3 is that correct?
 4 A. That's correct. We employed a legal team from 1989
 5 and worked with them and we were looking at
 6 the Society actually funding a test case. But as this
 7 was going on and on through the course of 1990, it
 8 became apparent this was not going to see a courtroom
 9 at any time in the immediate future and in the
 10 meantime the number of people dying of AIDS and
 11 getting AIDS was increasing rapidly. We then saw that
 12 the -- the compensation paid by the John Major-led
 13 Government in the UK, and we decided the time was
 14 right to try and settle this politically. So at
 15 the time the minister asked the Society for
 16 a submission to settle these legal cases and we
 17 entered, again, into a four or five-month political
 18 and media campaign, culminating in an offer of
 19 compensation in 1991.
 20 Q. That resulted in what I think you've described as
 21 tiered payments --
 22 A. Yes.
 23 Q. -- in a way that's a similar but not identical, but
 24 similar to the way in which it was done in the
 25 United Kingdom?

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1 developed empathy and a sense of understanding of
 2 the real issues in the community.
 3 Q. And you were asked in your statement if you thought
 4 that the HIV -- the Haemophilia HIV Trust, the HHT,
 5 had been successful, and you've told us in your
 6 statement that you think it has been, its objectives
 7 were met, and you've identified three factors:
 8 trustees acting with empathy and understanding;
 9 the ability to respond rapidly; and its relatively
 10 informal structure?
 11 A. Yes.
 12 Q. Is that right?
 13 A. Yes.
 14 Q. So that's the HHT.
 15 A. Mm.
 16 Q. Now, the second main plank of financial support for
 17 those who were infected is the compensation tribunal,
 18 and so I just wanted to ask you a little about how
 19 that --
 20 A. There was the earlier 1991 -- (overspeaking) --
 21 Q. I'm sorry, yes --
 22 A. -- as well, yes.
 23 Q. Yes. Yes, let's pick that up.
 24 So there was litigation in Ireland in the same way
 25 as we know that there was litigation --

18

1 A. Yes.
 2 Q. So if we look by at your statement, please.
 3 WITN7418001, page 24.
 4 It's paragraph 43, and you've set out in the
 5 previous paragraphs the process of the litigation, the
 6 campaign and so on.
 7 A. Yes.
 8 Q. "We secured an improved offer of £8 million, to be
 9 paid quickly and with no £1 million claw back."
 10 That was a clawback of what had been paid to the
 11 HHT, was it?
 12 A. Originally the Government offer was 7 million, and
 13 from that 7 they also wanted to claw back
 14 the 1 million paid to the HHT in 1996, and they wanted
 15 to stage the payments over a two-year period. So
 16 frankly, in the week between that 7 million and
 17 the improved offer, local elections were taking place
 18 a week later, we knew we had one more week to optimise
 19 our political and media campaign, we actually had four
 20 candidates running in the local elections, so we
 21 secured a better offer of 8 million and with no
 22 clawback. So in fact it was an increase of 2 million
 23 over the previous offer and it was paid over a course
 24 of two or three months.
 25 Q. Then we can see the figures that were agreed there.

20

1 A. Yes.

2 Q. So a married man with children, 101,000; widow,
3 93,000; married man with no children, 89,000;
4 single adult or child, £76,000; infected spouse,
5 25,000, although there were in fact none; and then
6 non-dependent relatives of a deceased man, 21,000.

7 So if we look at the position as at the end of
8 1991, you have those one-off *ex gratia* payments?

9 A. Yes.

10 Q. Then you have the operation of the HHT?

11 A. The HHT, yes.

12 SIR BRIAN LANGSTAFF: May I just ask a couple of questions
13 at this point.

14 First of all, the paragraph that we see on the
15 screen uses the pound symbol.

16 A. Well, we didn't change to the euro until, I think,
17 2006.

18 SIR BRIAN LANGSTAFF: So though this is punts?

19 A. Punts, yes.

20 SIR BRIAN LANGSTAFF: At this stage a punt was approaching
21 parity, was it?

22 A. It was equivalent to sterling, I think, at the time.

23 SIR BRIAN LANGSTAFF: So for the £8 million pounds, as
24 near as makes little difference, we can read that as
25 £8 million sterling?

21

1 discussions about the availability of Interferon and,
2 indeed, people being charged for treatment with
3 Interferon?

4 A. That's correct. Obviously, when the hepatitis C virus
5 was identified in 1989, it became a topic where --
6 which we discussed out our conferences in '89, '90,
7 '91, '92, we were doing quite a bit of work on this,
8 and the first treatment for hepatitis C, Interferon,
9 there was actually a monthly charge for this, which we
10 felt they should certainly not be charging to people
11 who had been infected through blood products supplied
12 by the state. So we had a series of meetings with
13 the Health Ministry to discuss removing that charge
14 for people with haemophilia, and we also initiated
15 discussions on compensation at that point.

16 Q. If we could just put your statement back on screen,
17 sorry, Lawrence, 7418001, and go to page 25. In
18 paragraph 46 you say this:

19 "Following many discussions, it became clear that
20 the Department of Health were willing to concede in
21 principle on the issue of compensation."

22 Then you go on to talk about how the Tribunal came
23 to be set up -- and I'll come on to that -- but what
24 was your understanding or impression of why it was
25 that the Department did ultimately agree to

23

1 A. Yes.

2 SIR BRIAN LANGSTAFF: This is for a country with
3 a population at the time of that about 3.5 million.

4 A. That's correct, yes, that's correct.

5 SIR BRIAN LANGSTAFF: So if -- to do the maths more
6 quickly, assume 4 million, there are 60 million people
7 roughly, a bit more, in the UK, so in order to
8 translate this into what would be an equivalent
9 payment in the UK, you'd have to multiply 8 million by
10 15.

11 A. 120.

12 SIR BRIAN LANGSTAFF: 120 million. That was what was paid
13 on the basis of a moral obligation and nothing else.

14 A. Yes, correct.

15 SIR BRIAN LANGSTAFF: Thank you.

16 MS RICHARDS: And is it right to understand that there was
17 no acceptance of liability, of legal liability, by
18 the Government?

19 A. That's correct.

20 Q. Now, as your statement then describes to us, what then
21 came to the forefront was the position of those who
22 had been infected with hepatitis C?

23 A. Yes.

24 Q. And you described that particularly coming to your
25 attention in I think, 1993, when there were

22

1 the establishment of what was initially going to be
2 a non-statutory but became a statutory Tribunal?

3 A. I think certainly there was discussion -- that we had
4 many, many discussions with them, but it was --
5 the atmosphere was different than in '89 and '91. We
6 were not getting the same resistance -- absolute
7 resistance that we were getting in '89 and '91, when
8 it was like trying to get blood from a stone frankly.

9 They were a bit more open to the issue, they were
10 a bit more open to the discussion. And, in hindsight,
11 I think that's because they were aware that they had
12 this infection of over 1,000 women with anti-D in
13 the background, and that came to the fore in February
14 of 1994. So I think they saw this was going to be
15 a wider issue and they needed to deal with this.

16 Q. So the Department agreed to set up a hepatitis C
17 compensation tribunal, and that became a statutory
18 tribunal under the Hepatitis C Compensation Tribunal
19 Act of 1997. If we just look briefly at that.

20 WITN7418010.

21 So we've got the arrangement of the Act there. If
22 we go, please, to page 4, we can see, bottom of the
23 page, section 3 establishes the Tribunal:

24 "... a Tribunal to be known as the Hepatitis C
25 Compensation Tribunal to award compensation ..."

24

1 And to a class of claimants.

2 Now, just before we look at who could claim from
3 this Tribunal, this uses the term "compensation"
4 rather than "*ex gratia* payments", so was that
5 significant to your mind, that this was an acceptance
6 of compensation, rather than the making of a payment
7 to dispose of litigation?

8 **A.** Yes, because there was no litigation ongoing at
9 the time in relation to hepatitis C infection, and
10 the word "compensation" was used very clearly by
11 Government and, in fact, they're not going to put
12 the word in an Act without thinking it through,
13 whereas in 1989 the word was banned, they talked about
14 "recompense" or "*ex gratia* payments" without admission
15 of liability. "Compensation" was clearly understood
16 to be compensation in --

17 **Q.** But there was still no acceptance of legal liability
18 by the Government?

19 **A.** That's correct. And in fact it's worth, I think,
20 reiterating that the compensation tribunal -- that
21 the first payments under the compensation tribunal
22 were made a year before the Lindsay Tribunal terms of
23 reference were even -- the discussions started
24 four years before the tribunal started hearings and
25 six years before the report. So I think they had

25

1 a *prima facie* entitlement to compensation?

2 **A.** That's correct. And, in fact, in the case of a person
3 with haemophilia, just being able to show, from
4 medical records, that the person had received factor
5 concentrate -- plasma-derived factor concentrate, was
6 deemed sufficient proof. And I think, yes, there
7 was -- in relation to negligence, if the individual
8 believed that they were entitled to aggravated or
9 exemplary damages they could look for that or, instead
10 of that, they could also -- any award that they would
11 get would be topped up by 20 per cent from a so-called
12 reparation fund.

13 **Q.** That's how we understand -- the reference
14 to section 5, subsection (3) there, is a reference
15 to -- if we go to the bottom of the next page, it's
16 the third paragraph from the bottom:

17 "An award in respect of aggravated or exemplary
18 damages may be made by the Tribunal where a claimant
19 establishes a legal entitlement to such against
20 a relevant agency or the Minister."

21 **A.** Yes.

22 **Q.** So if a claimant wanted aggravated or exemplary
23 damages, they had to establish that there was a basis
24 for it that was a basis recognised in law. But is
25 this right, they could opt then, instead, for

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1 clearly -- I think the Government put their hand up
2 and accepted responsibility at that point. Yeah,
3 there was no legal admission of responsibility but,
4 clearly, they were paying compensation.

5 **Q.** And if we go over to page 6, we've got Section 4 of
6 the Act, and that tells us who could claim, initially,
7 to the Tribunal?

8 **A.** Yes.

9 **Q.** So those diagnosed positive for hepatitis C resulting
10 from anti-D, those diagnosed with positive for
11 hepatitis C as a result of receiving a blood
12 transfusion or blood product, and then we have
13 children and spouses, carers, and dependants.

14 If we just go to the next page, just to pick up
15 something, it's in subsection 7, so it's the fourth
16 paragraph down:

17 "... a claimant shall not be required to produce
18 to the Tribunal any evidence of negligence of the part
19 of a relevant agency or other person in respect of her
20 or his claim."

21 So there was no investigation by the tribunal of
22 liability. The claimant had to establish that they
23 had been infected through either anti-D or blood or
24 blood products provided by the state, but that was all
25 they needed to show in order to establish

26

1 a 20 per cent uplift to their compensation?

2 **A.** That's correct. Any individual who felt that they
3 were entitled to aggravated or exemplary damages could
4 seek those as part of their hearing. If they decided
5 not to seek that, their award was automatically topped
6 up by an additional 20 per cent.

7 **Q.** And that came from something called the Reparation
8 Fund?

9 **A.** Yes.

10 **Q.** What was that?

11 **A.** It was basically a fund that topped up the awards by
12 20 per cent, in lieu of aggravated or exemplary
13 damages.

14 **Q.** But essentially a fund from the same source, from
15 Government?

16 **A.** Yes. Absolutely, yes.

17 **Q.** Then we can take the --

18 **SIR BRIAN LANGSTAFF:** Just before we do that, can we go
19 back to page 6, please, the list of those who can
20 claim? Under Section 4, 4(c) is a child or any
21 spouse, and (d) a person who is responsible for
22 the care of a person referred to in (a), (b) or (c).
23 So that suggests to me, on the language, that that
24 would include parents of children affected. Is that
25 the way it worked?

28

1 A. I believe so, yes. Yes.

2 SIR BRIAN LANGSTAFF: Thank you.

3 MS RICHARDS: I skated, sir, over subparagraph (f),
4 "a person referred to in section 9"; that refers to
5 the power of the minister to extend the classes of
6 persons who could bring claims.
7 So if we then go back to how the Tribunal operated
8 as set up under the 1997 Act, so the claimant had to
9 prove they had an infection caused by treatment from
10 the state on the balance of probabilities. And as
11 you've explained, for those with haemophilia, that was
12 a relatively straightforward exercise?

13 A. Yes.

14 Q. I don't know whether you know the answer to this
15 because obviously your focus will have been those with
16 haemophilia, but we have heard evidence in relation to
17 the United Kingdom of claims being made to the funds
18 established here for -- by those infected through
19 transfusion being difficult to establish because of
20 lost or missing or incomplete medical records.

21 Do you know whether that was a problem in Ireland
22 for those infected through the transfusion route?

23 A. Not that I'm aware of, and certainly we had quite
24 a lot of dealings with Transfusion Positive, the group
25 who represent people who got hep C through blood

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1 they could then go back to the tribunal for a further
2 award. So I think a number of people -- also some of
3 the younger claimants whose career path had not been
4 set, where the impact of the hepatitis C on their
5 medium to long-term future could not be wholly
6 ascertained, would often have a provisional award and
7 then go back later on for a full award.

8 Q. Is it right to understand that the approach that
9 the tribunal was required to take to the assessment of
10 compensation was to apply the same approach that
11 the courts would apply in a claim, a tortious claim,
12 for damages for personal injuries?

13 A. Yes, my clear understanding is that the tribunal was
14 assessing damages. It was as if you had won a court
15 case and there was purely an assessment of damages.
16 So there was no talk about liability or negligence, it
17 was purely -- it was as if a court case had been
18 completed, yes.

19 Q. Then in terms of legal representation, the costs of
20 legal representation were met through this process?

21 A. Yes.

22 Q. So those who were making the claims had the benefit of
23 lawyers to assist them in advancing their claim?

24 A. Yes. When the tribunal started in 1995, we had
25 a meeting with the members who agreed to go down

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1 transfusion. I hadn't heard that raised as an issue.
2 My understanding, again, is that the Government took
3 the view that, you know, if you had haemophilia and
4 you'd been treated with your factor concentrate or
5 cryoprecipitate and you got hep C, that was the cause.
6 If you could ever show that you had a blood
7 transfusion, that was sufficient cause. And if you
8 had received anti-D in one of a number of particular
9 years, that was the cause.

10 Q. Then is it right to understand that the claimant
11 making the claim to the compensation tribunal could
12 elect for a lump sum, so an assessment of their
13 compensation once and for all, or for provisional
14 damages?

15 A. Yes, the majority elected for a one-off lump sum
16 award, but there was also the option to take an
17 initial award, especially if the individual was
18 concerned about progression of liver disease or what
19 they were facing in the future. And then there would
20 be specific wording in their tribunal award which
21 would allow them to go back for further compensation
22 in specified circumstances. For example, an
23 individual who had cirrhosis might have wording in his
24 award saying that if he or she required a liver
25 transplant and there were costs associated with that,

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1 the route of a tribunal. They also agreed that the
2 Society should engage a legal team who would act on
3 behalf of any member who wanted them to act on their
4 behalf, and that we would also search out expert
5 witnesses that many of them could use. So they really
6 relied on us to find a legal team and to find a lot of
7 expert witnesses.

8 Now, of course, any individual was entirely free
9 to get their own legal team and their own expert
10 witnesses, but vast majority used the same legal team
11 and used the same expert witnesses, which actually was
12 really helpful because they quickly developed a level
13 of expertise and skill on this.

14 Q. Then there was a right of appeal against
15 the Tribunal --

16 A. Yes.

17 Q. -- award to the High Court?

18 A. That's correct.

19 Q. And is it right to understand that in the early years
20 there were a number of appeals because it was thought
21 that the tribunal assessments were too low?

22 A. Yes.

23 Q. Did that have the effect essentially of raising them
24 overall for the future or has the need to appeal to
25 the High Court continued to occur regularly?

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1 A. It continues, perhaps not to the same extent. I mean
 2 when the vast, vast, majority of appeals to the High
 3 Court resulted in a significant increase in the award.
 4 So I think that did start the tribunal thinking in
 5 terms of giving higher awards. So perhaps the
 6 number of appeals diminished but there were still
 7 appeals.
 8 Q. Now, this obviously covered hepatitis C only, but in
 9 2002 the tribunal's remit was extended to encompass
 10 HIV?
 11 A. Yes.
 12 Q. How did that come about?
 13 A. In 2002 we had an election coming up, again, and we'd
 14 had the hearings of the Lindsay Tribunal, including
 15 the very powerful public testimony of members, during
 16 the course of the tribunal, and in the two years
 17 leading up to the tribunal and during the course of
 18 the tribunal we had constant meetings with Government
 19 on various issues. But one of the things was pressing
 20 for was that we felt that the 1991 awards, while very,
 21 very welcome at the time, were -- were -- they were
 22 not fair and equitable compensation for people who
 23 got HIV. We felt, really, that those individuals had
 24 been shortchanged, and in particular -- in
 25 particular -- the families of those who had passed

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1 that:
 2 "New areas of claim were introduced under the
 3 [2002] Act ..."
 4 A. Yes.
 5 Q. "a. [Child], spouse, father or mother of those who had
 6 died could claim under loss of society or psychiatric
 7 injury including post-traumatic stress disorder;
 8 "b. Partners or spouses of those infected could
 9 claim under loss of consortium;
 10 "c. Children or spouses of those who died could
 11 claim for loss of society ([so] loss of [the] ...
 12 care, companionship or affection);
 13 "d. Dependents could also claim for aggravated or
 14 exemplary damages ..."
 15 Where there was a legal entitlement that could be
 16 established.
 17 These extensions covered both HIV and hepatitis C?
 18 A. Yes, correct.
 19 Q. So the significance of the 2002 Act -- is this
 20 right -- is twofold. First of all, it establishes, or
 21 extends the rights that were conferred by the 1997 Act
 22 to those infected through HIV, and then it provides
 23 for a wider range of types of claim that's applicable
 24 to both those infected with hepatitis C and those
 25 infected with HIV?

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1 away prior to 1991.
 2 So it basically came about, I think, as a result
 3 of our discussions with Government and, frankly, the
 4 public impact of the very powerful public testimony at
 5 Lindsay.
 6 Q. So if we go back to your statement, so WITN7418001,
 7 pages 28 to 29. If we start at the bottom of page 28,
 8 we can see there was an amendment to the 1997 Act
 9 through the Hepatitis C Compensation Tribunal
 10 (Amendment) Bill, 2002.
 11 Then if we go to the next page, you've listed in
 12 paragraph 59 those who could apply for compensation
 13 following the amendment. So, similar to what we've
 14 seen previously, but now encompassing HIV and the
 15 children or spouses of those infected with HIV,
 16 dependants and carers, HIV as well as hepatitis C?
 17 A. Yes. And I think the significant part of that for us,
 18 really, was if you look at the section e, that the:
 19 "Widows or Dependants of those who had died."
 20 So the individual was no longer disadvantaged by
 21 the fact that they'd passed away prior to the 1991
 22 Act, their families were getting the full compensation
 23 that they would have been entitled to had they
 24 survived to that point.
 25 Q. Then if we go to the next paragraph, you tell us also

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1 A. That's correct, and bear in mind, however, that all of
 2 those were infected with HIV were also co-infected
 3 with hepatitis C, so they had been compensated
 4 previously through the '91 settlement, but also
 5 through the 1997 Hepatitis C Compensation Tribunal
 6 Act. But this broadened it, really, to give more
 7 compensation to people with HIV and, particularly, to
 8 the families of those who had passed away.
 9 Q. In terms of assessment for loss of earnings, which is
 10 one of the heads of claim that can be advanced to
 11 the tribunal --
 12 A. Yes.
 13 Q. -- do you know how the tribunal typically assesses
 14 the loss of earnings?
 15 A. I think they bring a number of expert witnesses, they
 16 look at the person's educational record, they do
 17 IQ tests, they look at the career path they may have
 18 had without hepatitis C. There may be opportunities
 19 that the individual may have had to pass up on due to
 20 the hepatitis C, or HIV. So it's basically based on
 21 an assessment. There might be an educational
 22 psychologist and a couple of expert witnesses.
 23 Q. Then in terms of those who are bringing a claim as
 24 a carer --
 25 A. Yes.

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1 Q. -- effectively for the care that they will have
2 provided, gratuitously, to a relative, how is that
3 cost of care assessed? Do you know?
4 A. I can't answer that, no.
5 Q. In terms of the aggravated and exemplary damages or
6 the 20 per cent uplift, have there been many cases in
7 which claimants have opted to try to establish an
8 entitlement to aggravated or exemplary damages?
9 A. Not that I'm aware of, no.
10 Q. So claimants have typically gone for the 20 per cent
11 uplift?
12 A. Yes, yes.
13 Q. In terms of who sits on the tribunal, I don't mean by
14 name, but what are the kind of -- what kind of
15 individuals are appointed to the compensation
16 tribunal?
17 A. They tend to be barristers, all of them.
18 Q. How important has the availability of legal
19 representation been for the success of the tribunal in
20 your view?
21 A. Vital. I think the availability of legal expertise
22 and expert witnesses has been absolutely vital,
23 because if you have across the board payments, as we
24 had in '91, then you really don't need that, but when
25 you're having an individual assessment, each

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1 A. It's very daunting for individuals with haemophilia
2 who have been exposed to HIV or hepatitis C to have to
3 stand up or sit down at a legal hearing and make their
4 case. So even preparing for a non-adversarial hearing
5 was very, very difficult for many of them because it
6 means revisiting all the trauma, all of the issues
7 over the years. It was really helpful that, from
8 day one, the tribunal was -- it was sympathetic, in
9 terms of the way that the individuals were dealt with.
10 It wasn't -- it wasn't adversarial in terms of
11 the questioning.
12 They would, of course -- there would be questions,
13 they would question the figures, they would question
14 some of the financial statements and so on, but it was
15 non-adversarial for the most part. That has continued
16 for the most part.
17 Now, in the last couple of years, now the vast
18 majority of the cases -- primary cases, have been
19 heard. My understanding is the last year or two,
20 during Covid especially, it's become a little more
21 adversarial, they are trying to limit the number of
22 witnesses. Obviously they're doing virtual hearings
23 and they're questioning more. But I think that, for
24 the vast majority of our members going through
25 the tribunal, it was genuinely non-adversarial.

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1 individual's circumstances are going to be different,
2 their experience is going to be different, their life
3 with hepatitis C or HIV or both is going to be
4 different, the impact on their life is going to be
5 different, so I think you really need an expert team
6 to put that in place.

7 It's a legal process, so, you know, the vast
8 majority of individuals would have no idea how to
9 approach that, and there is a lot of structure
10 involved in terms of putting the case, you know,
11 getting it prepared. So I think you do need a legal
12 team, you need expert witnesses, and frankly, their
13 costs -- it's been very, very helpful that their costs
14 have been borne by the state as part of the process.

15 Q. You've set out your view in your statement that
16 the tribunal has been a success?

17 A. Yes.

18 Q. And again, you've identified, I think, a number of
19 the factors. One, the availability of excellent legal
20 support. Another, the availability of excellent
21 expert witness support. You've also identified
22 the non-adversarial nature of the tribunal, although
23 you've suggested that there might have been a shift in
24 that regard. Can you just help us understand a little
25 more about that?

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1 Q. So we can understand the typical pre-Covid process --

2 A. Yes.

3 Q. -- so a written application would be submitted --

4 A. Yes.

5 Q. -- is that right?

6 A. Yes.

7 Q. And that would set out, essentially, the basic facts
8 about the claimant, and then would that written
9 application be accompanied by supporting expert
10 evidence?

11 A. Yes, there would be a written application. There
12 would be proof from the medical records that
13 individual had been exposed to hepatitis C or HIV
14 through blood or blood products. There would be
15 a summary, I guess, of their medical records. There
16 would typically be a report from the haematologist who
17 treated them and the hepatologist or infectious
18 disease consultant who were treating them for HIV or
19 hepatitis C respectively.

20 There would be -- usually the individual going to
21 the tribunal would be asked by the legal team to
22 draft, basically, an essay on the impact of
23 hepatitis C or HIV in their life. They would draft
24 that, that would be included.

25 There would be reports on loss of earnings, there

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1 would be reports on the impact on their life, there
 2 would be a report from an educational psychologist,
 3 and also a counsellor who was specifically employed by
 4 the legal team, there would be a psychological
 5 assessment. So there would be quite a lot of reports
 6 going in.
 7 Q. So those would all be submitted to the tribunal?
 8 A. Yes.
 9 Q. Would there then always be a hearing in every case, or
 10 could an assessment be made on the basis of
 11 the written material?
 12 A. I'm not -- I think a hearing was -- in every case
 13 there was a hearing.
 14 Q. In terms of the structure of that hearing, there would
 15 be the claimant, their legal representative. Would it
 16 always be necessary for all the experts to come and
 17 give oral evidence?
 18 A. No, not necessarily. Very often the expert's written
 19 evidence would be read into the record and taken as
 20 read.
 21 Q. Would it be right to understand that there would be no
 22 other side represented? There would be no opposition
 23 to the claim? Or was there someone there representing
 24 the Department or the Government?
 25 A. There was usually somebody there from the Department

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1 the questions were usually directed to the legal team
 2 or to the expert witnesses but very rarely to
 3 the individual giving evidence on their own behalf.
 4 Q. Would the Department make competing submissions? So
 5 if you have got the claimant's representative making
 6 a submission as to how the loss of earnings should be
 7 calculated and what figure the tribunal should award,
 8 would you have the Department making submissions to
 9 say, "No, no, it should be a lesser figure"?
 10 A. Not that I'm aware of, no. You could, perhaps, check
 11 that with the legal team we had, but not that I'm
 12 aware of, no. I think they would -- they may question
 13 the submission that was made, but they wouldn't
 14 normally submit an additional submission of their own.
 15 Q. Now, in terms of the success of that process, in
 16 addition --
 17 **SIR BRIAN LANGSTAFF:** Just before we go to that, can I ask
 18 another question about the process? What you've
 19 described is very similar to a court assessing an
 20 amount of compensation, with one exception. In
 21 a court, as counsel has pointed out, there are, of
 22 course, two sides, just as there are in your tribunal,
 23 where the Department of Health has an interest as
 24 the paying party, but there is very often, if
 25 the issue is just -- I say "just" -- the amount, there

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1 of Health -- I guess keeping an eye on the public
 2 finances -- but that was it really, there was no
 3 adversarial people there. But the Department of
 4 Health were usually represented. The legal team,
 5 the individual, perhaps their family member -- before
 6 the hearing there would often be somebody from
 7 the Society -- one of my team might be with them
 8 outside just to help them through the day, help them
 9 make arrangements and so on.
 10 Q. To what extent did the individual have to give
 11 evidence to the tribunal in the hearings? Was that
 12 always the case?
 13 A. It wasn't obligatory but the vast majority of cases,
 14 they gave evidence.
 15 Q. So would the tribunal be composed, then, of one
 16 member? There would be a single lawyer --
 17 A. Usually, three, usually, yes.
 18 Q. Usually three?
 19 A. Yes.
 20 Q. And they would ask -- or could ask questions?
 21 A. Yes.
 22 Q. But did whoever was there representing the Department,
 23 did they play an active role in the proceedings,
 24 asking questions?
 25 A. They did at times, yeah. Yes, they did, yeah. But

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1 can be settlement of a claim beforehand. There was,
 2 of course, settlement of your litigation in Ireland
 3 beforehand. Is there any history of the Department
 4 saying, "Well, we've read the written submissions,
 5 we're making an offer", and the individual saying,
 6 "Well, that offer looks good to me"?
 7 A. No.
 8 **SIR BRIAN LANGSTAFF:** So there is no settlement process in
 9 this at all?
 10 A. No, not that I'm aware of, no, I haven't heard of that
 11 at all.
 12 **SIR BRIAN LANGSTAFF:** Thank you.
 13 **MS RICHARDS:** In terms of the success of the scheme, as
 14 well as the features you've identified, would it be
 15 right to understand that perhaps the major hallmark of
 16 success has been that it's resulted in the payment of
 17 substantial amounts of compensation to those who were
 18 infected and whose lives were devastated as a result?
 19 So they have received an award which is deliberately
 20 designed to compensate them for their losses?
 21 A. Yes, I think that's fair. But also I think --
 22 I wouldn't underestimate the importance of
 23 the individual having their day in court, having their
 24 hearing, having their individual circumstances, you
 25 know, investigated and looked at and a decision made,

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1 as opposed to just being part of a group.
 2 Q. So it's an element of individual recognition?
 3 A. Yes.
 4 Q. The recognition of the impact there has been on that
 5 individual's life?
 6 A. Yes.
 7 Q. In terms of the disadvantages of the scheme, would it
 8 be right to understand that the major downside has
 9 been the length of time it has taken for some cases to
 10 be finally resolved?
 11 A. Yes, I mean, I think the process has been very good
 12 for the vast majority of people but some cases have
 13 taken several years to get to a hearing. If
 14 the individual who was infected was a child, then you
 15 can't really ascertain their loss of earnings or their
 16 future potential career possibilities for many, many
 17 years, so there may be a provisional award, an award
 18 later, and that has meant that the process has taken
 19 quite a long time for some people. And, you know,
 20 even though it's a very good process, it does delay
 21 closure. So until an individual has finished entirely
 22 with the compensation tribunal, it's kind of hard to
 23 bring some closure to the issue. So I think that's
 24 the -- the big disadvantage is the time required.
 25 Q. And has there been any expressions of dissatisfaction

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1 any sense of how long typically, from the making of
 2 the claim to the tribunal award, how long a period
 3 elapsed?
 4 A. I mean, an educated guesstimate would be a year to
 5 18 months. Some cases significantly less than that,
 6 some cases significantly more than that.
 7 **SIR BRIAN LANGSTAFF:** May I ask, are there cases
 8 continuing to this day?
 9 A. Yes, and they tend to be primarily secondary cases:
 10 carers, family members, maybe loss of society, loss of
 11 consortium, psychiatric injury. So the vast majority
 12 of the primary cases have been dealt with quite some
 13 time ago.
 14 **SIR BRIAN LANGSTAFF:** But as far as the secondary cases
 15 are concerned or, for that matter, the delayed primary
 16 cases are concerned, there will be have been people
 17 who are claiming today whose claims have not yet been
 18 decided or determined, who will most probably have
 19 suffered some financial loss, and that financial loss
 20 will have been unrecompensed during the period that
 21 they've been waiting for the assessment, will it?
 22 A. I'm not sure. I'm not sure.
 23 **SIR BRIAN LANGSTAFF:** So there's -- it's really allied to
 24 my question about settlement, is the question of
 25 whether there is any way of, or any practice of

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1 on the part of those who have made claims, that you're
 2 aware of, or, broadly speaking, have those who have
 3 participated made their claims to the tribunal been
 4 content or accepting of the outcome?
 5 A. Well, I think where there was any level of
 6 dissatisfaction the award was appealed to
 7 the High Court and, in the vast majority of cases,
 8 that resulted in a significant uplink (sic) to
 9 the award. And in some cases, in one or two cases, it
 10 was actually appealed to the Supreme Court on a point
 11 of law. So I think in terms of the amount there was
 12 very little dissatisfaction. I think people genuinely
 13 felt that this was fair and equitable compensation.
 14 The dissatisfaction, where I've heard it expressed,
 15 relates to the length of time that the process has
 16 taken for some individuals.
 17 Q. There is obviously no such thing as a typical case,
 18 but is there a typical length of time that it's
 19 taken -- for those who were directly infected, to the
 20 primary cases, not the secondary cases, and who were
 21 infected as adults, so if we leave aside
 22 the additional complications in terms of time that
 23 might arise in relation to children, if they were
 24 making a claim in the late '90s or throughout the
 25 2000s, and once it was extended to HIV, do you have

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1 awarding anything on the interim, on the basis that
 2 the claim must be worth at least this and we're only
 3 really talking about the rest.
 4 A. I'm aware of the interim payments made here,
 5 Sir Brian, and I think that was greatly to be
 6 welcomed, and I think if we were starting off again at
 7 this point -- it's 20 years later, and our population
 8 is 20 years older than they were when compensation was
 9 awarded in 2002 -- I'm sure we'd have gone for interim
 10 payments initially as well, because there can be
 11 a long prime before the final case is heard.
 12 So I think our system has worked very well for our
 13 members, but I think -- in looking at this, I think it
 14 is wise to reflect on the potential for delay in
 15 hearing individual cases.
 16 **SIR BRIAN LANGSTAFF:** So the system works well for
 17 the reasons you've given, but it's not without the
 18 opportunity to -- without the potential for
 19 improvement?
 20 A. Yes.
 21 **COURT:** Thank you.
 22 **MS RICHARDS:** Brian, that anticipates what was going to be
 23 my next question to you, which was: if you were
 24 setting it up again, would there be any differences
 25 that you would make? One you've just referred to was

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1 the power to make interim payments. Are there any
2 other ways which, if you were starting from scratch
3 again, you would change what's been done, or ...?
4 **A.** When we were starting from scratch, I mean, I have to
5 say that, in the first instance, we were more in
6 favour of *ex gratia* payments, because we were
7 concerned about a very long complex system. Now, as
8 it turned out, we were wrong. The individual
9 assessment was better for members, the awards were
10 better, and they got more closure afterwards.

11 If I was starting again, and it's 20 years
12 later -- because bear in mind, this was 1995, it's
13 27 years later, and it's a much older population --
14 I'd be very concerned about the age profile of the
15 people claiming. So I think I'd be looking at
16 a system where I'd be looking for significant interim
17 payments, significant upfront payments, and then
18 a fairly quick individual assessment if you're going
19 down that road.

20 I think, as I said, the majority of cases were
21 heard in, you know, a year to 18 months, and I think
22 that should be the benchmark at -- no more than that.

23 **Q.** I'm going to move now to a separate issue, which is
24 the health amendment card and the Health Amendment
25 Act -- or the Health Amendment Card Act, I think it

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1 set up, and what you think swayed the Government and
2 influenced the Government into setting up?

3 **A.** It was not a hard battle. Unlike the compensation
4 battles, that was not a hard battle. I think the fact
5 that you had a couple of hundred people with
6 haemophilia; you had several hundred people who had
7 been infected through blood transfusion; you had in
8 excess of 1,000 women who had been infected through
9 anti-D; all of these groups collectively wanted access
10 to better healthcare.

11 So I think it was, very much, a case of coming up
12 with a solution for, in a sense, in relation to
13 the total population, a relatively small group of
14 people, 3,000 or 4,000 people in total. So I think
15 that's -- one of the reasons the card was put in place
16 was because the number of people who would benefit
17 would be finite and wouldn't be increasing. So it
18 wasn't a hard battle to have it put in place.

19 **Q.** If we just look briefly at the Act, WITN7418005,
20 please. If we go to page 3.

21 We've got the Health (Amendment) Act, 1996, and we
22 can just pick up the essence of it in paragraph 2:

23 "A health board shall make available without
24 charge to persons who, in the opinion of the chief
25 executive officer of the board, have contracted

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1 is. Can you tell us first of all, in broad terms, how
2 the Irish healthcare system works and what a medical
3 card is?

4 **A.** Well, a medical card is a card which gives
5 an individual free access to public hospitals, to
6 general practitioners, and it's means based, so it's
7 typically if you have relatively low income or a lot
8 of dependants. Generally, in Ireland, if you don't --
9 now, for haemophilia you have a separate card, called
10 a long-term illness card, which covers
11 the haemophilia-related costs such as factor
12 concentrates, ancillary supplies, they're all paid for
13 by the state. But for people in Ireland without
14 a medical card, then you pay for -- unlike the UK
15 National Health Service, you pay for your GPs visits,
16 you pay for your prescription drugs. And we have
17 a two-tier healthcare system: we have the public
18 hospitals, which are free for the vast majority of
19 the population, or you can also have private health
20 insurance. There are private hospitals or private
21 beds in public hospitals. So it's a mixed two-tier
22 system.

23 **Q.** Now, you've told us, in your statement, how the Health
24 Amendment Act Card came about. Can you just summarise
25 for us, what led to the campaign for that scheme to be

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1 hepatitis C directly or indirectly from the use of
2 Human Immunoglobulin-Anti-D or the receipt within the
3 State of another blood product or a blood transfusion
4 and to persons of such other classes (if any) as may
5 be prescribed ..."

6 Then we have set out a number of services.

7 Now, this is limited to hepatitis C. It doesn't
8 encompass HIV?

9 **A.** It actually does, in the sense that, I mean, all of
10 our members who were infected with HIV were also
11 infected with hepatitis C. But it does cover -- I'm
12 just looking at the specifics of the Act -- it does
13 cover HIV as well, through blood and blood products.
14 So if an individual had been infected with HIV through
15 blood or blood products but had not been co-infected
16 with hepatitis C, they would still get an HAA card.

17 **Q.** Then if we look at the guide you've appended to your
18 statement, WITN7418011, this is a 2020 piece of
19 guidance about the working of the card, and I think if
20 we can pick it up on page 3, under the heading
21 "Introduction":

22 "This 2020 Information Guide to Services is for
23 persons who contracted Hepatitis C through the
24 administration within the State of contaminated blood
25 and blood products and are currently eligible for a

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1 Health (Amendment) Act (HAA) Card."
 2 Then if we just look at the next paragraph:
 3 "The new drug treatment for Hepatitis C has been
 4 offered to all HAA card holders by the end of 2017 and
 5 many cardholders have been successfully treated in the
 6 last couple of years.
 7 "The HAA card is a like time care ..."
 8 So, is it right to understand that if an
 9 individual has been successfully treated through the
 10 new treatments and has cleared hepatitis C, they still
 11 have the HAA card for their lifetime?
 12 A. Correct, because they will still have hepatitis C
 13 antibodies.
 14 Q. Then if we go down to the bottom of the page, under
 15 the heading "What is the HAA Card?":
 16 "The ... Card is for eligible men, women and
 17 children who contracted Hepatitis C from the
 18 administration within the State of contaminated blood
 19 or blood products. It is not the same as a medical
 20 card [you've told us what that is], a GP visit
 21 card ..."
 22 What's that?
 23 A. The Government have been extending free GP care to
 24 different age groups. So you have -- so for people
 25 over the age of 70, there's -- they can visit a GP

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1 it would be unfair or amount to some form of queue
 2 jumping because it was prioritising or conferring an
 3 entitlement upon a particular group of individuals
 4 that others would not have?
 5 A. No, because the 3,500 individuals had developed
 6 serious medical conditions as a result of medical
 7 treatment already provided by the state, so you're
 8 effectively giving additional and faster healthcare to
 9 people who have already had their health impaired by
 10 the actions of the state.
 11 Q. So it wasn't something that was -- has led to any
 12 resentment or any sense of unfairness from the rest of
 13 the population to your knowledge?
 14 A. No, none whatsoever.
 15 Q. Then you've set out in your statement, if we go back
 16 to the statement, WITN7418001, and we go to page 33,
 17 please, paragraph 77.
 18 So you've set out in paragraph 77 the services
 19 that those who hold the HAA card receive, or are
 20 entitled receive?
 21 A. Yes.
 22 Q. The first is:
 23 "Open Access to public hospital facilities for
 24 Hepatitis C or any related condition. The cardholder
 25 should not have to wait more than two weeks for an

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1 without payment. For children under the age of 6,
 2 they can visit. So they have been kind of contracted
 3 from both ends.
 4 We're trying to get to a point of free GP visits
 5 but it's going to take a number of years. So that's
 6 a card that just gives you free GP visits. It doesn't
 7 give you the prescriptions and other things.
 8 Q. Then there is reference to a Drug Payment Scheme Card;
 9 what's that?
 10 A. That's if you have prescribed drugs there is a limit
 11 you have to pay every month, and after that you get it
 12 reimbursed anything additional you pay.
 13 Q. Then this guide goes on to explain that the:
 14 "The HAA Card gives eligibility to additional HSE
 15 services, on more flexible terms and conditions than
 16 the medical card."
 17 And then it explains it's for the lifetime of
 18 the card holder, and it's personal to the card holder.
 19 So it doesn't extend to family and members. But is
 20 there an exception to that in relation to counselling
 21 services?
 22 A. Yes, the card is for the individual but family members
 23 of a person who was infected with hep C or HIV can
 24 avail of counselling under the card.
 25 Q. Was there a concern when this scheme was enacted that

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1 appointment with their liver specialist and also for
 2 their first referral to another specialty. This is
 3 generally referred to as the two-week rule."
 4 Then if we go over the page:
 5 "Once the cardholder is referred by the liver
 6 consultant to another consultant in a public hospital
 7 for the testing investigation or treatment of any
 8 known or suspected condition related to Hepatitis C
 9 (or any condition which, while not related to
 10 Hepatitis C, requires special treatment or care as a
 11 result of the patient's infection with Hepatitis C),
 12 they will be given priority appointment within two
 13 weeks for the first consultation."
 14 And then:
 15 "Subsequent appointments [you go on to say] with
 16 a specialty outside hepatology [are done] on the basis
 17 of medical need ..."
 18 And there is no two-week rule applicable to that.
 19 So I just want to get a sense of how this works
 20 for the individual who has hepatitis C. This two-week
 21 rule, the entitlement to be seen within two weeks, in
 22 practice, at least prior to the pandemic, did that
 23 normally take place?
 24 A. It did for a number of years. I would say it worked
 25 reasonably well until such time as the direct-acting

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1 anti-virals meant that the vast majority of people
 2 were able to clear hepatitis C infection.
 3 Now, prior to that, you know, people with
 4 hepatitis C might have the need fairly urgently for
 5 a consultation with a dermatologist or
 6 a rheumatologist or a cardiologist, and this was
 7 designed that they weren't waiting in a long queue for
 8 that. So their hepatologist could say, "Okay, this
 9 individual, I want them to see a rheumatologist fairly
 10 quickly", so they'd get in within two weeks. It
 11 worked relatively well. But I think even before the
 12 pandemic, from, I'd say, maybe 2014, 2015, once the
 13 vast majority of people had been offered treatment for
 14 hepatitis C, it started to unravel somewhat. So
 15 that's one aspect of the cart that doesn't function
 16 very well, simply because of the pressure on the
 17 hospitals, on the pressure on the hospital beds. So
 18 I think also the requirement for people to see
 19 additional specialists outside of hepatology has
 20 diminished with successful treatment.
 21 Q. Then if we continue through the list of services, so
 22 if we go further down the page, we've got:
 23 "Access free of charge to a registered [GP] of
 24 [the individual's] choice and to all GP medical and
 25 surgical services for all medical conditions."

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1 at home.
 2 It works really well. We had a case in the last
 3 couple of weeks of one of our members who was being
 4 discharged from hospital, extremely sick, and within
 5 24 hours we had 24-hour nursing care for him at home.
 6 So, really, there is a clinical nurse coordinator
 7 who works for the HAA card scheme. She will assess
 8 this very quickly. The individual or the hospital
 9 will contact her or, if the individual contacts us, we
 10 will contact her. There is very good liaison between
 11 all of us so, really, we can get this in place very,
 12 very quickly.
 13 Q. Then if we go over the page, we can see the list
 14 continuing:
 15 "Access to chiropody and podiatry services ...
 16 "Access to complementary therapies [and that
 17 includes] massage, reflexology, acupuncture,
 18 aromatherapy and hydrotherapy."
 19 And they're all set out in the guide that we
 20 looked at a few minutes ago, and then:
 21 "Access to counselling services for the affected
 22 individual."
 23 And then we see they're also available to
 24 relatives or carers.
 25 What's the role, in relation to all of these

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1 And you've explained how that is different from
 2 the position of the ordinary medical card holder. Top
 3 of the next page there is an entitlement to all
 4 necessary routine and emergency dental treatment.
 5 Then paragraph (d), free hearing tests and hearing
 6 aids and entitlement to an eye examination,
 7 spectacles, contact lenses and so on.
 8 Then:
 9 "Certain aids and appliance ..."
 10 And you've given some examples there, walking
 11 sticks, frames, wheelchairs, et cetera:
 12 "Access to physiotherapy when prescribed ..."
 13 And then:
 14 "A home nursing service ... available in respect
 15 of all conditions affecting the health of eligible
 16 people."
 17 How does that work and how much recourse to it
 18 have those who hold the cards had to have, do you
 19 know?
 20 A. I think most card holders have not had to have
 21 recourse to that, but when they have it's very, very
 22 significant, in some cases 24-hour nursing care. So
 23 we've had a number of members where, certainly when
 24 they were extremely seriously ill, perhaps near the
 25 end of life, that they will get 24-hour nursing care

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1 services, of the liaison officer?
 2 A. It's crucial. You've got about 3,500 cards issued in
 3 a population of 5 million. You know, most GPs won't
 4 have seen the card, a lot of pharmacists won't be
 5 familiar with the card, so the role of liaison officer
 6 is to ensure that individual gets the services which
 7 they should be getting.
 8 I would say their role has been really important.
 9 There are 10 of them, they cover geographic areas, so
 10 each individual who has a card will have an assigned
 11 liaison officer, so if they have any difficulty
 12 getting access to any of the services, they contact
 13 the liaison officer and their job is to sort it out
 14 pretty quickly. In some cases the individual will
 15 contact us. Most weeks we're dealing with at least
 16 one query from a member about something to do with
 17 the HAA card. And they're usually in the grey areas
 18 where this may or may not be covered.
 19 And I have to say that we've found the liaison
 20 officers to be extremely good to work with, they cut
 21 through a lot of the bureaucracy. I would say that
 22 the scheme has been extremely successful. It would
 23 not have been successful if we didn't have the liaison
 24 officers.
 25 Q. Then if we just go to the next paragraph. We can see,

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1 here, the reference to home support services.
 2 **A.** Yes.
 3 **Q.** Now, as I understand it, this is something that's
 4 distinct from the home nursing service?
 5 **A.** Correct.
 6 **Q.** That's meeting clinical needs, care provided by, or
 7 arranged by nurses?
 8 **A.** Correct.
 9 **Q.** This is more along the lines of domiciliary support,
 10 assistance within the home with household tasks; is
 11 that right?
 12 **A.** Yes.
 13 **Q.** And, again, what's the take-up and importance been of
 14 that particular service?
 15 **A.** There has been a significant take-up of that.
 16 A significant number of our members, certainly, would
 17 have a home worker who comes in and does tasks around
 18 the house: cleaning, cooking, ironing, gardening.
 19 They would receive a defined number of days per week.
 20 They can either -- the Health Service will employ
 21 a home worker centrally and assign them, if they wish,
 22 or, if they wish, they can employ them themselves and
 23 be reimbursed for the costs of that. Because --
 24 the latter is necessary because of confidentiality.
 25 I think confidentiality permeates everything in

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1 If you were setting up the scheme again from scratch,
 2 would you make any changes to it or has it worked in
 3 the way you would have wished it to?
 4 **A.** No, I think I wouldn't make any changes, I think it
 5 works very well. I would clarify, perhaps,
 6 the two-week rule, and just, you know, include it if
 7 it's going to work and don't include it if it's not
 8 going to work.
 9 **SIR BRIAN LANGSTAFF:** That leaves the question of how
 10 long, doesn't it? It leaves the question of how long.
 11 **A.** How long?
 12 **SIR BRIAN LANGSTAFF:** How long one may have to wait for
 13 the various things that would be covered by
 14 the two-week rule. Because if you don't have a period
 15 of time, you've no yardstick to judge the length of
 16 delay.
 17 **A.** But in fairness, there has been a degree of pragmatism
 18 in the way that this is operated by the liaison
 19 officers. So I'm aware of cases among our members
 20 where they need to see a specialist in a particular
 21 area they're concerned about, they will go privately,
 22 even though the card doesn't pay for that, and
 23 the card has actually paid for that. So there are
 24 cases where, if you can make a case that an individual
 25 needs to see a specialist within a short period of

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1 relation to hepatitis C and that card. People are
 2 very concerned about maintaining their
 3 confidentiality, so in some cases that has meant that
 4 they will employ somebody locally, themselves, and
 5 then the costs will be reimbursed by the Health
 6 Service.
 7 **Q.** Now, you were asked in your statement whether you
 8 thought the HAA card was a success and you've said
 9 unequivocally yes. Why is that? Why is that your
 10 view?
 11 **A.** I would have said if we were speaking back in '95,
 12 '96, '97, our members were much more concerned about
 13 compensation on these issues and the forthcoming
 14 inquiry than they were about the HAA card. But when
 15 I look back on it now with the benefit of hindsight,
 16 the HAA card has been absolutely crucial because it
 17 gives people prioritised access to a lot of
 18 the healthcare and services and support they need on
 19 an ongoing basis. It has been invaluable for people
 20 when they run into trouble health-wise. And when
 21 people are at the point where -- if they are getting
 22 near to the end of their life, it has been absolutely
 23 amazing in terms of the help and support we can put in
 24 place very quickly.
 25 **Q.** And same question as with the compensation tribunal.

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1 time and they have to pay for that, then they can seek
 2 reimbursement. And in many cases there is
 3 reimbursement.
 4 **SIR BRIAN LANGSTAFF:** Without the two-week rule that would
 5 not be easy to achieve, I imagine.
 6 **A.** No, I think it's -- perhaps, perhaps not. I think the
 7 two-week rule is, you know, well intentioned. It just
 8 hasn't worked for the last number of years because of
 9 the overwhelming pressure on the Health Service.
 10 **SIR BRIAN LANGSTAFF:** I can see that in some societies it
 11 may be aspirational rather than realistic but the
 12 issue may be finding the right number of weeks to
 13 represent the balance.
 14 **A.** Yes, and you'd also, perhaps, run into the problem
 15 where some consultants will resent being told that you
 16 need to see a particular patient -- a group of
 17 patients within two weeks, when they have a long
 18 waiting list. I've never met a consultant who resents
 19 being paid, so that removes the problem.
 20 **SIR BRIAN LANGSTAFF:** Yes.
 21 **MS RICHARDS:** Sir, I note the time. I've probably only
 22 got about another 10, 15 minutes of questions, because
 23 there is really just one further topic I want to
 24 cover, which is that of insurance. So we could either
 25 continue now, or take a break and come back after the

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1 break.
2 **SIR BRIAN LANGSTAFF:** Well, it may be more sensible to
3 continue. Let me explain and ask Brian what he would
4 prefer to do.

5 Normally at this stage we would have a break of
6 about half an hour so that people can have a coffee,
7 and in particular for those who are listening to give
8 them a chance to have a break, bearing in mind the
9 effects or lingering effects of some of the conditions
10 which some of them may have.

11 But the general practice is, after counsel has
12 finished the questions from the Inquiry, there is an
13 opportunity, it's prescribed by law, for those who are
14 represented by legal representatives, to have those
15 legal representatives suggest to counsel questions
16 which it is appropriate should be asked, and that
17 process needs a bit of time, obviously, because they
18 haven't yet heard what you had to say in answer to the
19 earlier questions.

20 So if we go on for 15 minutes now, there will be
21 a break of perhaps longer than half an hour, and then
22 there will be the last session for today. You'll be
23 finished, I would suspect probably by lunchtime, but
24 I can't tell you how long because it depends how many
25 questions there will be and there may be quite

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1 becomes from very difficult to impossible.

2 So, really, people were in the situation where
3 they couldn't get life insurance, they couldn't get
4 mortgage insurance, which in some cases meant they
5 couldn't buy a house. So this issue was in the back
6 of our minds at all times. So when we were discussing
7 all of the issues in the two years and three months it
8 took us to agree the terms of reference for the
9 Lindsay Inquiry, we discussed all sorts of issues,
10 this was one of the issues that we kept raising:
11 insurance, mortgage insurance, life insurance,
12 mortgage insurance.

13 And then around the time of the 2002 Act we again
14 raised the issue. So the Government agreed that they
15 would set up a Steering Group with the organisations
16 representing those who had been affected. We had our
17 legal teams with the Department to try and see if they
18 could come up with a scheme. And that took -- it took
19 at least four years to get that up and running. And
20 that culminated in the 2006 Act.

21 Q. And so we have the Hepatitis C Compensation Tribunal
22 (Amendment) Act 2006, which set up the scheme. And
23 I think we've got some regulations?

24 A. Yes.

25 Q. But I don't think we need to look at those.

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1 a number. The alternative is breaking, 15 minutes
2 break, for half an hour or so --

3 A. No, please, proceed.

4 **SIR BRIAN LANGSTAFF:** I think we're still within the
5 period of time that's acceptable to the stenographers,
6 who also have been borne in mind. Let's proceed.

7 **MS RICHARDS:** Absolutely.

8 So the third area I wanted to ask you about in
9 terms of the state's response in Ireland, Brian, is in
10 relation to insurance. In 2006 something called the
11 Hepatitis C Insurance Scheme was set up. What led to
12 that being set up at that point in time?

13 A. Well, if I go right back to 1986, we first raised
14 concerns about the inability of people with
15 haemophilia, with hep C -- or with HIV, at the time,
16 to get life insurance or mortgage insurance. We
17 actually had a meeting with a Government minister in
18 1987 and, as you saw on the "AIDS, Haemophilia and the
19 Government" booklet, we put this in our list of issues
20 for the Government in 1988, and they didn't deal with
21 that at the time they set up the HHT. So we were
22 always conscious that even before HIV and hepatitis C,
23 it was difficult for people with haemophilia to get
24 life insurance or mortgage insurance without
25 a loading. Once you add in HIV and/or hepatitis C, it

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1 If we go back to that guide that we were looking
2 at earlier, because it's got a section on insurance,
3 and think it might be a convenient way of picking it
4 up.

5 WITN7418011, please, page 23.

6 So we've got the heading "Insurance Scheme",
7 travel insurance, mortgage protection insurance, life
8 insurance for persons who were infected through blood
9 or blood products within the state.

10 Then we've got the general rules for the insurance
11 scheme, and if we just look at the whole page for
12 a moment, we can see there is a heading at the bottom
13 half of the page:

14 "Eligibility.

15 "To avail of the insurance scheme you must have an
16 eligibility certificate."

17 Then there is a description of how you get that.

18 Then, in terms of getting an eligibility
19 certificate, if you've got an HAA card or you've been
20 awarded compensation by the tribunal, you get
21 the eligibility certificate automatically?

22 A. Correct, yes.

23 Q. If you don't fall within either of those categories,
24 I don't know if there are any who would, you then have
25 to make out a case for eligibility?

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1 A. Yes.

2 Q. But essentially it's proof of infection or acceptance

3 that you were infected and infected through blood or

4 blood products?

5 A. Yes, but you don't have to keep proving it. So as you

6 say, if you have an HAA card or if you got an award

7 from the Compensation Tribunal, as a person with hep C

8 or HIV then you can take out the insurance.

9 Q. Then if we just go back to the top half of the page,

10 so we can see the three types of insurance under the

11 scheme, so: life insurance, mortgage protection and

12 travel insurance.

13 Can I deal with life insurance first of all. How

14 does that work in practice? What does this give

15 people that they would otherwise have struggled to

16 get?

17 A. As I said, somebody with haemophilia, without HIV or

18 hepatitis C, is often loaded for life insurance. If

19 you have hepatitis C, if you can get life insurance

20 you will be severely loaded. If you have hepatitis C

21 and HIV, you will be deemed to be uninsurable, you

22 won't get life insurance.

23 Now, the scheme, first of all, you can take out

24 life insurance up to your 65th birthday. But if you

25 took it out in the first year of the scheme, we'd

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1 insurance attainable for people.

2 Q. Is this underwritten by the state?

3 A. Yes. And in fact the -- so what happens is, we have

4 two insurance companies who provide policies under

5 the scheme. They have to be accepted by the scheme.

6 And then the insurance company will -- you know,

7 they'll do an evaluation, as they normally do, and

8 then they will quote a premium, and the premium --

9 there is a premium quoted to the individual, but then

10 there is also a premium quoted to the Government.

11 So, for example, with somebody who has

12 hepatitis C, the premium to the individual is

13 the premium for a perfectly healthy person. The

14 premium -- there is an additional premium then to be

15 paid by the insurance scheme on behalf of

16 the Government.

17 If the individual is co-infected and is deemed to

18 be uninsurable, effectively the Government becomes the

19 re-insurer. So they'll still look at the policy from

20 the insurance company, they'll still pay the same

21 premium as a perfectly healthy person, but in effect

22 there is an arrangement between the Government and

23 the insurance company about who pays if and when the

24 person passes away.

25 Q. Just sticking with life insurance for a moment, how

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1 negotiate that you could be insured up to your 75th

2 birthday. So in fact for the first year after the

3 implementation of the scheme I was like an insurance

4 salesman trying to get as many of our members to take

5 it out as possible, because you got an extra ten years

6 of cover. And also, if you took it out after the

7 first year, if you were under the age of 30 or over

8 the age of 50, there was one or two years until you

9 got full cover. So it was -- really, the optimum time

10 to take out the insurance was in the first year of the

11 scheme.

12 What it covers is, you will basically get life

13 insurance up to I think it's seven times the average

14 income or up to a maximum of about EUR 525,000. You

15 will be able to take out life insurance at the same

16 premium for a person of your age who is perfectly

17 healthy, who doesn't have HIV, who doesn't have

18 hepatitis C, who doesn't have haemophilia. The only

19 difference is if you're a smoker. They actually --

20 they load that along the board.

21 So if you've got a 50-year-old man with

22 co-infection, with haemophilia, with

23 joint arthropathy, with kidney disease, with liver

24 disease, he will get insurance at the same rate as

25 a perfectly healthy 50-year old. So it makes

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1 important has that been for your members?

2 A. I think it's been very important because it means that

3 individuals can take out life insurance at

4 a reasonable cost; they can provide for their family,

5 their dependants, in the event of their death up to

6 the age of 65 or 75, depending on when they took it

7 out; and it also means that if they do get

8 compensation they can actually use that compensation

9 to live their life and not necessarily have to salt it

10 to away to provide for their family in the event of

11 their death.

12 Q. Then the second type of insurance, the mortgage

13 protection insurance for a new primary home or repair,

14 renovation or refurbishment of current primary home;

15 does that, essentially, work in the same way?

16 A. Yes.

17 Q. But you've told is in your statement that the uptake

18 of that has been relatively low. Do you know why that

19 was?

20 A. I think there was a reasonable uptake in year 1 but

21 after that, it just -- people just haven't been taking

22 it up. I'm not sure why. It's surprising. To me,

23 also, with the life insurance, I would have thought

24 that practically every person, you know, with Hep C or

25 HIV, would take out life insurance under the scheme in

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1 year 1 and a lot chose not to.
2 So the mortgage protection insurance was --
3 the uptake has been quite slow or low. Also, in
4 year 1 of the scheme there was a remortgage, so you
5 could actually take out additional insurance for
6 100,000 if you had an existing mortgage. Again, there
7 was very little take-up on that.

8 Q. Then the third form of insurance is travel insurance.
9 Again, is that essentially done in the same way, so
10 you're insured in the way you would be if you were
11 in --

12 A. Perfect health.

13 Q. -- perfect health, and then the increase is
14 effectively underwritten or paid for by the state?

15 A. Yes.

16 Q. And how important has that been for --

17 A. Extremely important, I think the vast majority of card
18 holders take that out, especially now we've started
19 travelling again post-Covid, but it's really
20 important. It means that the individual and their
21 family can take out travel insurance. That's been
22 very, very useful and it gives them low-cost travel
23 insurance. And I get queries all of the time from
24 people with haemophilia who don't have HIV or
25 hepatitis C who are concerned because they find it

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1 back about 2012, to come back on the board, he made me
2 promise he'd never have to go to an insurance meeting
3 again.

4 So it was -- it was a lot of work to put this one
5 in place, simply because of the -- it was a novel
6 concept. I don't think it had been done before. And
7 the insurance industry are, you know, they're very
8 conservative in the way they look at things, so it
9 took a lot of work to put it in place.

10 Q. Then just a final question from me for now, Brian.
11 Those three types of scheme that we've been looking
12 at, so the provision for compensation through
13 the tribunal, the HAA card and then the insurance
14 scheme, these are all measures that have been taken by
15 the state --

16 A. Yes.

17 Q. -- in recognition, would this be right to say, of
18 the suffering and disadvantage that individuals have
19 experienced through treatment at the hands of
20 the state. As well as the obvious benefits of
21 the schemes themselves, the provision of financial
22 assistance, access to health services and so on, how
23 important has it been for those who were infected in
24 Ireland to -- that very fact of state recognition that
25 something had to be done?

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1 expensive to get travel insurance. So, ironically, if
2 you're in Ireland and you have HIV or hepatitis C,
3 it's easier to get travel insurance, life insurance or
4 mortgage insurance than if you just have haemophilia.

5 Q. You told us how this was something raised back in
6 the '80s and it took all of the way through the
7 discussions following the 2002 Act and the Lindsay
8 Inquiry report for this to eventually come to
9 fruition. Was there resistance on the part of
10 Government or was it just ignored or ...?

11 A. There was a little bit of resistance initially, but,
12 again, as the personal stories come out from Lindsay,
13 as the public awareness increased -- and Government
14 were genuinely sympathetic and their response was
15 sympathetic, so there was a willingness to explore
16 this, but from a practical point of view it was still
17 quite difficult to put it in place, so we had -- you
18 know, we had four legal teams, we had a team of
19 actuaries, we had a couple of insurance specialists
20 and brokers, we had the Department of Health, we had
21 the four organisations. I think we had
22 35 excruciatingly long steering committee meetings
23 over those four years. I know my colleague -- or
24 former chairman, who was at those meetings with me,
25 when he left the Society board later and I asked him

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1 A. I think hugely important. When I look at the Lindsay
2 Inquiry and I think a couple of things come to mind.
3 The personal testimony was hugely important.
4 The public understanding of what had happened to
5 the community was very, very important, and the public
6 understanding was, frankly, helped by very responsible
7 media coverage in the Irish media. All of the main
8 daily newspapers covered it, you know, in great
9 detail.

10 I think the apology from the Government after the
11 report came out, the compensation which was put in
12 place without having to wait for the Inquiry report,
13 the HAA card, the insurance, the tax concessions,
14 these were all really important in an overall view
15 that: look, this happened, this was an awful thing
16 that happened to you, we're really sorry and we're
17 going to make it up to you in any way that we can.

18 MS RICHARDS: Thank you.

19 Sir, those are the questions I have for Brian.
20 But if we could now take our break and afford the
21 opportunity to the Core Participants to suggest
22 further matters they might want me to ask.

23 SIR BRIAN LANGSTAFF: How long a break do you think you
24 might need?

25 MS RICHARDS: Well, I think probably our normal half an

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1 hour break should suffice because a lot of
2 the questions I have asked have reflected
3 the suggestions already made to me, so if we take half
4 an hour.

5 **SIR BRIAN LANGSTAFF:** What I'll say in these circumstances
6 is my usual. We will take a break and come back not
7 before 12.00. It may be later; if so, we'll let you
8 know, but otherwise not before 12.00.

9 **MS RICHARDS:** And, sir, the normal advice to the witness.
10 (11.32 am)

11 (A short break)

12 (12.00 pm)

13 (Proceedings delayed)

14 (12.11 pm)

15 **MS RICHARDS:** Brian, just a handful of further questions.

16 The first is about the HAA card. Does it have any
17 implications in terms of accessing liver transplants?

18 **A.** No. The -- no. The short answer is no. Liver
19 transplants are assessed on a clinical need. If
20 a person with haemophilia requires a liver transplant
21 they go on the waiting list in the same way as
22 everybody else.

23 I guess where it does make a difference is, we've
24 had quite a number of members who have had to have
25 liver transplants in Ireland. We had a couple of

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1 dealt with vast majority of cases of carers, so he
2 would have all of the detail.

3 **Q.** Thank you.

4 In terms of the information that's publicly
5 available about the tribunal's approach, does the
6 Government publish data about the awards?
7 **A.** The tribunal publishes an annual report and they
8 publish the total number of cases heard and then
9 the -- the -- sort of, the total awards, and you can
10 divide one by the other and get the average or mean
11 amount. But in a sense that's fairly meaningless
12 because, you know, you might have a case of, you know,
13 somebody who has got hepatitis C and HIV co-infection
14 and has had serious clinical and social consequences
15 or somebody who is perhaps a hepatitis C antibody
16 positive, was never virus positive, so all of the
17 cases are put in together, they don't break it down in
18 tranches, so ...

19 But they do publish an annual report and the
20 annual report gives the breakdown of the total
21 number of cases. And I think if you look at
22 the annual report, the last annual report that was
23 published, I think for 2020, I think there were about
24 3,500 cases heard. The average award including the
25 reparation payment was about a quarter of a million

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1 members who had liver transplants in the UK because if
2 they're co-co-infected with HIV then they go to
3 a specialist unit in the UK, because the numbers in
4 the Republic of Ireland would be so small that the
5 specialist aftercare would be better in one centre.
6 So the card will provide extra help and support to the
7 individual when they're going over. So, for example,
8 you know, on one or two occasions I've come over to
9 the UK with a member when they were being assessed for
10 a liver transplant and the card would pay the costs of
11 that visit over.

12 **Q.** Then does the HAA card cover the joint operations for
13 haemophiliacs?

14 **A.** No, that's entirely under the Haemophilia Service.

15 **Q.** The home care that you described, what's the source of
16 funding for that? Is that the Department of Health?

17 **A.** The Department of Health.

18 **Q.** I asked you earlier about how the tribunal approaches
19 the assessment of the cost of care, if carers are
20 making a claim, and you indicated you weren't sure of
21 how they approached it?

22 **A.** Yes.

23 **Q.** Is there a way we would be able to find that out?

24 **A.** Absolutely. I think if you were to contact
25 Raymond Bradley from Malcomson Law, he would have

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1 Euros, and the average award which had been appealed
2 was about half a million Euros.

3 **Q.** You gave some figures that are quoted in
4 the Archer Inquiry Report about both the range and
5 average. Are those still accurate, do you know, or
6 has there been a significant change since then?

7 **A.** Can you remind me what figures I quoted for Archer.

8 **Q.** I can. I haven't got the report in front of me, but
9 the final report says that you told the Archer Inquiry
10 the average payment was -- it's about EUR 850,000,
11 from a range of between EUR 14,000 and
12 EUR 3.1 million.

13 **A.** That range would certainly be correct. It is
14 impossible to know what the average payment was to
15 a person with haemophilia, but it would certainly be
16 higher than the average payment for the tribunal
17 awards generally because, as I say, they cover an
18 entire range of cases from primary claimants, to
19 secondary claimants, to carers, so I would think
20 that's -- I think that's reasonable.

21 **Q.** And in terms of the tribunal awards, is it right to
22 understand then that the individual awards are not
23 published? There is no --

24 **A.** That's correct.

25 **Q.** There is no decision from the Tribunal?

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1 A. That's correct.

2 Q. If they are appealed to the High Court, the High Court

3 judgments would be publicly available?

4 A. Not that I'm aware of, no.

5 Q. Just --

6 A. Again, I think right through every step of this

7 process we've taken as much care as possible to ensure

8 confidentiality.

9 Q. Yes, understood.

10 Just turning back to the HAA card scheme. The

11 liaison officers, what's the background of

12 the officers?

13 A. They would generally be health service employees.

14 They would be -- perhaps some of them would have

15 a nursing background but generally they'd be health

16 service employees. But crucially, when they started

17 in that role, when the card was established, we did

18 some training for them, as did the other

19 organisations. So they came around to the

20 Irish Haemophilia Society, to the Transfusion Positive

21 Group, to the Anti-D support group. They heard about

22 the issues, they met the community. So they gained an

23 understanding of the areas they were going to be

24 dealing with.

25 Q. Then a much broader question next. Following the

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1 Selection Monitoring Advisory Board, which carries out

2 the tenders and procurement for the haemophilia

3 treatments. And I think that's now been running since

4 2002 and in that period of time our availability of

5 treatment has remarkably improved in terms of both

6 quantity and quality. I think we're the first country

7 in the world to switch every patient with haemophilia

8 to extended half-life factor concentrates, one of the

9 first to make the new subcutaneous treatments

10 available across the board to everybody who wanted it,

11 and, crucially, that's been done in a way where

12 the patient organisation and the doctors are formally

13 involved in the decision.

14 And ironically, despite the fears of the

15 Department of Health when this was agreed, it has

16 actually turned out to be cost effective. It has

17 saved them a lot of money because we've made it much

18 more competitive and efficient and effective than it

19 had been here before.

20 Q. Just --

21 A. Sorry, just again to expand, I mean I think

22 the culture has changed. I think everybody realised

23 that this can't be allowed to happen again, so, you

24 know, there is a co-designed approach to the

25 Haemophilia Service, major decisions were taken in

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1 publication of the Lindsay Tribunal report, has that

2 had any broader effect in terms of culture change in

3 Ireland in terms of the approach to treatment and

4 patient safety?

5 A. Absolutely. I think when you look at

6 the recommendations from the Lindsay Inquiry, which

7 were fairly broad, talking about the need for

8 a committee to look at blood products, and doctors and

9 patients to work more closely, I think we put a lot of

10 work before the end of the Lindsay Inquiry into

11 recommendations for the future and a lot of those have

12 come to pass. So you had the establishment of

13 a statutory National Haemophilia Council, which brings

14 together the four haemophilia treatment centres,

15 the Irish Haemophilia Society, the Health Service, the

16 Department of Health and a couple of key experts.

17 And crucially that Council recommends policy to

18 the Minister, but really sets priorities for the year

19 for the whole service. And it's really led to

20 a position where we now have a co-designed service

21 where the Society are involved in all of the major

22 decisions in relation to the implementation of the

23 haemophilia care service in the country.

24 Secondly, we had the establishment on

25 a non-statutory basis of the Haemophilia Product

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1 consultation with the patient organisation, and

2 especially now, as we're entering an era of, you know,

3 therapeutic choices, new therapies, new types of

4 therapies, gene therapy, where you absolutely have to

5 have shared decision-making, so I think the culture

6 has been changing, has changed, and I think will have

7 to evolve even more in the future.

8 Q. Do you have any sense of the extent to which that

9 culture change has extended beyond the haemophilia

10 community? For example, the other bodies,

11 organisations you mentioned, those involved with

12 the -- advocating on behalf of those who were infected

13 through transfusion or infected through anti-D, would

14 they, do you know, report a similar shift in terms of

15 culture and patient involvement and shared

16 decision-making?

17 A. No. Not at all. And, in fact, quite sadly, I think

18 the organisation which represented the women infected

19 through anti-D imploded. The transfusion group have

20 just -- they really have just concentrated on

21 the issues around the card and on compensation but

22 they haven't got involved in any sense in terms of

23 policy.

24 But, of course, haemophilia is different. If you

25 had a blood transfusion, you had an underlying

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1 condition which could be anything. With haemophilia
 2 and bleeding disorders there was a core set of the
 3 same treatments, the same ideals, that go right
 4 through that. So -- but I think none of the other
 5 organisations have been involved in policy in that
 6 sense, although we do have a statutory hepatitis C
 7 consultative council which does include
 8 the organisations whose members were affected, and we
 9 sit with the Department of Health and we monitor the
 10 implementation of the HAA card and also the council
 11 would organise information days every couple of years.
 12 Q. Then just going back to the work of the Compensation
 13 Tribunal. Do you know what approach is taken to
 14 the assessment of compensation if there is a dispute
 15 between family members? So there may have been --
 16 there may be competing claims in terms of care or
 17 dependency. Do you know whether that's arisen at all
 18 in the Tribunal?
 19 A. I can't really answer that. I think, again, you could
 20 talk to our legal team and they'd be able to clarify
 21 that for you, but I know that, I mean, there have been
 22 cases where several family members have been granted
 23 awards for taking care of a person at different points
 24 in time.
 25 Q. Then the awards made by the Tribunal, are they taken

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1 the World Federation and the European Consortium.
 2 Do you know to what extent the measures that
 3 you've been describing in Ireland, in particular in
 4 relation to the insurance scheme and the HAA card,
 5 whether those are schemes or measures that have been
 6 set up in other countries?
 7 A. Not that I'm aware of, no.
 8 MS RICHARDS: Sir, those are the questions I'm proposing
 9 to ask from those that have been suggested to me by
 10 the Core Participants.
 11 Do you have any further questions for Brian?
 12 SIR BRIAN LANGSTAFF: Yes, a couple of areas, if I may.
 13 Am I right in thinking that since the early 2000s,
 14 personal injury claims, except for those that arise
 15 out of medical negligence, alleged medical negligence,
 16 have been determined not in the courts, as they used
 17 to be, but by a compensation, or a tribunal, a PIAB,
 18 the Personal Injury Assessment Board?
 19 A. I think that's an option for people with personal
 20 injuries. I think it's an option that they can go to
 21 the PIAB but they can also take legal action and go to
 22 the court. I'm not fully aware of it but think it's
 23 an option that they have. They don't have to go to
 24 the PIAB.
 25 SIR BRIAN LANGSTAFF: When they do go to the PIAB, to what

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1 into account for the purposes of any applications for
 2 welfare benefits?
 3 A. No, they're not, they're specifically excluded. And
 4 in fact, because of the arrangements we've made with
 5 the Revenue Confidential Service, they can't even know
 6 about them.
 7 Q. And in relation to taxation, you've explained
 8 the position in your statement, but for the benefit of
 9 those who may not have been able to read through your
 10 statement, what in short is the position in terms of
 11 taxation and the compensation awards?
 12 A. The compensation awards are tax-free. That's clear.
 13 But we also made submissions to the Revenue that there
 14 is a section 189 in the Taxes Consolidation Act which
 15 states that if an individual is permanently and
 16 totally incapacitated then the income arising from
 17 the award can also be tax exempt or exempt from
 18 capital gains tax. And we made a submission which was
 19 accepted that, in fact, every person with haemophilia
 20 who got hepatitis C or HIV would fall under
 21 section 189, so their awards are tax-free but also any
 22 income or capital gains earned from the awards, income
 23 from the awards, is also tax-free.
 24 Q. And then last question arises from your involvement
 25 internationally, you've been involved both in terms of

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1 extent does the process there differ, if at all, from
 2 the process that you're describing in the compensation
 3 tribunal specifically for HCV and HIV?
 4 A. I have no experience or exposure to the PIAB so
 5 I can't answer that question, Sir Brian, but I would
 6 say that the Compensation Tribunal was much more like
 7 a court hearing to assess damages. I'm not sure
 8 the PIAB is the same.
 9 SIR BRIAN LANGSTAFF: All right. It was essentially that,
 10 that I was just trying to get a sense of how similar
 11 the process is in terms of compensating those who have
 12 suffered infection through the action of the state --
 13 A. Mm-hmm.
 14 SIR BRIAN LANGSTAFF: -- in respect of their haemophilia
 15 treatment or their transfusions, with the process that
 16 would be applied in the courts.
 17 The next question you may not be able to answer,
 18 but I'm given to understand that there may be moves in
 19 Ireland, in the Dáil, to introduce legislation which
 20 will effectively reduce the amount of money which is
 21 paid out in terms of compensation payments for those
 22 who succeed in claims. Do you have any awareness of
 23 that or can you enlighten me on that?
 24 A. No, I think that the vast -- in terms of
 25 the Hepatitis C Compensation Tribunal, the vast

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1 majority of the claims have been dealt with at this
2 point in time. I think the vast proportion of
3 the expenditure has already been spent. I'm not aware
4 of any push by Government to limit the amount
5 of funding being made available to the tribunal. If
6 that was the case we would wholeheartedly oppose that.

7 **SIR BRIAN LANGSTAFF:** It really arises out of your
8 evidence that, in effect, there is no benchmarking of
9 awards in this area. It's all a question of what
10 the Tribunal feels is appropriate, subject to appeal?

11 **A.** Yes.

12 **SIR BRIAN LANGSTAFF:** The second area which I wanted to
13 ask you about was just this, curiosity really.

14 You described how the hepatitis C problems were
15 sorted by legislation well before the Lindsay Tribunal
16 was established. What was it, do you think, that
17 persuaded Government to set up the Lindsay Tribunal?

18 **A.** Well, the Lindsay Tribunal was set up --
19 the Government established the Finlay Tribunal
20 in 1997, and that was meant to look at the infection
21 of people with hepatitis C through anti-D blood
22 transfusion and blood products.

23 Unfortunately, it became ... [technical issues -
24 audio drop] on blood transfusion and they were not
25 focusing on haemophilia issues, our legal team was not

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1 not accept the first Inquiry, where it clearly and
2 patently was not going to deal with our issues.

3 **SIR BRIAN LANGSTAFF:** Thank you.

4 The other matter is this: you mentioned that the
5 Haemophilia Society of Ireland had made a number of
6 recommendations on the back of the Lindsay Tribunal.

7 **A.** Yes.

8 **SIR BRIAN LANGSTAFF:** And most of those or some of those
9 have been put into effect. What are you most
10 disappointed was not put into effect?

11 **A.** I can't think of any recommendation that we made that
12 we regret not being put into effect. There really
13 wasn't -- I mean, I think all of our major
14 recommendations have been implemented and accepted.

15 **SIR BRIAN LANGSTAFF:** And which of those do you think has
16 been perhaps the most significant?

17 **A.** The formal role for the patient organisation and
18 the doctors in decision-making, learning from the past
19 where decisions were taken on financial grounds would
20 not be acceptable. So I think the formal role for the
21 Haemophilia Society and the doctors in the choice of
22 treatments on the tender board, the formal
23 establishment of a statutory haemophilia council,
24 which brings together the Ministry of Health,
25 the doctors and the Society -- and that's actually

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1 able to get to the questions asked that they wanted,
2 they wouldn't accept witnesses. So it became very
3 clear to us that the Finlay Tribunal was purely
4 limited in its scope and we decided to withdraw from
5 that.

6 And then we had a further two-year and three-month
7 period where we spent that time negotiating with the
8 Government to establish the Lindsay Tribunal.

9 I think the reason it was established was because,
10 first of all, we kept the pressure up, we kept
11 demanding a new Inquiry which specifically would look
12 at haemophilia. The discussions on the Terms of
13 Reference took a long, long time. They took longer
14 than the Inquiry, you know, two years and
15 three months.

16 Having said that, during the course of those
17 discussions we got Government agreement to the
18 provision of recombinant factor concentrates for
19 everybody. We got Government agreement to the funding
20 for a new national haemophilia treatment centre. But
21 I think there was a lot of discussion on the terms of
22 reference. Which, in the end, probably worked well
23 because it did define it very, very clearly. But,
24 I mean, I think the Government were not keen on having
25 a second Inquiry, but we were not keen and we would

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1 crucially important, not just in terms of looking at
2 recommendations and priorities but it means six times
3 per year, at least, we sit down with the Health
4 Ministry, with the doctors, to discuss haemophilia
5 policy and, in fact, the Council meets in our office.
6 That's been really important.

7 And I think the funding for
8 the Irish Haemophilia Society was really important.
9 We were funded prior to the Lindsay Tribunal. We got
10 our first funding from the Government back in 1989,
11 after the first recompense campaign, and we're now at
12 the point where the Irish Haemophilia Society, about
13 75 per cent of our funding comes from the Government.
14 That's really -- it really allows us to do the work
15 that we do very, very well.

16 It also means, frankly, the Government see the
17 advantage of this because in terms of the procurement
18 process for medications and factor concentrates we
19 will always insist on having the safest and most
20 efficacious treatments.

21 We carried out a full economic assessment in 2018
22 of our work on that board since 2002 and we have saved
23 them EUR 175 million. In that point, in that entire
24 period of time, they had given us grants of about EUR
25 6 million. So they gave us grants of 6 million, we

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1 saved them 175 million. So I think the Government at
 2 this point accepts that it definitely makes sense as
 3 well to continue that.

4 **SIR BRIAN LANGSTAFF:** I don't know if there are questions
 5 which arise out of that.

6 **MS RICHARDS:** There are not, but I have one further issue
 7 I've been asked to raise with you, Brian.

8 Do you know whether the Irish Government had any
 9 discussions with the pharmaceutical industry -- pharma
 10 companies who had supplied concentrates that had
 11 caused infection -- at any time, in terms of trying to
 12 secure a contribution by pharma to the funding of
 13 the compensation schemes?

14 **A.** When we started our legal cases back in 1989, 1990 --
 15 and these were proceeding very, very slowly -- then,
 16 I mentioned earlier that at the end of 1990 we started
 17 a political and media campaign to get the Ministry of
 18 Health to agree compensation, and, you know, again,
 19 there was a total lack of response from the Government
 20 for several months, culminating at a point when,
 21 actually, an offer was made on the same evening that
 22 I was due to appear on a live TV debate with
 23 the Minister.

24 But one of his rationales for the delay was that
 25 they were engaged in negotiations with the

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1 restitution, and that, in fact, when the report is
 2 published finally, the report will be seen as
 3 a healing well by the community, and thank you for
 4 the opportunity to give evidence.

5 **SIR BRIAN LANGSTAFF:** Well, thank you. Thank you very
 6 much indeed for the most valuable of evidence. As
 7 you'll know, we are spending this week and next
 8 largely on the issues which arise consequent upon any
 9 findings of fact which I might make, none having yet
 10 been finally determined, but you have certainly shone
 11 a very bright light in certain areas which might well
 12 feature in recommendations. So thank you for that.

13 **MS RICHARDS:** Sir, then that's it for today.

14 **SIR BRIAN LANGSTAFF:** Yes, but tomorrow we have a very
 15 early start, don't we?

16 **MS RICHARDS:** We do, we have a long day tomorrow, sir.

17 We start at 9.00 am with the evidence of
 18 Lord Evans, who is chair of the Committee on Standards
 19 in Public Life.

20 **SIR BRIAN LANGSTAFF:** Yes.

21 **MS RICHARDS:** And I anticipate his evidence will take an
 22 hour or say, an hour, maybe an hour and a half. Then
 23 we have the postponed evidence from the statisticians.
 24 So it will be a full and long day.

25 **SIR BRIAN LANGSTAFF:** So a full day tomorrow, largely

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1 US companies to see if they would give a contribution
 2 to any eventual Irish compensation scheme. My
 3 understanding is that they were unsuccessful in that
 4 attempt.

5 Now, we did assist our members -- a number of our
 6 members in taking legal against some of the US pharma
 7 companies and some of them did receive an award
 8 separately.

9 **Q.** Thank you.

10 **MS RICHARDS:** Sir, that's it for my questions.

11 Brian, is there anything that you would wish to
 12 add?

13 **A.** Yes. Preparing the statement was a lot of work but
 14 that was easy. I found -- when I got the section 9
 15 letter, I found it opened up a lot of issues for me.
 16 You know, I found it difficult emotionally,
 17 personally. I was seeing names, faces, scenarios,
 18 events coming back into my head from the last 20, 30,
 19 40 years. And I think -- Seamus Heaney said that once
 20 in a lifetime the longed for tidal wave of justice can
 21 rise up and hope and history rhyme, and he talks about
 22 cures and healing wells.

23 I hope that by looking at the history, that this
 24 Inquiry can meet the hope of the community for
 25 answers, for acknowledgement, for a sense of

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1 statistics, but also standards in public life, and
 2 recommendations which may follow from that, plainly,
 3 that evidence will go to informing. So thank you once
 4 again, and that's it for today.

(12.35 pm)

(The hearing was adjourned until 9.00 am on
 Wednesday, 9 November 2022)

MR BRIAN O'MAHONY (sworn) 1
 Questioned by MS RICHARDS 1

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<p>COURT: [1] 48/21 MS RICHARDS: [17] 1/24 22/16 29/3 44/13 48/22 64/21 66/7 76/18 76/25 77/9 77/15 87/8 93/6 94/10 95/13 95/16 95/21 SIR BRIAN LANGSTAFF: [43] 1/3 1/5 1/11 21/12 21/18 21/20 21/23 22/2 22/5 22/12 22/15 28/18 29/2 43/17 44/8 44/12 47/7 47/14 47/23 48/16 63/9 63/12 64/4 64/10 64/20 65/2 66/4 76/23 77/5 87/12 87/25 88/9 88/14 89/7 89/12 91/3 91/8 91/15 93/4 95/5 95/14 95/20 95/25 THE WITNESS: [2] 1/4 1/10</p> <hr/> <p>'</p> <hr/> <p>'80s [2] 4/21 74/6 '83 [1] 6/4 '89 [4] 13/21 23/6 24/5 24/7 '90 [1] 23/6 '90s [2] 4/17 46/24 '91 [5] 23/7 24/5 24/7 36/4 37/24 '92 [1] 23/7 '95 [1] 62/11 '96 [1] 62/12 '97 [1] 62/12 'full [1] 9/20</p> <hr/> <p>0</p> <hr/> <p>04 [1] 2/10</p> <hr/> <p>1</p> <hr/> <p>1 million claw [1] 20/9 1 per cent [1] 9/2 1,000 [2] 24/12 51/8 1.5 per cent [1] 8/18 10 [2] 60/9 64/22 10.00 [1] 1/2 100,000 [1] 73/6 101,000 [1] 21/2 106 [2] 9/19 10/4 11.32 [1] 77/10 12.00 [2] 77/7 77/8 12.00 pm [1] 77/12 12.11 [1] 77/14 12.35 pm [1] 96/5 120 [1] 22/11 120 million [1] 22/12 14,000 [1] 80/11 15 [1] 22/10 15 minutes [3] 64/22</p>	<p>65/20 66/1 175 million [1] 93/1 18 months [2] 47/5 49/21 189 [2] 86/14 86/21 1980s [3] 2/7 4/17 5/10 1982 [3] 2/8 2/9 4/23 1983 [6] 5/15 5/22 5/24 7/13 7/18 7/21 1984 [2] 8/1 8/22 1985 [1] 8/17 1986 [1] 66/13 1987 [7] 2/13 5/4 5/7 11/3 11/4 13/19 66/18 1988 [2] 9/11 66/20 1989 [8] 5/8 13/21 15/13 19/4 23/5 25/13 92/10 93/14 1990 [3] 19/7 93/14 93/16 1991 [12] 13/19 13/21 14/2 14/5 14/8 18/20 19/2 19/19 21/8 33/20 34/1 34/21 1993 [1] 22/25 1994 [4] 2/15 3/2 3/14 24/14 1995 [3] 3/24 31/24 49/12 1996 [2] 20/14 51/21 1997 [6] 24/19 29/8 34/8 35/21 36/5 89/20</p> <hr/> <p>2</p> <hr/> <p>2 million [1] 20/22 20 [1] 94/18 20 per cent [5] 27/11 28/6 28/12 37/6 37/10 20 years [3] 48/7 48/8 49/11 2000s [2] 46/25 87/13 2002 [11] 15/24 33/9 33/13 34/10 35/3 35/19 48/9 67/13 74/7 83/4 92/22 2003 [1] 2/13 2003-04 [1] 2/10 2004 [1] 2/15 2006 [6] 2/3 17/5 21/17 66/10 67/20 67/22 2011 [1] 2/18 2012 [1] 75/1 2014 [1] 57/12 2015 [1] 57/12 2017 [1] 53/4 2018 [1] 92/21 2019 [1] 2/18 2020 [3] 52/18 52/22 79/23 2022 [2] 1/1 96/7 21,000 [1] 21/6</p>	<p>23 [1] 68/5 24 [1] 20/3 24 hours [1] 59/5 24-hour [3] 58/22 58/25 59/5 240 [1] 10/11 245 [1] 10/11 25 [1] 23/17 25,000 [1] 21/5 265 [1] 9/18 27 years [1] 49/13 28 [2] 34/7 34/7 29 [1] 34/7 296 [2] 9/17 9/24</p> <hr/> <p>3</p> <hr/> <p>3,000 [1] 51/14 3,500 [1] 79/24 3,500 cards [1] 60/2 3,500 individuals [1] 55/5 3.5 million [1] 22/3 30 [2] 70/7 94/18 300,000 [1] 17/7 33 [1] 55/16 35 excruciatingly [1] 74/22</p> <hr/> <p>4</p> <hr/> <p>4 million [1] 22/6 4,000 [2] 5/3 51/14 40 per cent [1] 10/5 40 years [1] 94/19 43 [1] 20/4 46 [1] 23/18</p> <hr/> <p>5</p> <hr/> <p>5 million [1] 60/3 50 [1] 70/8 50-year [1] 70/25 525,000 [1] 70/14 58 responses [1] 11/11 59 [1] 34/12</p> <hr/> <p>6</p> <hr/> <p>6 million [2] 92/25 92/25 60 million [1] 22/6 65 [1] 72/6 65th [1] 69/24</p> <hr/> <p>7</p> <hr/> <p>7 million [2] 20/12 20/16 70 [2] 9/22 53/25 70 surveys [1] 11/11 7418001 [1] 23/17 75 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