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

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.

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.

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 individual was who happened to be honorary secretary, all of the mail arrived at their house. So the annual budget at the time was around £4,000.

Q. And it was, I think, 1987 before there was any kind of staff member at all?

A. We had a part-time member of staff, two mornings a week from 1987 and our first full-time staff member in 1989.

Q. Then I just wanted to ask you briefly about your own knowledge of AIDS back in the 1980s and how you came to be aware of the possibility of a risk of transmission through blood or blood products.

Your statement indicates that that came to the attention of the Haemophilia Society in Ireland in 1983?

A. Correct.

Q. And you yourself learnt about it through reading an article in a laboratory magazine?

A. Yes.

Q. So through your own scientific work?

A. Yes.

Q. Do you have any recollection of roughly when in 1983 that might have been?

A. March or April of 1983.

Q. Then it was, I think, following a newspaper article,

and you've referred, I think, in your statement to the "killer blood" article, which I think dates it, for our purposes, to the Mail on Sunday article at the beginning of May '83. You then had a meeting with the Irish Blood Transfusion Service?

A. That's correct.

Q. There was a suggestion that you discuss the issue with someone you've described in your witness statement as the "treating consultant". Would it be right to understand that's Professor Temperley that you were talking about there?

A. Yes.

Q. Again, just so that others can understand your statement, what was his role?

A. Professor Temperley was the national haemophilia director, so he was the director of the main National Haemophilia Treatment Centre in Dublin at the time. The discussions I had were with Sean Hanratty, who was the chief scientific officer of the Blood Transfusion Service Board, and my meeting with him, which I actually took a handwritten minute of, was based on the fact that I was concerned that there seemed to be little or no progress being made in relation to self-sufficiency for factor concentrates from Irish plasma. And I was -- you know, I had this idea in my

head that if we were self-sufficient there would be a lower risk of transmission of potentially blood-borne viruses.

Q. In your witness statement, if we just have it up on screen.

WITN7418001, please, Lawrence, and if we could go to page 5.

If we pick it up, top of the page, this is paragraph 7 of your statement, you've said --

A. Yes.

Q. "In his replies to us ..."

And the context in the previous paragraph was the discussions you've referred to in 1983.

"... the treating consultant pointed out that all blood products could potentially cause AIDS or non A non B Hepatitis, and that the risk of bleeding was much greater than the risk from any viral infection."

Do you have any recollection of when in 1983 that was being said, roughly, by the treating consultant?

A. That would have been around, I think, May or June of 1983, shortly after my meeting with the Blood Transfusion Service.

Q. Then just one other request for clarification from your statement. If we go over the page to page 6, please. Paragraph 9, you report that:

"In December 1984 we had the first diagnosis of AIDS in an Irish person with haemophilia."

A. Yes.

Q. And then this:

"The indication from the treating consultant at that time was that this may be the only case of AIDS we would see in a person with haemophilia and that perhaps only 1% of those who were HIV positive would go on to develop AIDS."

Do you know whether any reason was given for that rather optimistic prediction that it might be the only case of AIDS?

A. I think it seemed to be very much the prevailing clinical opinion at the time. Professor Temperley would have had a close relationship with the UKHCDO, attended their meetings. If you look at similar -- people like Dr Peter Jones in his book in 1985 he talked about 1, 1.5 per cent. So initially the advice was very much that, you know, to stop taking factor concentrates was much more dangerous, because there was risk of bleeding, than the potential risk of a potential blood-borne virus. By the end of 1984, when we had the first case, I remember Professor Temperley saying very clearly that he expected this would be the only case we would see, that the risk of people with -- who were HIV positive going on to develop AIDS was probably 1 per cent.

Q. Can I then just ask you, in terms of the numbers of people with haemophilia in Ireland and numbers infected, if we look at a document you've exhibited to your statement -- it's WITN7418004 -- we can see it's entitled "AIDS, Haemophilia and the Government, A submission from the Irish Haemophilia Society calling for financial provision for people with haemophilia infected with the AIDS virus", and the date is April 1988.

If we could go to page 3, please, Lawrence. We've just got some figures on the right-hand side of the page.

A. Yes.

Q. Third paragraph:

"Of the 296 Haemophiliacs registered in Ireland.

"- 265 have been tested for exposure to HIV.

"- 106 have been infected with HIV ...

"- 9 have developed 'full blown' AIDS.

"- 4 [by that time] have died.

"- 70% of severe Haemophilia A patients have been infected."

So the 296 haemophiliacs registered in Ireland, did that encompass, as far as you understand it, those

who were mild, moderate and severe?

A. No, looking at the numbers, that would probably have been moderate and severe.

Q. Then we have the figures there, 106 infected with HIV, so 40 per cent. Does that remain the figure, as far as you know, of the numbers infected with HIV?

A. Yes, yes.

Q. Then in terms of the numbers infected with hepatitis C, do you have any knowledge of what proportion were infected with hepatitis C?

A. We're talking about 240, 245 people.

Q. Okay. So a very significant proportion?

A. Yes, but also that would have encompassed a number of people with mild haemophilia as well.

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

I want to ask you now, Brian, about some of the measures that have been put in place, over the decades in Ireland, to address the needs and the circumstances of those who were infected through contaminated blood and blood products. The purpose, as I know you understand, being for us to understand whether there is anything that can be learnt from how Ireland has responded to the plight of those infected.

So I wanted to start with the Haemophilia HIV Trust. As I understand your statement, Brian, this

emerged following, first of all, a survey that the Irish Haemophilia Society undertook of its members in 1987; is that right?

A. Yes, I became Chairman of the Society in 1987, and my top priority was helping our members who had been exposed to HIV and who had developed AIDS. So, in order to understand what their real requirements and needs were, a dental surgeon and I -- who sat on our board as well -- we did a survey of as many people as possible who had HIV and AIDS, so I think we got 58 responses out of 70 surveys sent out and that allowed us to draft up this proposal for Government, based on a real understanding of what their needs were.

Q. That resulted in the submission that we looked at briefly --

A. Yes.

Q. -- a couple of minutes ago?

A. Correct.

Q. The argument that was being made at that point in time, as I understand it, was that there was a moral responsibility on the Government to respond to the situation of those who had been infected, through no fault of their own, with HIV?

A. Yes.

Q. That wasn't accepted by the Government to start with and the Society embarked upon a public and political campaign?

A. I mean, when you say it wasn't accepted, all we received, actually, was an acknowledgement of receipt of the document and then five months of silence. And despite the fact I was naive enough to think, at the time, that if you sent in a well reasoned, well argued case that it would receive a fair response from the Department of Health, that didn't happen. So at the end of that year people were getting sicker and they were dying, so we realised we had no option really but to try and put political and media pressure on the Government to respond to this.

Q. Now, that resulted, eventually, in an agreement which led to the establishment of the Haemophilia HIV Trust?

A. Yes.

Q. Did you -- what was your understanding of what ultimately persuaded the Government to accede to that?

A. Well, the fact that the political media campaign was very successful, we got a lot of traction, a lot of media coverage, we had some of our members with HIV who spoke publicly and very bravely to highlight the issue. And then it went all of the way to -- we had a minority Government at the time -- it went all of the way to a vote in Parliament.

The week before the vote I had assumed that the Government would offer some sort of compromise. We spent the week in discussions, the Government didn't move whatsoever on this. They made it an issue of financial management so that when -- they then threatened that if they lost that vote in the Parliament they would call for an election. So the Prime Minister lost the vote in Parliament, called a general election, lost seats in the election, and fortunately, in the course of the election campaign, we had received written commitments from the leaders of all of the other parties to implement a trust fund if they got into office. The outgoing Prime Minister then had to go into a coalition with another party and, as part of the negotiations for the programme for Government, the trust fund was established.

Q. Now, initially, that trust paid regular payments, so from about 1987 to 1991 there was some regular payments?

A. 1989 to 1991, it was established in '89. We made regular payments to some individuals, not to all individuals. It was very much based on an assessment of individual need and people's individual circumstances, and people really were struggling, some people were really struggling. So regular payments were made to those who needed them until 1991 when, in fact, a further tranche of compensation was paid.

Q. Those are the *ex gratia* payments, essentially, from 1991?

A. Yes, yes.

Q. We'll pick up those in a moment. If we then -- just staying with the Haemophilia HIV Trust, from 1991 onwards it was one-off payments?

A. Yes.

Q. So it might be for funeral grants or equipment, those kinds of --

A. Yes. Hospital beds, wheelchairs, any -- special mattresses, anything that would be required by the person with HIV or AIDS to help them to deal with the condition or -- and certainly one-off items which would not easily be provided, in any sort of timely manner, by the Health Service.

Q. And what you've told us in your statement is that the way it was designed to operate was that it didn't have overly complex procedures, or requirements for lots of different types of proof. The individual would communicate with the trust, it might be by letter or by telephone, and a decision would be made as to whether to make the payment, and it was designed to be done as quickly as possible; is that right?

A. Yes, it was very non-complicated. I think the Society had people on the board of trustees with independent trustees. So a request would come in for funding, it may be based on a phone call, it may be based on a letter and then that would be discussed very, very quickly and a decision made. In some cases where it was a very urgent situation and the request came in directly to the Irish Haemophilia Society, we would pay the item ourselves and then seek to recoup the money later from the HHT.

If you look at our audited accounts for all the years from 1989 to now, there is always an in and out from the HHT and they never match up because, typically, there can be a couple of months' delay before recouping the money back. But it's always been our view that the trust fund should be non-complex, it should be easy to administer and that payments should be made quickly where they're required. In fact the procedures were set up following meetings with the beneficiaries, so that was very important. They were consulted on how they wanted the trust fund to operate.

Q. Now, in 2002 there were further payments made, we'll come on to that, but the Tribunal that had been set up in relation to hepatitis C was extended to cover HIV?

A. Yes.

Q. And as a result there was a decision that needed to be made about the future of the Haemophilia HIV Trust?

A. Yes.

Q. As I understand it, the decision was taken through consultation with those who had been infected; is that right -- with a range of beneficiaries?

A. Yes, we organised a meeting with as many of those as possible who survived with HIV and we asked them -- you know, at that point there wasn't an enormous amount of money left in the trust fund so we offered them the option of closing down the trust fund and dividing the remaining funds equally between the participants, or keep it going as sort of an emergency fund, and they were very adamant they wanted it kept going.

Q. That's the way in which it has continued to operate, again, through -- it continues, is this right, to make one-off --

A. Yes, yes.

Q. -- payments? Again, it might be for equipment or -- you refer to Christmas payments?

A. Yes, we also look very carefully at, you know, the people's individual circumstances, and we make a number of payments at Christmas each year to individuals who we believe are still in particular financial need.

Q. And there was a top-up of the amount that the trust had in 2006?

A. Yes, yes.

Q. EUR 300,000?

A. Yes, that's right.

Q. The trust was chaired initially by one High Court judge and then since then has been chaired by another High Court judge?

A. Yes.

Q. You tell us in your statement that they had met with a lot of those who were infected, but, you know, they also made themselves known to the community?

A. Yes.

Q. Is that right?

A. Yes.

Q. And how important has that been?

A. Both Judge Carroll and latterly Judge Murphy, we had several meetings with the members who had HIV to hear about their concerns and their issues, and also both chairs of the trust would usually attend our annual conference for the full weekend and meet members and just have conversations with them. So they really developed empathy and a sense of understanding of the real issues in the community.

Q. And you were asked in your statement if you thought that the HIV -- the Haemophilia HIV Trust, the HHT, had been successful, and you've told us in your statement that you think it has been, its objectives were met, and you've identified three factors: trustees acting with empathy and understanding; the ability to respond rapidly; and its relatively informal structure?

A. Yes.

Q. Is that right?

A. Yes.

Q. So that's the HHT.

A. Mm.

Q. Now, the second main plank of financial support for those who were infected is the compensation tribunal, and so I just wanted to ask you a little about how that --

A. There was the earlier 1991 -- (overspeaking) --

Q. I'm sorry, yes --

A. -- as well, yes.

Q. Yes. Yes, let's pick that up.

So there was litigation in Ireland in the same way as we know that there was litigation --

A. Yes.

Q. -- in the United Kingdom, which was settled in 1991; is that correct?

A. That's correct. We employed a legal team from 1989 and worked with them and we were looking at the Society actually funding a test case. But as this was going on and on through the course of 1990, it became apparent this was not going to see a courtroom at any time in the immediate future and in the meantime the number of people dying of AIDS and getting AIDS was increasing rapidly. We then saw that the -- the compensation paid by the John Major-led Government in the UK, and we decided the time was right to try and settle this politically. So at the time the minister asked the Society for a submission to settle these legal cases and we entered, again, into a four or five-month political and media campaign, culminating in an offer of compensation in 1991.

Q. That resulted in what I think you've described as tiered payments --

A. Yes.

Q. -- in a way that's a similar but not identical, but similar to the way in which it was done in the United Kingdom?

A. Yes.

Q. So if we look by at your statement, please.

WITN7418001, page 24.

It's paragraph 43, and you've set out in the previous paragraphs the process of the litigation, the campaign and so on.

A. Yes.

Q. "We secured an improved offer of £8 million, to be paid quickly and with no £1 million claw back."

That was a clawback of what had been paid to the HHT, was it?

A. Originally the Government offer was 7 million, and from that 7 they also wanted to claw back the 1 million paid to the HHT in 1996, and they wanted to stage the payments over a two-year period. So frankly, in the week between that 7 million and the improved offer, local elections were taking place a week later, we knew we had one more week to optimise our political and media campaign, we actually had four candidates running in the local elections, so we secured a better offer of 8 million and with no clawback. So in fact it was an increase of 2 million over the previous offer and it was paid over a course of two or three months.

Q. Then we can see the figures that were agreed there.

A. Yes.

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

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

A. Yes.

Q. Then you have the operation of the HHT?

A. The HHT, yes.

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

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

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

SIR BRIAN LANGSTAFF: So though this is punts?

A. Punts, yes.

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

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

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

A. Yes.

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

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

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

A. 120.

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

A. Yes, correct.

SIR BRIAN LANGSTAFF: Thank you.

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

A. That's correct.

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

A. Yes.

Q. And you described that particularly coming to your attention in I think, 1993, when there were discussions about the availability of Interferon and, indeed, people being charged for treatment with Interferon?

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

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

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

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

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

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

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

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

WITN7418010.

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

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

And to a class of claimants.

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

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

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

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

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

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

A. Yes.

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

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

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

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

a *prima facie* entitlement to compensation?

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

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

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

A. Yes.

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

a 20 per cent uplift to their compensation?

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

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

A. Yes.

Q. What was that?

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

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

A. Yes. Absolutely, yes.

Q. Then we can take the --

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

A. I believe so, yes. Yes.

SIR BRIAN LANGSTAFF: Thank you.

MS RICHARDS: I skated, sir, over subparagraph (f), "a person referred to in section 9"; that refers to the power of the minister to extend the classes of persons who could bring claims.

So if we then go back to how the Tribunal operated as set up under the 1997 Act, so the claimant had to prove they had an infection caused by treatment from the state on the balance of probabilities. And as you've explained, for those with haemophilia, that was a relatively straightforward exercise?

A. Yes.

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

A. Yes.

Q. -- award to the High Court?

A. That's correct.

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

A. Yes.

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

A. It continues, perhaps not to the same extent. I mean when the vast, vast, majority of appeals to the High Court resulted in a significant increase in the award. So I think that did start the tribunal thinking in terms of giving higher awards. So perhaps the number of appeals diminished but there were still appeals.

Q. Now, this obviously covered hepatitis C only, but in 2002 the tribunal's remit was extended to encompass HIV?

A. Yes.

Q. How did that come about?

A. In 2002 we had an election coming up, again, and we'd had the hearings of the Lindsay Tribunal, including the very powerful public testimony of members, during the course of the tribunal, and in the two years leading up to the tribunal and during the course of the tribunal we had constant meetings with Government on various issues. But one of the things was pressing for was that we felt that the 1991 awards, while very, very welcome at the time, were -- were -- they were not fair and equitable compensation for people who got HIV. We felt, really, that those individuals had been shortchanged, and in particular -- in particular -- the families of those who had passed away prior to 1991.

So it basically came about, I think, as a result of our discussions with Government and, frankly, the public impact of the very powerful public testimony at Lindsay.

Q. So if we go back to your statement, so WITN7418001, pages 28 to 29. If we start at the bottom of page 28, we can see there was an amendment to the 1997 Act through the Hepatitis C Compensation Tribunal (Amendment) Bill, 2002.

Then if we go to the next page, you've listed in paragraph 59 those who could apply for compensation following the amendment. So, similar to what we've seen previously, but now encompassing HIV and the children or spouses of those infected with HIV, dependants and carers, HIV as well as hepatitis C?

A. Yes. And I think the significant part of that for us, really, was if you look at the section e, that the:

"Widows or Dependants of those who had died."

So the individual was no longer disadvantaged by the fact that they'd passed away prior to the 1991 Act, their families were getting the full compensation that they would have been entitled to had they survived to that point.

Q. Then if we go to the next paragraph, you tell us also that:

"New areas of claim were introduced under the [2002] Act ..."

A. Yes.

Q. "a. [Child], spouse, father or mother of those who had died could claim under loss of society or psychiatric injury including post-traumatic stress disorder;

"b. Partners or spouses of those infected could claim under loss of consortium;

"c. Children or spouses of those who died could claim for loss of society ([so] loss of [the] ... care, companionship or affection);

"d. Dependents could also claim for aggravated or exemplary damages ..."

Where there was a legal entitlement that could be established.

These extensions covered both HIV and hepatitis C?

A. Yes, correct.

Q. So the significance of the 2002 Act -- is this right -- is twofold. First of all, it establishes, or extends the rights that were conferred by the 1997 Act to those infected through HIV, and then it provides for a wider range of types of claim that's applicable to both those infected with hepatitis C and those infected with HIV?

A. That's correct, and bear in mind, however, that all of those were infected with HIV were also co-infected with hepatitis C, so they had been compensated previously through the '91 settlement, but also through the 1997 Hepatitis C Compensation Tribunal Act. But this broadened it, really, to give more compensation to people with HIV and, particularly, to the families of those who had passed away.

Q. In terms of assessment for loss of earnings, which is one of the heads of claim that can be advanced to the tribunal --

A. Yes.

Q. -- do you know how the tribunal typically assesses the loss of earnings?

A. I think they bring a number of expert witnesses, they look at the person's educational record, they do IQ tests, they look at the career path they may have had without hepatitis C. There may be opportunities that the individual may have had to pass up on due to the hepatitis C, or HIV. So it's basically based on an assessment. There might be an educational psychologist and a couple of expert witnesses.

Q. Then in terms of those who are bringing a claim as a carer --

A. Yes.

Q. -- effectively for the care that they will have provided, gratuitously, to a relative, how is that cost of care assessed? Do you know?

A. I can't answer that, no.

Q. In terms of the aggravated and exemplary damages or the 20 per cent uplift, have there been many cases in which claimants have opted to try to establish an entitlement to aggravated or exemplary damages?

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

Q. So claimants have typically gone for the 20 per cent uplift?

A. Yes, yes.

Q. In terms of who sits on the tribunal, I don't mean by name, but what are the kind of -- what kind of individuals are appointed to the compensation tribunal?

A. They tend to be barristers, all of them.

Q. How important has the availability of legal representation been for the success of the tribunal in your view?

A. Vital. I think the availability of legal expertise and expert witnesses has been absolutely vital, because if you have across the board payments, as we had in '91, then you really don't need that, but when you're having an individual assessment, each individual's circumstances are going to be different, their experience is going to be different, their life with hepatitis C or HIV or both is going to be different, the impact on their life is going to be different, so I think you really need an expert team to put that in place.

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

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

A. Yes.

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

A. It's very daunting for individuals with haemophilia who have been exposed to HIV or hepatitis C to have to stand up or sit down at a legal hearing and make their case. So even preparing for a non-adversarial hearing was very, very difficult for many of them because it means revisiting all the trauma, all of the issues over the years. It was really helpful that, from day one, the tribunal was -- it was sympathetic, in terms of the way that the individuals were dealt with. It wasn't -- it wasn't adversarial in terms of the questioning.

They would, of course -- there would be questions, they would question the figures, they would question some of the financial statements and so on, but it was non-adversarial for the most part. That has continued for the most part.

Now, in the last couple of years, now the vast majority of the cases -- primary cases, have been heard. My understanding is the last year or two, during Covid especially, it's become a little more adversarial, they are trying to limit the number of witnesses. Obviously they're doing virtual hearings and they're questioning more. But I think that, for the vast majority of our members going through the tribunal, it was genuinely non-adversarial.

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

A. Yes.

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

A. Yes.

Q. -- is that right?

A. Yes.

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

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

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

There would be reports on loss of earnings, there would be reports on the impact on their life, there would be a report from an educational psychologist, and also a counsellor who was specifically employed by the legal team, there would be a psychological assessment. So there would be quite a lot of reports going in.

Q. So those would all be submitted to the tribunal?

A. Yes.

Q. Would there then always be a hearing in every case, or could an assessment be made on the basis of the written material?

A. I'm not -- I think a hearing was -- in every case there was a hearing.

Q. In terms of the structure of that hearing, there would be the claimant, their legal representative. Would it always be necessary for all the experts to come and give oral evidence?

A. No, not necessarily. Very often the expert's written evidence would be read into the record and taken as read.

Q. Would it be right to understand that there would be no other side represented? There would be no opposition to the claim? Or was there someone there representing the Department or the Government?

A. There was usually somebody there from the Department

of Health -- I guess keeping an eye on the public finances -- but that was it really, there was no adversarial people there. But the Department of Health were usually represented. The legal team, the individual, perhaps their family member -- before the hearing there would often be somebody from the Society -- one of my team might be with them outside just to help them through the day, help them make arrangements and so on.

Q. To what extent did the individual have to give evidence to the tribunal in the hearings? Was that always the case?

A. It wasn't obligatory but the vast majority of cases, they gave evidence.

Q. So would the tribunal be composed, then, of one member? There would be a single lawyer --

A. Usually, three, usually, yes.

Q. Usually three?

A. Yes.

Q. And they would ask -- or could ask questions?

A. Yes.

Q. But did whoever was there representing the Department, did they play an active role in the proceedings, asking questions?

A. They did at times, yeah. Yes, they did, yeah. But

the questions were usually directed to the legal team or to the expert witnesses but very rarely to the individual giving evidence on their own behalf.

Q. Would the Department make competing submissions? So if you have got the claimant's representative making a submission as to how the loss of earnings should be calculated and what figure the tribunal should award, would you have the Department making submissions to say, "No, no, it should be a lesser figure"?

A. Not that I'm aware of, no. You could, perhaps, check that with the legal team we had, but not that I'm aware of, no. I think they would -- they may question the submission that was made, but they wouldn't normally submit an additional submission of their own.

Q. Now, in terms of the success of that process, in addition --

SIR BRIAN LANGSTAFF: Just before we go to that, can I ask another question about the process? What you've described is very similar to a court assessing an amount of compensation, with one exception. In a court, as counsel has pointed out, there are, of course, two sides, just as there are in your tribunal, where the Department of Health has an interest as the paying party, but there is very often, if the issue is just -- I say "just" -- the amount, there

can be settlement of a claim beforehand. There was, of course, settlement of your litigation in Ireland beforehand. Is there any history of the Department saying, "Well, we've read the written submissions, we're making an offer", and the individual saying, "Well, that offer looks good to me"?

A. No.

SIR BRIAN LANGSTAFF: So there is no settlement process in this at all?

A. No, not that I'm aware of, no, I haven't heard of that at all.

SIR BRIAN LANGSTAFF: Thank you.

MS RICHARDS: In terms of the success of the scheme, as well as the features you've identified, would it be right to understand that perhaps the major hallmark of success has been that it's resulted in the payment of substantial amounts of compensation to those who were infected and whose lives were devastated as a result? So they have received an award which is deliberately designed to compensate them for their losses?

A. Yes, I think that's fair. But also I think -- I wouldn't underestimate the importance of the individual having their day in court, having their hearing, having their individual circumstances, you know, investigated and looked at and a decision made, as opposed to just being part of a group.

Q. So it's an element of individual recognition?

A. Yes.

Q. The recognition of the impact there has been on that individual's life?

A. Yes.

Q. In terms of the disadvantages of the scheme, would it be right to understand that the major downside has been the length of time it has taken for some cases to be finally resolved?

A. Yes, I mean, I think the process has been very good for the vast majority of people but some cases have taken several years to get to a hearing. If the individual who was infected was a child, then you can't really ascertain their loss of earnings or their future potential career possibilities for many, many years, so there may be a provisional award, an award later, and that has meant that the process has taken quite a long time for some people. And, you know, even though it's a very good process, it does delay closure. So until an individual has finished entirely with the compensation tribunal, it's kind of hard to bring some closure to the issue. So I think that's the -- the big disadvantage is the time required.

Q. And has there been any expressions of dissatisfaction on the part of those who have made claims, that you're aware of, or, broadly speaking, have those who have participated made their claims to the tribunal been content or accepting of the outcome?

A. Well, I think where there was any level of dissatisfaction the award was appealed to the High Court and, in the vast majority of cases, that resulted in a significant uplink (sic) to the award. And in some cases, in one or two cases, it was actually appealed to the Supreme Court on a point of law. So I think in terms of the amount there was very little dissatisfaction. I think people genuinely felt that this was fair and equitable compensation. The dissatisfaction, where I've heard it expressed, relates to the length of time that the process has taken for some individuals.

Q. There is obviously no such thing as a typical case, but is there a typical length of time that it's taken -- for those who were directly infected, to the primary cases, not the secondary cases, and who were infected as adults, so if we leave aside the additional complications in terms of time that might arise in relation to children, if they were making a claim in the late '90s or throughout the 2000s, and once it was extended to HIV, do you have any sense of how long typically, from the making of the claim to the tribunal award, how long a period elapsed?

A. I mean, an educated guesstimate would be a year to 18 months. Some cases significantly less than that, some cases significantly more than that.

SIR BRIAN LANGSTAFF: May I ask, are there cases continuing to this day?

A. Yes, and they tend to be primarily secondary cases: carers, family members, maybe loss of society, loss of consortium, psychiatric injury. So the vast majority of the primary cases have been dealt with quite some time ago.

SIR BRIAN LANGSTAFF: But as far as the secondary cases are concerned or, for that matter, the delayed primary cases are concerned, there will be have been people who are claiming today whose claims have not yet been decided or determined, who will most probably have suffered some financial loss, and that financial loss will have been unrecompensed during the period that they've been waiting for the assessment, will it?

A. I'm not sure. I'm not sure.

SIR BRIAN LANGSTAFF: So there's -- it's really allied to my question about settlement, is the question of whether there is any way of, or any practice of awarding anything on the interim, on the basis that the claim must be worth at least this and we're only really talking about the rest.

A. I'm aware of the interim payments made here, Sir Brian, and I think that was greatly to be welcomed, and I think if we were starting off again at this point -- it's 20 years later, and our population is 20 years older than they were when compensation was awarded in 2002 -- I'm sure we'd have gone for interim payments initially as well, because there can be a long prime before the final case is heard.

So I think our system has worked very well for our members, but I think -- in looking at this, I think it is wise to reflect on the potential for delay in hearing individual cases.

SIR BRIAN LANGSTAFF: So the system works well for the reasons you've given, but it's not without the opportunity to -- without the potential for improvement?

A. Yes.

COURT: Thank you.

MS RICHARDS: Brian, that anticipates what was going to be my next question to you, which was: if you were setting it up again, would there be any differences that you would make? One you've just referred to was the power to make interim payments. Are there any other ways which, if you were starting from scratch again, you would change what's been done, or ...?

A. When we were starting from scratch, I mean, I have to say that, in the first instance, we were more in favour of *ex gratia* payments, because we were concerned about a very long complex system. Now, as it turned out, we were wrong. The individual assessment was better for members, the awards were better, and they got more closure afterwards.

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

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

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

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

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

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

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

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

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

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

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

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

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

Then we have set out a number of services.

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

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

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

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

Health (Amendment) Act (HAA) Card."

Then if we just look at the next paragraph:

"The new drug treatment for Hepatitis C has been offered to all HAA card holders by the end of 2017 and many cardholders have been successfully treated in the last couple of years.

"The HAA card is a like time care ..."

So, is it right to understand that if an individual has been successfully treated through the new treatments and has cleared hepatitis C, they still have the HAA card for their lifetime?

A. Correct, because they will still have hepatitis C antibodies.

Q. Then if we go down to the bottom of the page, under the heading "What is the HAA Card?":

"The ... Card is for eligible men, women and children who contracted Hepatitis C from the administration within the State of contaminated blood or blood products. It is not the same as a medical card [you've told us what that is], a GP visit card ..."

What's that?

A. The Government have been extending free GP care to different age groups. So you have -- so for people over the age of 70, there's -- they can visit a GP

without payment. For children under the age of 6, they can visit. So they have been kind of contracted from both ends.

We're trying to get to a point of free GP visits but it's going to take a number of years. So that's a card that just gives you free GP visits. It doesn't give you the prescriptions and other things.

Q. Then there is reference to a Drug Payment Scheme Card; what's that?

A. That's if you have prescribed drugs there is a limit you have to pay every month, and after that you get it reimbursed anything additional you pay.

Q. Then this guide goes on to explain that the:

"The HAA Card gives eligibility to additional HSE services, on more flexible terms and conditions than the medical card."

And then it explains it's for the lifetime of the card holder, and it's personal to the card holder. So it doesn't extend to family and members. But is there an exception to that in relation to counselling services?

A. Yes, the card is for the individual but family members of a person who was infected with hep C or HIV can avail of counselling under the card.

Q. Was there a concern when this scheme was enacted that

it would be unfair or amount to some form of queue jumping because it was prioritising or conferring an entitlement upon a particular group of individuals that others would not have?

A. No, because the 3,500 individuals had developed serious medical conditions as a result of medical treatment already provided by the state, so you're effectively giving additional and faster healthcare to people who have already had their health impaired by the actions of the state.

Q. So it wasn't something that was -- has led to any resentment or any sense of unfairness from the rest of the population to your knowledge?

A. No, none whatsoever.

Q. Then you've set out in your statement, if we go back to the statement, WITN7418001, and we go to page 33, please, paragraph 77.

So you've set out in paragraph 77 the services that those who hold the HAA card receive, or are entitled receive?

A. Yes.

Q. The first is:

"Open Access to public hospital facilities for Hepatitis C or any related condition. The cardholder should not have to wait more than two weeks for an

appointment with their liver specialist and also for their first referral to another specialty. This is generally referred to as the two-week rule."

Then if we go over the page:

"Once the cardholder is referred by the liver consultant to another consultant in a public hospital for the testing investigation or treatment of any known or suspected condition related to Hepatitis C (or any condition which, while not related to Hepatitis C, requires special treatment or care as a result of the patient's infection with Hepatitis C), they will be given priority appointment within two weeks for the first consultation."

And then:

"Subsequent appointments [you go on to say] with a specialty outside hepatology [are done] on the basis of medical need ..."

And there is no two-week rule applicable to that.

So I just want to get a sense of how this works for the individual who has hepatitis C. This two-week rule, the entitlement to be seen within two weeks, in practice, at least prior to the pandemic, did that normally take place?

A. It did for a number of years. I would say it worked reasonably well until such time as the direct-acting anti-virals meant that the vast majority of people were able to clear hepatitis C infection.

Now, prior to that, you know, people with hepatitis C might have the need fairly urgently for a consultation with a dermatologist or a rheumatologist or a cardiologist, and this was designed that they weren't waiting in a long queue for that. So their hepatologist could say, "Okay, this individual, I want them to see a rheumatologist fairly quickly", so they'd get in within two weeks. It worked relatively well. But I think even before the pandemic, from, I'd say, maybe 2014, 2015, once the vast majority of people had been offered treatment for hepatitis C, it started to unravel somewhat. So that's one aspect of the cart that doesn't function very well, simply because of the pressure on the hospitals, on the pressure on the hospital beds. So I think also the requirement for people to see additional specialists outside of hepatology has diminished with successful treatment.

Q. Then if we continue through the list of services, so if we go further down the page, we've got:

"Access free of charge to a registered [GP] of [the individual's] choice and to all GP medical and surgical services for all medical conditions."

And you've explained how that is different from the position of the ordinary medical card holder. Top of the next page there is an entitlement to all necessary routine and emergency dental treatment.

Then paragraph (d), free hearing tests and hearing aids and entitlement to an eye examination, spectacles, contact lenses and so on.

Then:

"Certain aids and appliance ..."

And you've given some examples there, walking sticks, frames, wheelchairs, et cetera:

"Access to physiotherapy when prescribed ..."

And then:

"A home nursing service ... available in respect of all conditions affecting the health of eligible people."

How does that work and how much recourse to it have those who hold the cards had to have, do you know?

A. I think most card holders have not had to have recourse to that, but when they have it's very, very significant, in some cases 24-hour nursing care. So we've had a number of members where, certainly when they were extremely seriously ill, perhaps near the end of life, that they will get 24-hour nursing care

at home.

It works really well. We had a case in the last couple of weeks of one of our members who was being discharged from hospital, extremely sick, and within 24 hours we had 24-hour nursing care for him at home.

So, really, there is a clinical nurse coordinator who works for the HAA card scheme. She will assess this very quickly. The individual or the hospital will contact her or, if the individual contacts us, we will contact her. There is very good liaison between all of us so, really, we can get this in place very, very quickly.

Q. Then if we go over the page, we can see the list continuing:

"Access to chiropody and podiatry services ...

"Access to complementary therapies [and that includes] massage, reflexology, acupuncture, aromatherapy and hydrotherapy."

And they're all set out in the guide that we looked at a few minutes ago, and then:

"Access to counselling services for the affected individual."

And then we see they're also available to relatives or carers.

What's the role, in relation to all of these

services, of the liaison officer?

A. It's crucial. You've got about 3,500 cards issued in a population of 5 million. You know, most GPs won't have seen the card, a lot of pharmacists won't be familiar with the card, so the role of liaison officer is to ensure that individual gets the services which they should be getting.

I would say their role has been really important. There are 10 of them, they cover geographic areas, so each individual who has a card will have an assigned liaison officer, so if they have any difficulty getting access to any of the services, they contact the liaison officer and their job is to sort it out pretty quickly. In some cases the individual will contact us. Most weeks we're dealing with at least one query from a member about something to do with the HAA card. And they're usually in the grey areas where this may or may not be covered.

And I have to say that we've found the liaison officers to be extremely good to work with, they cut through a lot of the bureaucracy. I would say that the scheme has been extremely successful. It would not have been successful if we didn't have the liaison officers.

Q. Then if we just go to the next paragraph. We can see, here, the reference to home support services.

A. Yes.

Q. Now, as I understand it, this is something that's distinct from the home nursing service?

A. Correct.

Q. That's meeting clinical needs, care provided by, or arranged by nurses?

A. Correct.

Q. This is more along the lines of domiciliary support, assistance within the home with household tasks; is that right?

A. Yes.

Q. And, again, what's the take-up and importance been of that particular service?

A. There has been a significant take-up of that. A significant number of our members, certainly, would have a home worker who comes in and does tasks around the house: cleaning, cooking, ironing, gardening. They would receive a defined number of days per week. They can either -- the Health Service will employ a home worker centrally and assign them, if they wish, or, if they wish, they can employ them themselves and be reimbursed for the costs of that. Because -- the latter is necessary because of confidentiality.

I think confidentiality permeates everything in relation to hepatitis C and that card. People are very concerned about maintaining their confidentiality, so in some cases that has meant that they will employ somebody locally, themselves, and then the costs will be reimbursed by the Health Service.

Q. Now, you were asked in your statement whether you thought the HAA card was a success and you've said unequivocally yes. Why is that? Why is that your view?

A. I would have said if we were speaking back in '95, '96, '97, our members were much more concerned about compensation on these issues and the forthcoming inquiry than they were about the HAA card. But when I look back on it now with the benefit of hindsight, the HAA card has been absolutely crucial because it gives people prioritised access to a lot of the healthcare and services and support they need on an ongoing basis. It has been invaluable for people when they run into trouble health-wise. And when people are at the point where -- if they are getting near to the end of their life, it has been absolutely amazing in terms of the help and support we can put in place very quickly.

Q. And same question as with the compensation tribunal. If you were setting up the scheme again from scratch, would you make any changes to it or has it worked in the way you would have wished it to?

A. No, I think I wouldn't make any changes, I think it works very well. I would clarify, perhaps, the two-week rule, and just, you know, include it if it's going to work and don't include it if it's not going to work.

SIR BRIAN LANGSTAFF: That leaves the question of how long, doesn't it? It leaves the question of how long.

A. How long?

SIR BRIAN LANGSTAFF: How long one may have to wait for the various things that would be covered by the two-week rule. Because if you don't have a period of time, you've no yardstick to judge the length of delay.

A. But in fairness, there has been a degree of pragmatism in the way that this is operated by the liaison officers. So I'm aware of cases among our members where they need to see a specialist in a particular area they're concerned about, they will go privately, even though the card doesn't pay for that, and the card has actually paid for that. So there are cases where, if you can make a case that an individual needs to see a specialist within a short period of time and they have to pay for that, then they can seek reimbursement. And in many cases there is reimbursement.

SIR BRIAN LANGSTAFF: Without the two-week rule that would not be easy to achieve, I imagine.

A. No, I think it's -- perhaps, perhaps not. I think the two-week rule is, you know, well intentioned. It just hasn't worked for the last number of years because of the overwhelming pressure on the Health Service.

SIR BRIAN LANGSTAFF: I can see that in some societies it may be aspirational rather than realistic but the issue may be finding the right number of weeks to represent the balance.

A. Yes, and you'd also, perhaps, run into the problem where some consultants will resent being told that you need to see a particular patient -- a group of patients within two weeks, when they have a long waiting list. I've never met a consultant who resents being paid, so that removes the problem.

SIR BRIAN LANGSTAFF: Yes.

MS RICHARDS: Sir, I note the time. I've probably only got about another 10, 15 minutes of questions, because there is really just one further topic I want to cover, which is that of insurance. So we could either continue now, or take a break and come back after the break.

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

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

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

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

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

A. No, please, proceed.

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

MS RICHARDS: Absolutely.

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

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

becomes from very difficult to impossible.

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

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

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

A. Yes.

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

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

WITN7418011, please, page 23.

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

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

"Eligibility.

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

Then there is a description of how you get that.

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

A. Correct, yes.

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

A. Yes.

Q. But essentially it's proof of infection or acceptance that you were infected and infected through blood or blood products?

A. Yes, but you don't have to keep proving it. So as you say, if you have an HAA card or if you got an award from the Compensation Tribunal, as a person with hep C or HIV then you can take out the insurance.

Q. Then if we just go back to the top half of the page, so we can see the three types of insurance under the scheme, so: life insurance, mortgage protection and travel insurance.

Can I deal with life insurance first of all. How does that work in practice? What does this give people that they would otherwise have struggled to get?

A. As I said, somebody with haemophilia, without HIV or hepatitis C, is often loaded for life insurance. If you have hepatitis C, if you can get life insurance you will be severely loaded. If you have hepatitis C and HIV, you will be deemed to be uninsurable, you won't get life insurance.

Now, the scheme, first of all, you can take out life insurance up to your 65th birthday. But if you took it out in the first year of the scheme, we'd

negotiate that you could be insured up to your 75th birthday. So in fact for the first year after the implementation of the scheme I was like an insurance salesman trying to get as many of our members to take it out as possible, because you got an extra ten years of cover. And also, if you took it out after the first year, if you were under the age of 30 or over the age of 50, there was one or two years until you got full cover. So it was -- really, the optimum time to take out the insurance was in the first year of the scheme.

What it covers is, you will basically get life insurance up to I think it's seven times the average income or up to a maximum of about EUR 525,000. You will be able to take out life insurance at the same premium for a person of your age who is perfectly healthy, who doesn't have HIV, who doesn't have hepatitis C, who doesn't have haemophilia. The only difference is if you're a smoker. They actually -- they load that along the board.

So if you've got a 50-year-old man with co-infection, with haemophilia, with joint arthropathy, with kidney disease, with liver disease, he will get insurance at the same rate as a perfectly healthy 50-year old. So it makes

insurance attainable for people.

Q. Is this underwritten by the state?

A. Yes. And in fact the -- so what happens is, we have two insurance companies who provide policies under the scheme. They have to be accepted by the scheme. And then the insurance company will -- you know, they'll do an evaluation, as they normally do, and then they will quote a premium, and the premium -- there is a premium quoted to the individual, but then there is also a premium quoted to the Government.

So, for example, with somebody who has hepatitis C, the premium to the individual is the premium for a perfectly healthy person. The premium -- there is an additional premium then to be paid by the insurance scheme on behalf of the Government.

If the individual is co-infected and is deemed to be uninsurable, effectively the Government becomes the re-insurer. So they'll still look at the policy from the insurance company, they'll still pay the same premium as a perfectly healthy person, but in effect there is an arrangement between the Government and the insurance company about who pays if and when the person passes away.

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

important has that been for your members?

A. I think it's been very important because it means that individuals can take out life insurance at a reasonable cost; they can provide for their family, their dependants, in the event of their death up to the age of 65 or 75, depending on when they took it out; and it also means that if they do get compensation they can actually use that compensation to live their life and not necessarily have to salt it to away to provide for their family in the event of their death.

Q. Then the second type of insurance, the mortgage protection insurance for a new primary home or repair, renovation or refurbishment of current primary home; does that, essentially, work in the same way?

A. Yes.

Q. But you've told is in your statement that the uptake of that has been relatively low. Do you know why that was?

A. I think there was a reasonable uptake in year 1 but after that, it just -- people just haven't been taking it up. I'm not sure why. It's surprising. To me, also, with the life insurance, I would have thought that practically every person, you know, with Hep C or HIV, would take out life insurance under the scheme in year 1 and a lot chose not to.

So the mortgage protection insurance was -- the uptake has been quite slow or low. Also, in year 1 of the scheme there was a remortgage, so you could actually take out additional insurance for 100,000 if you had an existing mortgage. Again, there was very little take-up on that.

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

A. Perfect health.

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

A. Yes.

Q. And how important has that been for --

A. Extremely important, I think the vast majority of card holders take that out, especially now we've started travelling again post-Covid, but it's really important. It means that the individual and their family can take out travel insurance. That's been very, very useful and it gives them low-cost travel insurance. And I get queries all of the time from people with haemophilia who don't have HIV or hepatitis C who are concerned because they find it expensive to get travel insurance. So, ironically, if you're in Ireland and you have HIV or hepatitis C, it's easier to get travel insurance, life insurance or mortgage insurance than if you just have haemophilia.

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

A. There was a little bit of resistance initially, but, again, as the personal stories come out from Lindsay, as the public awareness increased -- and Government were genuinely sympathetic and their response was sympathetic, so there was a willingness to explore this, but from a practical point of view it was still quite difficult to put it in place, so we had -- you know, we had four legal teams, we had a team of actuaries, we had a couple of insurance specialists and brokers, we had the Department of Health, we had the four organisations. I think we had 35 excruciatingly long steering committee meetings over those four years. I know my colleague -- or former chairman, who was at those meetings with me, when he left the Society board later and I asked him back about 2012, to come back on the board, he made me promise he'd never have to go to an insurance meeting again.

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

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

A. Yes.

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

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

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

MS RICHARDS: Thank you.

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

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

MS RICHARDS: Well, I think probably our normal half an hour break should suffice because a lot of the questions I have asked have reflected the suggestions already made to me, so if we take half an hour.

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

MS RICHARDS: And, sir, the normal advice to the witness.

(11.32 am)

(A short break)

(12.00 pm)

(Proceedings delayed)

(12.11 pm)

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

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

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

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

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

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

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

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

A. The Department of Health.

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

A. Yes.

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

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

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

Q. Thank you.

In terms of the information that's publicly available about the tribunal's approach, does the Government publish data about the awards?

A. The tribunal publishes an annual report and they publish the total number of cases heard and then the -- the -- sort of, the total awards, and you can divide one by the other and get the average or mean amount. But in a sense that's fairly meaningless because, you know, you might have a case of, you know, somebody who has got hepatitis C and HIV co-infection and has had serious clinical and social consequences or somebody who is perhaps a hepatitis C antibody positive, was never virus positive, so all of the cases are put in together, they don't break it down in tranches, so ...

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

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

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

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

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

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

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

A. That's correct.

Q. There is no decision from the Tribunal?

A. That's correct.

Q. If they are appealed to the High Court, the High Court judgments would be publicly available?

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

Q. Just --

A. Again, I think right through every step of this process we've taken as much care as possible to ensure confidentiality.

Q. Yes, understood.

Just turning back to the HAA card scheme. The liaison officers, what's the background of the officers?

A. They would generally be health service employees. They would be -- perhaps some of them would have a nursing background but generally they'd be health service employees. But crucially, when they started in that role, when the card was established, we did some training for them, as did the other organisations. So they came around to the Irish Haemophilia Society, to the Transfusion Positive Group, to the Anti-D support group. They heard about the issues, they met the community. So they gained an understanding of the areas they were going to be dealing with.

Q. Then a much broader question next. Following the

publication of the Lindsay Tribunal report, has that had any broader effect in terms of culture change in Ireland in terms of the approach to treatment and patient safety?

A. Absolutely. I think when you look at the recommendations from the Lindsay Inquiry, which were fairly broad, talking about the need for a committee to look at blood products, and doctors and patients to work more closely, I think we put a lot of work before the end of the Lindsay Inquiry into recommendations for the future and a lot of those have come to pass. So you had the establishment of a statutory National Haemophilia Council, which brings together the four haemophilia treatment centres, the Irish Haemophilia Society, the Health Service, the Department of Health and a couple of key experts.

And crucially that Council recommends policy to the Minister, but really sets priorities for the year for the whole service. And it's really led to a position where we now have a co-designed service where the Society are involved in all of the major decisions in relation to the implementation of the haemophilia care service in the country.

Secondly, we had the establishment on a non-statutory basis of the Haemophilia Product

Selection Monitoring Advisory Board, which carries out the tenders and procurement for the haemophilia treatments. And I think that's now been running since 2002 and in that period of time our availability of treatment has remarkably improved in terms of both quantity and quality. I think we're the first country in the world to switch every patient with haemophilia to extended half-life factor concentrates, one of the first to make the new subcutaneous treatments available across the board to everybody who wanted it, and, crucially, that's been done in a way where the patient organisation and the doctors are formally involved in the decision.

And ironically, despite the fears of the Department of Health when this was agreed, it has actually turned out to be cost effective. It has saved them a lot of money because we've made it much more competitive and efficient and effective than it had been here before.

Q. Just --

A. Sorry, just again to expand, I mean I think the culture has changed. I think everybody realised that this can't be allowed to happen again, so, you know, there is a co-designed approach to the Haemophilia Service, major decisions were taken in

consultation with the patient organisation, and especially now, as we're entering an era of, you know, therapeutic choices, new therapies, new types of therapies, gene therapy, where you absolutely have to have shared decision-making, so I think the culture has been changing, has changed, and I think will have to evolve even more in the future.

Q. Do you have any sense of the extent to which that culture change has extended beyond the haemophilia community? For example, the other bodies, organisations you mentioned, those involved with the -- advocating on behalf of those who were infected through transfusion or infected through anti-D, would they, do you know, report a similar shift in terms of culture and patient involvement and shared decision-making?

A. No. Not at all. And, in fact, quite sadly, I think the organisation which represented the women infected through anti-D imploded. The transfusion group have just -- they really have just concentrated on the issues around the card and on compensation but they haven't got involved in any sense in terms of policy.

But, of course, haemophilia is different. If you had a blood transfusion, you had an underlying condition which could be anything. With haemophilia and bleeding disorders there was a core set of the same treatments, the same ideals, that go right through that. So -- but I think none of the other organisations have been involved in policy in that sense, although we do have a statutory hepatitis C consultative council which does include the organisations whose members were affected, and we sit with the Department of Health and we monitor the implementation of the HAA card and also the council would organise information days every couple of years.

Q. Then just going back to the work of the Compensation Tribunal. Do you know what approach is taken to the assessment of compensation if there is a dispute between family members? So there may have been -- there may be competing claims in terms of care or dependency. Do you know whether that's arisen at all in the Tribunal?

A. I can't really answer that. I think, again, you could talk to our legal team and they'd be able to clarify that for you, but I know that, I mean, there have been cases where several family members have been granted awards for taking care of a person at different points in time.

Q. Then the awards made by the Tribunal, are they taken

into account for the purposes of any applications for welfare benefits?

A. No, they're not, they're specifically excluded. And in fact, because of the arrangements we've made with the Revenue Confidential Service, they can't even know about them.

Q. And in relation to taxation, you've explained the position in your statement, but for the benefit of those who may not have been able to read through your statement, what in short is the position in terms of taxation and the compensation awards?

A. The compensation awards are tax-free. That's clear. But we also made submissions to the Revenue that there is a section 189 in the Taxes Consolidation Act which states that if an individual is permanently and totally incapacitated then the income arising from the award can also be tax exempt or exempt from capital gains tax. And we made a submission which was accepted that, in fact, every person with haemophilia who got hepatitis C or HIV would fall under section 189, so their awards are tax-free but also any income or capital gains earned from the awards, income from the awards, is also tax-free.

Q. And then last question arises from your involvement internationally, you've been involved both in terms of

the World Federation and the European Consortium.

Do you know to what extent the measures that you've been describing in Ireland, in particular in relation to the insurance scheme and the HAA card, whether those are schemes or measures that have been set up in other countries?

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

MS RICHARDS: Sir, those are the questions I'm proposing to ask from those that have been suggested to me by the Core Participants.

Do you have any further questions for Brian?

SIR BRIAN LANGSTAFF: Yes, a couple of areas, if I may.

Am I right in thinking that since the early 2000s, personal injury claims, except for those that arise out of medical negligence, alleged medical negligence, have been determined not in the courts, as they used to be, but by a compensation, or a tribunal, a PIAB, the Personal Injury Assessment Board?

A. I think that's an option for people with personal injuries. I think it's an option that they can go to the PIAB but they can also take legal action and go to the court. I'm not fully aware of it but think it's an option that they have. They don't have to go to the PIAB.

SIR BRIAN LANGSTAFF: When they do go to the PIAB, to what

extent does the process there differ, if at all, from the process that you're describing in the compensation tribunal specifically for HCV and HIV?

A. I have no experience or exposure to the PIAB so I can't answer that question, Sir Brian, but I would say that the Compensation Tribunal was much more like a court hearing to assess damages. I'm not sure the PIAB is the same.

SIR BRIAN LANGSTAFF: All right. It was essentially that, that I was just trying to get a sense of how similar the process is in terms of compensating those who have suffered infection through the action of the state --

A. Mm-hmm.

SIR BRIAN LANGSTAFF: -- in respect of their haemophilia treatment or their transfusions, with the process that would be applied in the courts.

The next question you may not be able to answer, but I'm given to understand that there may be moves in Ireland, in the Dáil, to introduce legislation which will effectively reduce the amount of money which is paid out in terms of compensation payments for those who succeed in claims. Do you have any awareness of that or can you enlighten me on that?

A. No, I think that the vast -- in terms of the Hepatitis C Compensation Tribunal, the vast majority of the claims have been dealt with at this point in time. I think the vast proportion of the expenditure has already been spent. I'm not aware of any push by Government to limit the amount of funding being made available to the tribunal. If that was the case we would wholeheartedly oppose that.

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

A. Yes.

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

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

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

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

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

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

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

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

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

SIR BRIAN LANGSTAFF: Thank you.

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

A. Yes.

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

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

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

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

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

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

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

We carried out a full economic assessment in 2018 of our work on that board since 2002 and we have saved them EUR 175 million. In that point, in that entire period of time, they had given us grants of about EUR 6 million. So they gave us grants of 6 million, we saved them 175 million. So I think the Government at this point accepts that it definitely makes sense as well to continue that.

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

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

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

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

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

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

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

Q. Thank you.

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

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

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

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

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

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

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

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

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

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

SIR BRIAN LANGSTAFF: Yes.

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

SIR BRIAN LANGSTAFF: So a full day tomorrow, largely

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

(12.35 pm)

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