Monday, 11 July 2022

(10.00 am)

SIR BRIAN LANGSTAFF: Good morning, Sir Robert.

THE WITNESS: Good morning, sir.

SIR BRIAN LANGSTAFF: In a moment or two I'm going to ask Mary to ask you to take the oath but, first, let me just explain the arrangements. They are probably obvious but in front of you, you have a large and reasonably well packed room.

On your left there are lawyers. In front of you there are members of the public and Core Participants and participants. At the very far back there are representatives of the press.

Others will be watching remotely, either here or elsewhere on either You Tube or live stream, and the audience in total will number in the high hundreds, I expect.

So, so much for today. We all know it is hot today. The hearing room is deliberately set at a fairly low temperature to allow people to concentrate all the better, but it may well be that you may wish to go out and bring in water and drink it in the room. That's entirely acceptable. Please feel free to do that. The last thing I would want is anyone to feel that the heat was in any way affecting them. If you do so, please do avoid disturbing your neighbour, it is important for evidence like this that everyone should be able to concentrate and so bear in mind that. If you feel the need to talk to your neighbour, do so, please if you can in a way that doesn't disturb the concentration of those around you. That's enough of the headmaster from me. So Mary.

SIR ROBERT ANTHONY FRANCIS (sworn)

Examination-in-chief by MS RICHARDS

MS RICHARDS: Sir Robert, I'm going to start with a quick precis of your career. You qualified as a barrister in 1972.

A. Yes.

Q. And you became Queen's Counsel in 1992.

A. Yes.

Q. And the focus of your practice throughout your career as a barrister has been predominantly aspects of health care and medical law.

A. That is correct.

Q. You chaired the public Inquiry into Mid Staffordshire NHS Foundation Trust, which I think began in around 2010 and reported in 2013.

A. Yes.

Q. You have also chaired the NHS Freedom to Speak Up review, which was a review into whistle blowing in the NHS in England.

A. Yes, that was in 2014, reporting in 2015.

Q. You were knighted in 2014 essentially for services to patients.

A. Yes.

Q. And you are Chair of Healthwatch England.

A. Yes.

Q. What is that exactly?

A. It is the statutory by the independent champion of patients and service users for health and social care, NHS and social care --

Q. And it is the statutory committee of the Care Quality Commission?

A. It is a statutory committee of the Care Quality Commission who provide, as it were, infrastructure support, but that we are an independent statutory entity.

Q. You have produced a report, the infected blood compensation study entitled "Compensation and redress for the victims of infected blood, recommendations for a framework". We will obviously be coming back to the content of that time and again today and tomorrow. I just want to start by looking at how you came to be appointed.

A. Yes.

Q. So there are a handful of documents we will go through. Could we have, please, RLIT0001123. This is an announcement -- a written Parliamentary statement made on 25 March 2021 by Penny Mordaunt, the then Paymaster General?

If we go to the second page, please, Lawrence, we have the heading "Compensation Framework". So if we can have those paragraphs highlighted:

"To meet the Government's commitment to consider a framework for compensation, we can confirm our intention to appoint an independent reviewer to carry out a study, looking at options for a framework for compensation, and to report back to the Paymaster General with recommendations, before the Inquiry reports.

"The terms of reference of this study will be finalised in consultation between the independent reviewer and those infected and affected. The study will include consideration of the scope and levels of such compensation, and the relationship between a compensation framework and the existing financial support schemes in place.

"The study is entirely separate from the public inquiry, which continues to have this Government's full support; it will not duplicate the work of the

Inquiry, or cut across the Inquiry's findings. The study shall provide the Paymaster General with advice on potential compensation framework design and solutions which can be ready to implement upon the conclusion of the Inquiry should the Inquiry's findings and recommendations require it.

"The name of the independent reviewer will be announced shortly."

That is the initial statement and that is a broad description of what it is you then became the independent reviewer to undertake.

A. Yes. I should say, at the time of this announcement, I frankly paid little attention to it and I certainly haven't been contacted at that point.

Q. Then if we go to RLIT0001138. I don't need to read it aloud, but it is just to give us a date. This is an announcement on 20 May 2021 and this announced your appointment to undertake the study that had been described in the Paymaster General's previous statement?

A. Yes.

Q. Now the terms of reference for your study are at RLIT0001125. I'm not going to read them aloud, I'm just going to identify the headings. So:

"Rationale for compensation.

"Independent advice to Government.

"Scope of compensation.

"Categories of injury and loss.

"Types of award and method of assessment."

Over the page:

"Measures for compensation.

"Relationship with current schemes.

"Options for administering the scheme.

"Other issues.

"Reporting to the Government by February 2022", which I think was subsequently put back by two weeks to the middle of March 2022.

A. Yes.

Q. So those were your terms of reference. How were those terms of reference drawn up?

A. Well, the Paymaster General issued some, as it were, draft terms of reference for consultation, and the idea was that I should hold a consultation and then make recommendations about the final terms of reference. That I did.

It is fair to say that the time for consultation was relatively short because the job appeared to be urgent but I did receive a number of representations from Core Participants at this Inquiry and others, as a result of which I made recommendations to the

Paymaster General, all of which, from recollection, were accepted and were in this document.

Q. So these terms of reference built on an initial draft produced by the Paymaster General --

A. Yes.

Q. -- but reflect your own thinking --

A. Yes.

Q. -- and the input of those during the consultation?

A. Yes.

Q. Then if we then can just pick up a subsequent key dates and course of events. First of all at RLIT0001132, please.

This is a statement made on 23 September 2021 by Ms Mordaunt's successor as Paymaster General, Michael Ellis.

We can see if we go a little further down the page, under the heading "Statement", I'm not going to read this aloud, but it describes the process of formulating the terms of reference, and explains in the third paragraph that the Paymaster General is happy to accept Sir Robert's recommendations in full as to what the terms of reference should be.

Then, if we just go to the third page, please, Lawrence, to pick up the last paragraph of the statement, the Paymaster General says this:

"I, like my predecessor, am deeply committed to ensuring that Sir Brian Langstaff's Independent public inquiry has all the resources it needs to complete its work; in Sir Brian's words, 'as quickly as thoroughness permits'. The infected blood scandal continues to claim the lives of infected people, and those directly affected have waited too long for answers, and for justice."

So that is the statement made as at 23 September 2021. You then embarked upon your work. Just so that there is no doubt or misconception about your role. You undertook your work entirely independent of Government?

A. I did.

Q. You were essentially asked as an experienced lawyer to come up with a review of what might be a fair and proper compensation scheme?

A. Yes. Obviously one of the challenges being that it was very dependent upon the findings of this Inquiry, which, of course, it was a bit of egg before chicken, if that's the right expression, about it.

Q. The aim of doing that way, as I understand public statements, and please correct me if this is not your understanding, is to try and ensure that essentially as soon as the Inquiry has reported, if the Inquiry's

recommendations and conclusions essentially invite compensation, that the work would already have been done to then enable that to be established as soon as possible.

A. Yes. I think it fair to say I regarded my task as to try and produce a framework of compensation independent of this Inquiry and I think the text of my report probably shows that. But, yes, you are correct.

Q. To what extent did financial or economic factors for affordability play any part in your decision-making?

A. Only in very broad terms. I deliberately did not go into detail into figures. I sought to have regard to proportionality in relation to balancing the perceived wrongs and injuries inflicted on people and to have regard to other forms of compensation. But I did not take -- look at, as it were, physical issues as to what might or might not be affordable by the government.

Q. Is it right to understand you weren't given any sum or cap with which to work by the government?

A. No, I was given a blank piece of paper.

Q. Then, in broad terms, can you explain how you set about your task?

A. Well, I thought, first and foremost, it was extremely important to have regard to the -- this is what I do in Healthwatch England is having regard to the lived

experience of people who have suffered in this case from infected blood and blood products, so I needed to hear and also, of course, to read what many of them had said. Obviously, there was a background to be studied in terms of material available to this Inquiry, but also other sources, so there was a matter of collecting evidence but at the same time organising to meet people who wanted to see me, followed by some consultations with people who were already involved in providing support of one sort or the other in both England and the devolved nations, and then analysing what I heard, but all the time it is right to say, I was conscious of the need, as expressed in the document you have just shown us, to get on with it and, therefore, I had to judge -- they were difficult judgments -- to judge how many people I needed to see in order to acquire the information I needed and that, I'm afraid, meant that I couldn't see everyone that might otherwise have been seen and had been seen by this Inquiry. Likewise, I cannot claim to have read every page of evidence submitted to this Inquiry, but I hope I have done what was necessary in order to come up with an informed framework.

Q. Did you, in the course of your work, receive any recommendations in The Department of Health and Social

Care or anyone else in government as to what your recommendations should be?

A. None at all. That is not to say there weren't communications, as I think is clear from the report. I did meet officials in the Department of Health, NHS resolution and organisations like that in order to establish what was happening and what had happened in the past.

Q. Were there any representations from any of the devolved governments as to what your recommendation should be?

A. No, except to the extent that there was an anxiety expressed, at least some of them to be involved, if I can put it in that way. They recognised that I was principally looking at the situation in England but they wanted what was happening in the devolved administrations taken into account. But certainly there were no suggestions made to me as to what my recommendations should be.

Q. Can we then just pick up a further few dates.

You delivered your report on 14 March 2022 to the Paymaster General.

A. Yes.

Q. Then if we look at RLIT0001137. This is a statement made by Mr Ellis, the Paymaster General and minister

for the Cabinet Office on 15 March 2022. If we just zoom in on these three paragraphs of the statement, please.

So we can see the second paragraph refers to the delivery of your report by you on 14 March, and then the third paragraph reads:

"I will now carefully consider Sir Robert's findings and recommendations. It is my intention to publish the Study and the Government response, in time for the Inquiry and its core participants to consider them before Sir Robert gives evidence to the Inquiry."

Then there is a reference to writing to Sir Brian about plans for responding and publication.

I will just look at a handful of documents with you, Sir Robert, and then just pick up on the issue of government response. So that is a statement on 15 March.

If we look at RLIT0001133, please. This is a written question by Dame Diana Johnson. Then the answer, if we go towards the bottom of the page from Mr Ellis, at 22 March:

"It is my intention to publish Sir Robert Francis' study alongside the Government's response. Before I am able to do so, you will understand that work must be undertaken within Government to formalise

our response. That work is already underway.

"I recognise how important it is for the Inquiry and its core participants to have sufficient time to consider the study before Sir Robert gives evidence to the Inquiry. It is my intention to publish the study alongside the Government's response as soon as possible."

So that is 22 March.

If we then pick it up at RLIT0001134. This is 27 April, bottom of the page. It is in response to a question from Ian Lavery MP. It is the same message on 27 April:

"Ongoing funding of the Infected Blood support scheme payments is a matter for the Department of Health and Social Care.

"I recognise how important it is that the views of infected and affected people are reflected in Sir Robert's study."

Then there is reference to consultation for those infected and affected.

Then the last sentence:

"It is my intention to publish the Study and the Government response, in time for the Inquiry and its core participants to consider them before Sir Robert gives evidence to the Inquiry."

So that is the position as at the end of April.

Now, your report was ultimately published on or around the second week of June of this year, so some weeks after the report had been provided by you to the Cabinet Office. As I understand it, the published report is in the same form as the report which you submitted. There are some minor textual matters about referencing and watermarks and so on --

A. Yes.

Q. -- but the content of the report is the same.

A. It is, and I have to say, given more time retrospective -- having read it again for today, there are no substantive changes I would make, but the presentation wasn't as good in terms of headings as it might have been, for which I apologise.

Q. Do you have any understanding or knowledge as to why you having delivered the report in the middle of March 2022 the Cabinet Office didn't publish it until June 2022?

A. It was always intended I think that the Government would take time to consider the report and publish a response at the same time as they published the report. I think that -- and in terms of how long that was going to take, it was clear that the report had to be published in time for interested parties to consider

it before it was formally produced at this hearing today. So there was a sort of outside time limit for it. You would have to ask the Government about the detail of what happened in the immediate time. I only have sort of third-hand hearsay about that.

Q. We will. Just to bring it up to date, RLIT0001135. This is again Mr Ellis, if we go to the bottom of the page. This is in response to a question from Lisa Nandy MP. This is on 20 June 2022. There is reference to you giving evidence in the second paragraph and then it says:

"The Government is considering Sir Robert's recommendations and it is most important that the government is able to reflect upon Sir Robert's evidence and the evidence of others to the Inquiry as part of that consideration."

So it appears that, as between the end of April and this date in June, the Government's position has shifted from publishing the response as well as your study in time for you to give evidence to simply publishing your study. Have you had discussions with Cabinet Office or anyone else in Government that would throw any light on why the Government has decided to take that course?

A. No, the only meeting I've had with Mr Ellis was on the

day I handed in the report, at which point, obviously, he had nothing to say about it, apart from thanking us.

Q. Then the most recent I think communication of the Government's position, and this is really just to complete the chronology of events and put matters into the open, rather than the focus of any question for you, Sir Robert, but it is JEVA0000129.

This is a letter from Mr Ellis to Factor VIII campaigning organisation. We have seen I think letters in similar terms around this time to others, but this happens to be dated 30 June and the second report reads:

"I would like to emphasise that there is a great deal of complexity to the issues covered in Sir Robert's study. At present, officials from across Government are conducting a thorough analysis of the report and its recommendations; that analysis requires careful and diligent work given the very many factors that must be taken into account. I should note that Sir Robert is due to give evidence to the Inquiry on 11 and 12 July. Following his appearance at the Inquiry, officials will also need to factor in his oral evidence as well as the recall evidence of others appearing at the Inquiry."

Sir Robert, do you know -- I suspect the answer

to this is probably "no", in light of your earlier answers, but do you know what oral evidence of others is thought by the Cabinet Office to be particularly relevant to their consideration of your report?

A. No, I'm afraid I don't.

Q. In terms of those with whom you have dealt at the Cabinet Office, I think your statement tells us you met Ms Mordaunt once and Mr Ellis once; is that right?

A. Before the publication of the report and then there was our meeting with Mr Ellis on the presentation of the report, which was obviously afterwards, after the report was prepared.

Q. Again in terms of the question of what your recommendations should be or might be, have you had any dealings with any civil servants within the Cabinet Office as to what the content of your report should be?

A. No, the only contact I have had with the Cabinet Office, including senior officials in the Cabinet Office, has been about administrative matters.

Q. I just want to pick up on the question of your recommendation for interim payments.

A. Yes.

Q. We will come back to some detailed issues relating to the scope of that recommendation at a later stage.

But if we pick up your report at RLIT0001129 and we go to, first of all, page 10. I just want to read out two or three passages concerning interim payment and then ask you a little about it.

So at paragraph 1.10, under the heading "The pressures of time", you say this:

"Unfortunately, a disadvantage from the point of view of those who might be eligible for compensation, is that there is little or no prospect of the scheme getting going before the conclusion of the Inquiry. This is unfortunate for the many potentially eligible applicants who are now of advanced years or worryingly unwell. There are those who fear they will not survive long enough to see, let alone enjoy, the fruits of an award of compensation. This is a principle reason why I have recommended the unusual measure of an immediate interim award to those infected persons who are already beneficiaries of the existing support schemes, in anticipation of, but before, the scheme has been set up. If at all possible, it is a matter of justice that so far as possible the infected likely to receive compensation can receive at least a significant part of it in time to make a disposition of the award as part of their assets before they die."

Then if we turn to page 29, please. Top of the page, paragraph 2.69 you say:

"There is a compelling case for awarding interim payments as soon as possible to the infected who have already been accepted as eligible for the support schemes. Many wish to be able to settle their affairs before they die. Challenging though it is to do this before the scheme has been set up and is fully operational, and before the conclusions of the Inquiry are available, I suggest that such a payment should be made now reflecting the minimum any infected person could be expected to receive under the scheme. I have suggested this is unlikely to be less than £100,000 in any case. Naturally, any such payment would be on account of any final award, and may suffice for some who might not wish to proceed further."

Then if we go to page 122. Under the heading "Interim payments" you set out, in paragraphs 9.128 through to 9.137, in a little more detail your thinking about the issue of an interim payment, and referring, in particular in paragraph 9.128, the fear of many that they have not got long to live.

You describe there a compelling case but also that it's, in some respects, a relatively unusual step to take. In your own words, Sir Robert, what was it

that led you to make, in fairly strong terms, this recommendation?

A. I think principally the impact the stories I heard and read had on me, as I believe they would have on anyone in relation to the dreadful experience the infected, if I can use that term, have had. And the pressing need -- and it underlay the whole setting up of this review -- for people to be -- know that there was something on the way, that their affairs could be settled as they got older and before they died.

The Government were clearly correct in the response we have had to say that the issues around this are very complex and -- across government, and it was clear to me, as I wrote what was not a simple report, that it would take time to set that up, whenever the starting gun was fired for that, and it seemed to me that if the principle of compensation was accepted -- if -- that something -- to wait until a fully fledged scheme had been set up and then set about giving compensation would be too late for many to achieve the justice they sought.

I was also influenced, I think, by the remarkable achievements of the 9/11 Compensation Fund in the United States, which I deal with in an appendix, where there actually the scheme was set

up within months actually. But that -- the circumstances and political background to that were very different, but what I think I learnt from that is that the sooner you can get compensation into people's hands, the more effective it is. So that's why, amongst other reasons, I put in my report I recommended this.

I also felt that if the entitlement to an interim payment was limited to those who were already deemed to be eligible by the support scheme, as an infected person, identifying people and determining their eligibility should be quite easy compared to more complex assessments required for say new categories of eligible people or others who hadn't yet got on the support scheme. So I thought even if the scheme hadn't been actually set up, there was a mechanism and, indeed, an administration through which an interim payment should be made.

Q. As I read this part of your report, the two things you called on the Government to do, or that you recommended to the Government that they do now, whilst they took, then, the time to consider some of the longer term issues in more detail, was to accept in principle the setting up, again, of a compensation scheme, and then to offer the immediate interim

payment which, as you say in your report, could be done through the existing scheme, so it didn't need to wait for what might be some complex machinery of a new scheme?

A. Yes. I felt also it might have the advantage that for some, it didn't say how many, if the amount of money was generous, that might be enough for some people, which would therefore simplify the task of the scheme later on.

Q. Was it your expectation that four months on from your report there'd have been radio silence on that issue from the Government?

A. I'm afraid I have been in the business of looking at Inquiry reviews for long enough not to have any expectations one way or the other. These are the decisions for the accountable government and I recognise that whatever it is I've been involved in isn't the only thing on their minds.

Q. What I want to do next then is just to do a quick overview of your recommendations, to get an idea of the shape of what it is and the scope of what it is you are recommending, and then to look at different aspects of it in more detail.

You will appreciate, Sir Robert, a lot of what I ask are those representing Core Participants, and

those representing those who are infected and affected, have been -- put forward issues that they are keen to understand your thinking and know in more detail how things might work if your recommendations were accepted.

So if we go back in the report, to the executive summary, which starts on page 15 -- I'm going to come back to the question of compensation and moral case in principles, but -- so if we go over to the bottom of the next page, we see there the heading "Coverage of compensation".

In terms of the infections that would trigger entitlement to compensation under the scheme that you have suggested. You have suggested compensation for hepatitis C and for HIV.

A. Yes.

Q. We will come back to the detail of hepatitis B, but you have suggested hepatitis B would not be routinely included within the scheme that you've suggested, but that there might be a case for an exception for chronic hepatitis B infection with serious symptoms requiring treatment for cirrhosis?

A. Yes, I should say that all I've said about hepatitis B is very conditional and it is clearly a complex issue and, with all due respect, in the end I think that was

probably one of the principal areas which is for this Inquiry to assist the government on.

Q. I will come back to that issue again, but just in terms of outline. So hepatitis C and HIV included hepatitis B for the time being at least not.

A. Yes.

Q. Likewise hepatitis D which is --

A. Except insofar as it was a co-infection of --

Q. Yes.

A. -- hepatitis C or HIV or particularly extreme cases.

Q. You then did not include vCJD.

A. No.

Q. As I understand it, a principal reason for that is that there was a separate scheme, the vCJD trust for those who are infected with vCJD.

A. Yes.

Q. In terms of those who are at risk of vCJD, you have not recommended that that's a feature of the scheme.

A. No. But insofar as that's a risk applicable to all who are infected, then no doubt that's something that can be taken into account in the sorts of awards I was suggesting.

Q. Again, I may pick up on that when we get to the range of awards. In terms, then, of the scope of eligibility, eligibility for infected persons you deal

with at the bottom of this page -- I'm so sorry, next page.

So you set out -- paragraph 2.13 -- four "conditions for eligibility for the directly infected": diagnosis with hepatitis C or HIV.

Over the page, condition 2 is:

"the applicant received one or more blood transfusions or blood products known to be capable of transmitting one or more of the relevant diseases ..."

3 is:

"the applicant received the relevant treatment within - or from stocks created within - the periods of eligibility employed by the current support schemes,

"OR ..."

As an alternative, a different period.

I will come back to that again, Sir Robert, in due course.

Then, 4:

"the applicant's infection was likely to have been caused by the administration of a relevant treatment."

So those are the four conditions for eligibility if directly infected.

Then paragraph 2.14 deals with "Indirectly

infected persons", so they would be those, for example, who were infected through a sexual relationship --

A. Yes.

Q. -- by a partner.

Then, in terms of proof of eligibility, we will come back to that, but you have urged a sympathetic and sensitive attitude without rigid adherence to legal concepts of proof.

If we go then further down the page. You anticipate at 2.16 that the "Estates of deceased infected persons" may be able to claim.

A. Yes.

Q. Then "Eligibility for affected persons". Is it right to understand, you have recommended widening the categories of those who may currently claim?

If we go over the page, you suggest an entitlement to claim to those in a marital or comparable relationship, children of infected persons, parents of an infected person and siblings of an infected persons.

There are some qualifications in relation to those, which I will come back to, but in broad terms, those are the principal categories of the affected.

A. Yes.

Q. You also recommend that carers may be able to make a claim. That is paragraph 2.18. Again, we will unpick the detail of that in due course.

Then at 2.19 you have suggested, is this right, a residual discretion to the scheme to make awards to other categories of affected individuals who don't fall within those that you listed above?

A. Yes, the trouble with any definition of eligibility is that there are likely to be cases that come out, particularly in -- where there are complex social and family situations. And it calls -- it is a potential extension because probably at Common Law many people in this category who suffered a mental injury wouldn't be able to claim damages, for instance for negligence, but it struck me that there were people, both in the more clear eligible categories and this rather inchoate category for whom there was a strong moral case for compensation.

Q. In terms then of the types of awards, if we go to page 23. So an infected individual or their estate who is eligible, you have identified in paragraph 2.36 five components to the compensation: injury impact award, and that's to reflect both physical and mental suffering.

A. Past and future.

Q. "A social impact award for past and future stigma and social consequences;

"A care award for past and future paid and unpaid care ...

"An autonomy award for the aggravation of the distress and suffering caused by the direct physical and mental impact, through interference and family and private life and autonomy;

"A financial loss award for past and future financial losses."

A. Yes.

Q. Now, again, obviously we will look at these in a lot more detail in due course, but would it be right to understand that the social impact award and the autonomy award are not regular features of damages payments in a claim, for example, for negligence?

A. No, exactly, and they may, as defined in this report, to some extent overlap --

Q. Yes.

A. -- a little bit with each other and there may need to be, I think looking at this, further work done about how you define this. But it seemed to me that to be bound by the categories of damages recognised in Harvey McGregor's law of damages would be too limiting, and -- but if there's to be a compensation scheme, that there

was an opportunity to look at things in a slightly different way to reflect the real injuries that people were telling me they were suffering from.

Q. Then, in terms of those who are affected, the eligible affected, the components of the awards for that category would be:

"An injury impact award for past and future physical and mental injury caused by their experience of the relevant infection, its consequences and/or the death of the infected person, where a recognised consequence of a close and established association with the infected person ..."

So would it be right to understand that that's not going to necessarily be an award that's payable to every affected person? Does it require --

A. No, it wouldn't.

Q. So it would require evidence of some --

A. It requires proof of some injury in that category, yes.

Q. Again, we'll --

A. Yes.

Q. -- unpick that in due course. But the "social impact award for stigma and social consequences", you identify for the affected.

A. Yes.

Q. A "family care award", and that would be as

an alternative to the care award claimed by the infected person?

A. Yes, and also instead of, I suppose, the separate award for care that might be for someone who wasn't otherwise eligible but had provided care.

Q. "A bereavement award payable to defined family members ..."

A. Yes.

Q. And:

"A bereaved family loss award to redress loss of dependency."

Now, again, I'll need to come back to this in more detail, but just so those listening can understand the term there, what do you have in mind where you refer to "loss of dependency"?

A. The bereavement award was intended by me to be the equivalent of what is awarded under the Fatal Accidents Act as a nominal and, some people would say, unduly small sum of money, but it reflects the fact of the loss and bereavement. The family loss award was more about, in effect, the financial losses families will suffer because of the death of the infected person.

Q. If we just go over the page, in terms of some other elements of the scheme that you are recommending. You suggested that, in terms of whether the individual

takes it as a lump sum or a periodical payment, that should be a choice for applicants.

Again, for those who may not be familiar with the terms, periodical payments are what?

A. Periodical payments are instead of receiving a lump sum, which reflects both past and future losses, it is a payment by definition to recover future losses which on the whole are thought to be regular, and they have to be ordered by the court in a damages claim but they are these days in serious cases very frequently used to spread the payments over a period of time. They are always uplifted for inflation. They are guaranteed for life. It has the advantage of regularity of income and it also has the advantage of assurance of security of the payment, which, of course, a lump sum doesn't because if you have a lump sum, then you have to work out how to invest it, and anyone looking at the newspapers in the last few weeks will understand how risky that can be.

Q. But, importantly, would it be right to understand one of the reasons you say this should be a choice for the applicants is, in a sense, caught up with the idea again of autonomy --

A. Yes.

Q. -- for those for whom they perhaps have been given

little choice over decades this is something where they could exercise a degree of autonomy?

A. Yes. That will have to be subject, I think, to some definition around what periodical payments can be for, because it is not every item in a damages claim that would qualify for a periodical payment, but, yes, that's correct.

SIR BRIAN LANGSTAFF: I think, am I right in thinking, that in making this recommendation you are looking at the nature of the award which reflect losses which are periodic in their nature?

A. Yes.

SIR BRIAN LANGSTAFF: So it is not simply a choice of either having a lump or your money spread over time, you will get, as you do in Common Law damages, a lump sum for whatever a lump sum is appropriate for and the losses which would otherwise come over a period, every week you would get earning which you don't get, every week you pay out for a carer which you wouldn't have to pay, for treatment which you wouldn't have to pay and so on, those losses are periodic in their nature and they may be either brought together in one payment in advance, if you like, which may be higher, may be lower than what it actually costs or you may get it over time uprated for the appropriate rate of

inflation?
A. Yes, sir, and I think it's probably worth also worth making it clear that the assessment of the entitlement is a once-and-for-all assessment.
SIR BRIAN LANGSTAFF: Yes.
A. That's the difference between that and a provisional award, it's not revisited at a later date, but you know at the date of the assessment you are going to receive X pounds per year uprated for inflation for the rest of your life. Or sometimes it is divided into periods. The classic example would be in relation to care costs where it's known as you get older or more disabled you will need more care, so might be periods -- uplifts of the actual amount over a period but that will all be determined at the date of the first assessment rather than constantly being revisited, so you get finality but security.
SIR BRIAN LANGSTAFF: Picking up that point on finality, the lump sum. For instance, let us suppose a lump sum had been awarded in 1980 --
A. Yes.
SIR BRIAN LANGSTAFF: -- to someone, there would be no opportunity, no right for the individual to come back in 2020 and say, "That was 40 years ago" --
A. No.

SIR BRIAN LANGSTAFF: -- "it is a pittance compared to what that sum would be worth now, please can I have some more?" You can't do that?
A. No. Well, the theory in damages is that the recipient of the damages invests wisely and, therefore, the money keeps up with inflation but not necessarily changes in circumstances, that's correct. That's the rough justice, if you like, that the system of damages gives us.
SIR BRIAN LANGSTAFF: As you pointed out, one advantage it is said of periodical payments is that the risk of a bad investment is shifted to the person who is making the payment --
A. Yes.
SIR BRIAN LANGSTAFF: -- and it doesn't lie, as it otherwise would, on the shoulders of the person who has the money --
A. Yes.
SIR BRIAN LANGSTAFF: And may need to invest it wisely.
A. Yes, and my professional experience would be that families who are in receipt of large lump sums worry a great deal about that very fact and it is the periodical -- therefore, they welcome the periodical payments as a solution to that particular issue.
MS RICHARDS: We can see from the paragraph immediately

below that you have suggested that a past waiver of litigation rights shouldn't be a barrier to compensation and that there shouldn't be a waiver of litigation rights required to claim compensation. I'll come back to what you say the interrelationship might be between awards under this scheme, court awards and indeed what account might need to be taken of previous payments, current payments and benefits in due course.

So that's the basic architecture of the structure of compensation.

In terms of the scheme that would deliver it, you considered a number of other schemes, and we will look at some of them, but you considered the bespoke individual assessment model that's used, for example, in the Republic of Ireland under the Tribunal established there --
A. Yes.
Q. -- and rejected that. Briefly, what was the reason for rejecting that as the model?
A. Well, I come back to the message that was continually given to me by those I spoke to and wrote to me, which was the need for something that would happen quickly, as quickly as possible. As I think I said somewhere in the report, there was the conflicting demand, as it

were, for something that was quick and easy to do but also as detailed in terms of the recognition of the individual as possible, and unfortunately the two aren't necessarily compatible. The more detail the best scheme is required to look into in relation to individual circumstances, the longer it will take, the more information that's required, the more evidence and argument there can be.

Unfortunately, as is apparent, I was unable to avoid all complexity. That's just impossible but the idea was to try and produce something which had more easily understandable categories into which you could slot a case with perhaps the descriptions already available about a particular individual but perhaps leaving the choice in some areas that someone who wanted a more bespoke assessment, say in relation to financial loss, could proceed to get it, but penalty, as it were, for that or the burden of that being it was going to take longer, it would be more complicated and their final determination by definition would take a longer time.
Q. So the model you came up with is what you described as a more standardised tariff-based model?
A. Yes.
Q. Again, just really by way of overview, you envisaged

that it might be possible to create categories in relation to the infections and types of loss and then create a tariff. So if someone fell within a category of, let's say, the hepatitis C liver transplant profound psychological damage through treatment with interferon over the years and so on, that would attract a sum of X amount of money. You gave some suggestions of figures, and again we will look at those, but you weren't suggesting, as I understand it, those would have to be the figures?

A. Definitely, no, it was just in order to give some reality to, if you like, what I was talking about -- illustrating what I was talking about.

Q. As against that, you might have somebody who, I think in a rather smaller number of cases in terms of those from whom the Inquiry has heard, infected with hepatitis C, fewer side effects, successfully treated, fewer longer-term consequences?

A. Yes.

Q. Although we will have to come back to the question of -- (overspeaking) --

A. The model that appealed to me -- I came up with that having regard to the -- it sounds in a completely different area really but the criminal injuries compensation scheme which has a tariff for virtually

every conceivable type of injury you might suffer at the hands of a criminal. In a sense, whereas here where you are obviously dealing with a limited number of conditions, albeit very serious ones with lots of complexity within them, and it seemed to me that if we could come up -- or a scheme could come up with a grid and categories of severe, moderate and less serious, you could slot people into those and within each of those there would be a range of figures to recognise that one point would be a bit artificial to reflect the many variations -- everyone I saw's condition was it seemed to be entirely different to everyone else's, so you do need to recognise that to some extent. But it is much simpler if everyone knows that actually I'm okay since it's in that grid and what we are talking about is the difference between that figure and this figure.

Q. As I understand your report, probably the principal reason for recommending an attempt to create those kind of tariffs was comparative speed?

A. Yes.

Q. So it would take -- it would be thought to be capable of being done more quickly than setting up a tribunal in which every individual's case was individually --

A. Yes.

Q. -- assessed at large?

A. Yes, and I looked, as you know, in some detail at the Republic of Ireland scheme, which, of course, had an advantage, which this scheme will not have, of starting much earlier in the process of people suffering from these awful conditions. But looking at the number of cases they process and the number of claims they have, it struck me, as was inevitable, it is pretty slow and that confirmed to me that it's slow, it's complex and it is -- the experience would be very similar to bringing a claim for damages in negligence, which is -- even I will know can unfortunately will take years.

Q. Is it right to understand that you contemplate that kind of tariff approach not simply for the injury award but also for the social impact award and your autonomy awards?

A. Yes. Well, I thought with the social impact award I was actually tending towards suggesting there should be a single figure in each category simply maybe by reference to time suffered, in that it is so unquantifiable the different ways in which stigma and social impact has affected people, whereas other people there has to be more room for looking at it individual circumstances. But what I was really envisaging is

there is complexity in all this but I was actually hoping that all that would be upfront and done on a generalised basis by the panels I suggested as opposed to requiring the individuals to, as it were, reinvent the wheel for each of their cases.

Q. In terms of the care award and financial losses award, would you envisage that in most cases those would be most likely to be done on an individualised basis?

A. On an individualised basis but by reference to some standardised figures.

I confess, it is one of my biases in civil cases that an awful lot of time is spent arguing about how much per hour ought to be spent on the care provided, and actually it seemed to me that, in a case like this, there ought to be just agreed standard figures which were applied, and adjusted, obviously, to the length of time care was needed and then how many hours roughly it was thought it was needed, without having to produce -- as would happen in Ireland -- independent expert evidence in every case about how much nursing care was required, for how long, and so on.

Q. Now, you referred there to the panels and what you have described in your report is a medical panel and a legal panel. Again, we will come onto some detailed

questions about how they might work and who might sit on them and what their full role would be.

In terms on the medical panel, the initial role, at least as outlined in your report, would be to help identify these tariffs or grids and to identify what might be the features of something that was very severe or moderately severe, for example; is that right?

A. Yes. It seemed to me having the benefit of reading at least some if not all of the evidence of the expert panels that have given evidence to this Inquiry, that doctors -- this would be a slightly novel question to ask of them -- but they are quite used to categorising conditions into stages and degrees of severity and in some of these cases of these diseases they have probably done that already.

I would have thought that they could be asked to look at the range of cases, as they have already been in this Inquiry that exist and they have clinical experience of and to be able to categorise people and they of course would not be awarding money to individual people but they would be able to assist what looks like something serious as opposed to less serious. They would need, I absolutely understand, to be informed by information from patients who suffered

in this way because a lot of the suffering is about people's personal experience.

But when we are talking about the same diseases, it is not a denial of people's individuality to understand that they have common features.

Q. Then in terms of the role of the legal panel, they would have a role, first of all, in filling in the figures in the grid or tariff. So, again, if we took an example of hepatitis C, liver transplant, profound damage from attempts at treatment with interferon, as the relevant example, the legal panel would determine by reference to a range of sources, including but not limited to the sources that are used by courts when making damages awards, and they would identify what the range of figures would be for that category.

A. Yes. It is now common experience -- when I first started doing personal injury work, which is far too long ago, literally barristers and lawyers would think, "Oh, well, that seems like the right figure for the case", without anyone quite understanding how, mysteriously, that figure arose. Whereas today there is comprehensive advice provided by the Judicial College as to what the range of figures should be for any particular injury.

Happily, or perhaps happily in a way, there are

very few figures in their guidance, or very few categories in their guidance which one could easily apply to the situations in these cases, but lawyers in this field are very experienced at being able to draw from comparable conditions, which may be quite different but actually have the same features in terms of suffering in order to illustrate a range of figures.

Q. Then with these tariffs having been identified and the range of figures for each tariffs having been identified by the legal panel, who did you -- do you envisage would then decide where an individual fell and what sums they should be entitled for these various different awards?

A. You would then need a team of assessors and I think I have said ideally they should be lawyers experienced in the field, as I believe they are with the criminal injuries compensation scheme.

An alternative would be to train assessors to make those judgments. Personally I think in the long run -- although lawyers are notoriously thought to be more expensive for doing it that way, I think in the long run I think it would be cheaper to have people who have real experience in this doing that job, rather than people who had been trained up for this

particular purpose.

Q. So that would be a job, even if done by lawyers, as distinct from the role of the legal panel?

A. Yes. I'm not sure I could see an objection to the same people doing both. But, I mean, going back to the 9/11 scheme, all the assessments were made there on the basis of references to tariffs but by lawyers and, as a result, on the whole the determinations were accepted I think in 99% of the cases.

Q. Then, in terms of whether they are accepted or not, you would anticipate there being a process of internal review?

A. Yes.

Q. So if an individual applicant was unhappy with what the assessor had provisionally identified, there would be a process of internal review and then an independent appeal panel if the matter was not resolved internally?

A. Yes. I have to say, I was very keen, probably to the distress of my legal colleagues, to keep this as far away from the court as possible. I don't think it is impossible to prevent there being an appeal by way of judicial review as a last resort, but the whole -- everything I've tried to recommend is to enable something to be done as informally as possible but as

quickly as possible, and the more you become involved in a legal process the less chance you have of doing that.

Q. And your suggestion is that this scheme should essentially be administered by an arm's length body?

A. Yes.

Q. So a body distinct from any government department?

A. Yes. Arm's length bodies hold -- I should say they are not politically popular in all quarters because it is another bureaucracy, it costs money to set up. It seemed to me that the need of this particularly group of people were such and the need for independence from government was such that an independent body was needed, which, of course, is funded by the government and ultimately there is a form of government oversight of it, but legally they are responsible for their own decisions and run things in their own way.

One of the issues that became very clear to me, certainly from the people I met and from the correspondence we had, was that there is no -- a complete absence of trust on the part of many infected and affected people of the government because of their experience over many years, and if they are to have trust in a system of compensation they would require it to be independent. The sort of pragmatic

need for that is that unless the victims -- and I call them victims for this purpose, people who might make a claim -- are confident in the system that's offered to them, they won't go down that route, they will still want to litigate, if they can, and, of course, there may be obstacles in the way of that, but it will mean this is not -- this issue is not solved.

Q. In terms of your recommendation, you have made 19 recommendations.

If we turn to page 33 of the report. I'm not going to read them aloud, I'm going to deal briefly with each of them, I'm going to come back to each of them in the course of the day.

Recommendation 1 was a recommendation that the Government accepts the "strong moral case for a publicly funded scheme", "irrespective of the findings of the Inquiry".

I wanted to ask you about that once we've looked at the recommendations.

Recommendation 2 concerns the diseases that would be covered, so hepatitis C, HIV, defined serious cases of hepatitis B.

Recommendation 3 are the conditions of eligibility for those who were infected.

If we go over the page, recommendation 4 is the

conditions of eligibility for those -- sorry, recommendation 4 is about the process of establishing eligibility, I should say.

A. Yes.

Q. I will want to unpick a number of those points.

Recommendation 5 is eligibility for those who were affected.

Recommendation 6 then, is this right, captures your idea about there being these tariffs --

A. Yes.

Q. -- with input from a medical panel and a legal panel?

A. Yes.

Q. Recommendation 7 relates to aggravated and exemplary damages. We will come back to those concepts in a while.

Over the page, recommendation 8 then sets out the five heads of awards that you recommend for those who were infected, so: the injury impact, social impact, care, autonomy and financial loss awards.

Recommendation 9 sets out your recommendations for heads of award for those who were affected.

Recommendation 10 is essentially, although you avoided giving figures, as I understand it, you were suggesting that the rate should broadly reflect Common Law damages and other compensation schemes.

A. I thought it necessary to provide some guidance for that and for there to be a relationship between the compensation under this scheme and the Common Law in order to promote proportionality and -- and fairness, to be honest.

Q. Recommendation 11 concerns the interrelationship between awards and past or contemplated legal claims.

Recommendation 12 deals with awards being final. That's final with no provisional element.

A. Yes.

Q. Again, we will come back to that. Then the lump sum or periodical payment that you have already described.

Over the page, recommendation 13 is concerned with issues of interest or uplifts for inflation.

Recommendation 14 is the immediate consideration of substantial interim payment.

Recommendation 15 deals with matters such as interrelationship with benefits, taxation and the like. Again, I will have some further questions in relation to that.

Then over the page, recommendation 16 is the establishment of the arm's length body accountable to Parliament, and with independence from Government.

Recommendation 17 was that the scheme should include certain support services including advocacy

and advice and other matters. Again, we will come back to that.

Recommendation 18 was a degree of local delivery within each devolved nation. Again, I want to come back to that.

Then recommendation 19 was that these proposals:

"... should be reviewed by the Government in light of the findings and recommendations of the Inquiry, and thereafter, on a periodic basis and reported on to Parliament."

Again, we will come back to that, but those are the recommendations for when I, in due course, ask you about recommendation 4 or 9 or the like. I will, as I do so, remind those listening of what the recommendation is, because it is not otherwise necessarily easy to follow.

Before we look at any of the individual recommendations in terms of mechanics, I just wanted to go back to the issue touched on in recommendation 1, this issue of the moral case.

A. Yes.

Q. And, indeed, a moral case in which you describe as strong and arising irrespective of the findings of the Inquiry. What was it that led you to that conclusion?

A. Well, I hope I've set it out reasonably clearly in the

first chapter of this report but, but it is not in -- when there is a disaster in which people are injured through no fault of their own, in many cases, even if there's no one else to blame at all, the state will move in and intervene in some way or another, and in this case, albeit many people were telling me it was unsatisfactory, successive governments have done so in relation to this particular tragedy.

In my view, one of the special features of this case is that whatever it can be said about fault or no fault, the injuries that have been inflicted on people, firstly have been inflicted on them by the state, putting it bluntly. The state-delivered Health Service has done this to people.

It seemed to me, and without wishing to pre-judge this Inquiry, that much of what happened, and it is not for me to make the judgment, was in retrospect avoidable. In other words, if we look back on things from now it could be avoided for many if not all cases.

And while we do not have a law in this country which promotes legal liability on that basis, it seems to me that where there is such a widespread disaster as this, there can be a strong moral obligation on the state which inflicted harm on people when the state

was in effect trying to do the very opposite to put that right. And when people have suffered, as people have here, their entire lives, which is another exceptional feature of this case, then putting that right is not just a matter of an apology, sympathy and, one would hope, perhaps that's not always happened either, proper material support in relation to medical help and so on, that it can only be put right by -- insofar as anything can be -- by money, and that is a measure of the gravity with which the public, represented by the government, see this particular issue.

So those are, in overall terms it seems to me, the grounds I felt produced a strong moral case and I have cited and I've looked in some detail in the report at the pronouncements made in the past about this by government figures and trying to look at what the rationale was behind the support schemes, which hasn't -- I don't think I'm pre-judging anything here -- always been entirely coherent. But what it reflects was this instinct, both political but also human, that these were a very unfortunate group of people who had been damaged by the state, that it probably had been avoidable and they needed to be put in as far as possible back to where they would have

been if this had been avoided. So for those reasons, I considered there was a strong moral case.

And if I may also say one of the reasons I looked at was -- and there has been evidence given about it recently -- that a lot of the decisions that seem to have been taken about support seemed to have been around a wish to avoid accepting a legal liability when actually what needed to be looked at was the moral case for looking after people.

Q. And you referred in your report, amongst other governmental pronouncements over the years, to the then Prime Minister, Mr Cameron, identifying this as something that should not have happened.

A. Yes.

Q. And it is perhaps also worthy of note, before we break, that the Department of Health in its opening submissions to this Inquiry said this:

"This acceptance that this should not have happened is an acceptance that things went wrong, things happened that should not have happened."

And what was said to be an unreserved apology was offered:

"I say unreservedly we are sorry. We are sorry this should be so, that this happened when it should not have done."

That is also, I think, from your report an element of this --

A. Yes.

Q. -- moral case?

A. Just a personal -- and it is a personal view, but I'm an independent reviewer and asked to put a review forward, that to bedevil this area with legal -- strict legal position about negligence is to overcomplicate things, and I appreciate when Government ministers say this should not have happened, that is a very high level almost -- not superficial, but it is a high level undetailed examination of what is a very complicated picture. But if the general feeling is this is something that should not have happened and in retrospect there were ways of stopping it happening, then it seems to me that in itself is a strong moral case for compensation.

Q. And you have set out in your report, I'm not going to go through them but it is paragraphs 4.64 through to 4.74, and for those who are following the report itself it is pages 58 to 59, but you have set out a number of factors that --

A. Yes.

Q. -- seem to you to be significant in identifying the strength of the moral case --

A. Yes.

Q. -- including all the matters that you have just summarised in your answer, Sir Robert, but also you have referred to what I think you describe as a rollercoaster of raised and dashed expectations, and you have looked at how over the years the state has responded or not responded to the plight of those infected --

A. Yes.

Q. -- and drawn that into part of the moral case as well.

A. Yes.

MS RICHARDS: Sir, I note the time. Perhaps a convenient moment for the morning break.

SIR BRIAN LANGSTAFF: Yes, it is. Before we do that, let me just ask one question which arises out of your discussion with counsel about the arm's length body.

The reason why I think you would prefer a body independent of government but not court is that if it were a court, there would be the delays caused by the formality caused by process, the probable need to involve lawyers, you didn't say that but I think it is at the back of it --

A. Definitely.

SIR BRIAN LANGSTAFF: -- and the costs necessarily involved and the time?

A. Yes.

SIR BRIAN LANGSTAFF: None of which make for the justice which appeals to you.

One of the dangers with an arm's length body may -- and it may be that I have representations about this in respect of the various bodies which were set up at some length from the government, though quite what length it was is a matter for my determination, but Macfarlane, Eileen, Caxton, Skipton -- the -- that they may not, because of their size, have been adequately staffed or equipped to deal with everything which arose.

Was it part of your consideration whether a tribunal within the tribunal service might be the arm's length body -- as part of the tribunal service it would be what is increasingly recognised as part of the court system but not a court. So the advantages of informality, speed, experienced chairman and independence, plus the clout and oversight that comes to reinforce that independence by being part of a system with the senior president of tribunals, a very senior judge, at its head. Had that crossed your thinking?

A. It is not in the report, sir, but I did consider that. I think the attraction to me of an arm's length body --

and I should hasten to add I don't see an arm's length body being comparable to something like the Macfarlane Trust, I see it being more comparable to something like, but obviously not as large, as the General Medical Council, that sort of arm's length body -- is that there will be a degree -- we need administrative flexibility in this. We also need, it seems to me, the direct oversight and accountability to Parliament for the administration of this scheme and its funding.

I wouldn't have been -- I don't think I would be persuaded that a tribunal service in itself would be able to provide the support actually required to the claimants, the expertise required, because it is not just an expertise siting on a tribunal, it is an expertise of maybe investigating some things but looking into things. There are a whole range of functions which, it seems to me, would be better done by an arm's length body in terms of, say, administering advocacy, support, communications of a supportive nature with claimants and a wider community, which don't sit, to my mind, happily within the tribunal service.

I can see the tribunal service being a route of appeal and having oversight in that way, but I just

feel there are -- there's too much going on or will be going on for the tribunal service itself to accept.

And also I would not like to see, in terms of the funding of the administration of this, that to be diluted with or competing with the other considerations of the budget of the Ministry of Justice, if I can put that fairly bluntly.

SIR BRIAN LANGSTAFF: That's very clear, thank you.

We will take a break now, in that case, until 11.50 am.

(11.21 am)

(A short break)

(11.50 am)

MS RICHARDS: Sir Robert, I've identified in your statement what you have described as the principles which should underpin a compensation scheme, and if we could just look at those.

If we could have the report back, Lawrence, page 60.

You set out there in paragraph 4.75 a range of principles:

"Remedial ...

"Respect for dignity: The scheme must restore and preserve applicants' dignity and treat them with respect and confidentiality.

"Collaborative: The scheme should be collaborative with, and supportive of, applicants and, so far as possible, avoid an adversarial approach to claims: applicants should be believed unless the contrary is proved.

"Choice: The scheme should respect and enhance the autonomy of applicants, including offering a choice of how remedies are delivered.

"Individualised ... [reflecting] individual circumstances and experience ..."

I'll come back to that

"Inclusive ...

"Non-technical: There should be no bar to eligibility based on technical issues ..."

"Accessible ... readily accessible, understandable and free of complexity and stress ...

"Ease of proof: Unjust, distressing and disproportionate requirements of proof and evidence should be avoided."

Then:

"Broad ...

"Improving: No claimant for compensation should be worse off than they would be without such a scheme ..."

Then, over the page:

"Complementary: The continuing payments under the existing support schemes should be continued, and made more secure regardless of any claim for, or award of, compensation."

Then:

"Holistic: Compensation is not just about money, but should also include consideration of material means to compensate for what has been lost."

Would it be right to understand that, particularly the reference to respect, collaboration, choice, accessibility, ease of proof and so on, that those principles have been identified by you because they reflect some of the problems or concerns or unhappiness that those infected and their families have had in dealing with schemes over the years?

A. Yes, I received I think strong messages about all those matters in the submissions, information given to me, and I think what I was trying to do here was partly to synthesise that but also the very helpful submissions I received from some RLRs, which appear in the appendix. The order, I'm afraid, is not -- if you ask me about the logic of the order there might not be one but I think they're all probably important features, and it passed the moral code too.

It is a very particular feature of what I was

hearing of what people had gone through that they felt there had been a lack -- respect for them was significantly missing. Their ability to choose things had gone. They lacked information. All these things it seemed to me that there was a risk that any scheme of compensation could make some of those things worse and it was very important that it shouldn't do that but actually should do the opposite.

Q. Then a suggestion of an additional principle that I have been asked to explore with you is the requirement that the scheme be properly funded whether it appears here as a principle or some other facet of the scheme, to try and avoid the difficulties that have arisen with previous incarnations of support schemes where -- and there has been uncertainty over continuity of funding, difficulties for the schemes themselves sometimes and planning. How important would you regard a requirement that the scheme be properly funded?

A. Well, obviously it's extremely important, and there is the explicit underpinning, if you like, of everything else I've recommended in terms of awards, so it appears to be the case that some of the previous schemes have suffered through limitation of funding in the sense that a lump sum is provided and the struggle has been

how to distribute that. This is starting the other way round, their compensation scheme, which is that people will be eligible for an assessment of amounts which are to a large extent capable of being judged objectively. Clearly that doesn't work if the funding is not available to them.

I appreciate that probably means that funding has to be to some extent open-ended. Obviously estimates will need to be made about what is required and when in just the same way, if I may put it this way, that NHS resolutions administration of the damages schemes for the National Health Service is in a sense an open-ended budget, in that they have to pay whatever is determined by way of settlement or award in damages claims. Any arm's length body for this scheme would require a similar approach to funding but in a way that's -- I mean, without that you can't have a compensation scheme.

Q. We can close that for the moment, thank you.

Now, your terms of reference provided that the study should take into account differences in current practice and/or law in the devolved nations.

A. Yes.

Q. In practice, perhaps the most discreet area of law, where there's a difference between some of the

principles you apply would be in relation to Scotland.

A. Yes.

Q. I want to come back tomorrow and deal with certain particular issues relating to the approach to damages in Scotland. But in broad terms, would it be right to say that you have drawn more from the approach to awarding compensation in England?

A. Yes, I think that's fair, and that may be either a strength or a weakness, whichever you prefer to see it. I think the -- overarching that would be a message that the compensation awarded should be, you know, subject to individual circumstances, but the same principle should be adopted whether you are in England, Scotland, Northern Ireland or Wales.

Q. In terms of other compensation schemes, you have referred obviously to the scheme in the Republic of Ireland. You've referred to the September 11th Victim Compensation Fund and the Criminal Injuries Compensation Scheme.

You've explained in your report that you had access to both, I think, a textbook which looked at compensation schemes around the world and then there is a summary of some of that in a PowerPoint. We don't need to put it on screen but the reference for those who want to look at it is SLFS0000002.

Were there any other particular compensation schemes or features of compensation schemes elsewhere in the world that struck you as either particularly useful or something which should be avoided?

A. Well, the textbook which you mentioned is really helpful in giving me a sort of world view of compensation schemes, and is well worth a read if you are interested in such things.

What came through to me was that all compensation schemes are different and they all arise out of a social, legal and maybe sometimes a political context. So schemes, for instance, that are often referred to when we are talking about compensation here tend to be New Zealand, some of the Scandinavian countries. When you actually look at those they do have many features which I think would accord with the principles I put forward. But a lot of them, particularly, say, in Sweden, are there because they are run and supported by a sort of structure of insurance companies and so on, and this is a way of bringing together the obligation of insurance companies, the liabilities of the state and so on, which isn't quite where we are here.

So quite a lot of schemes, it seems to me, have an origin, and so in New Zealand they brought

together -- they now have a scheme which has brought together various streams of compensation from all sorts of different areas, motor insurers, medical and so on, and so lead to something which perhaps becomes even more complicated, one might say, than what I'm recommending here.

So the ones I picked, and it is obviously a subjective selection, I thought were illustrations of some of the good things about schemes but also some of the challenges. One you haven't mentioned, and I haven't mentioned yet is the -- because it's still topical is the Windrush Scheme and the Home Affairs Committee's report about that, which I think is a very useful reminder of the difficulties that can arise in relation to schemes if they are not very carefully thought through in consultation with the people who are intended to benefit from them.

Q. I want to turn now in more detail to some of the specific recommendations. I'm going to start with recommendation 2, and recommendation 2, if we just go back to -- I will just pluck out the relevant pages of the recommendations. I think it is about page 30 something of the report. Page 33.

So recommendation 2 was the scheme offering redress to those infected with HCV and/or HIV -- I

obviously don't intend to ask you about the inclusion of those -- and then defined serious cases of hepatitis B. I just want to ask you a little more about hepatitis B.

If we go to page 62, please. Under the heading "Conclusions on Coverage" you explain your reasons for approaching hepatitis B in the way that you did. So you said:

"Of necessity, this very generalised view of the impact HBV can have is based on a reading largely of the expert evidence to the Inquiry. It was not a subject which the infected raised at our meetings, although I have been pressed in written submissions to include HBV infections as a category of eligibility.

"4.84 On the basis of the description of HBV and its effects, which I hope is a fair one, I am unable to recommend that this infection be included in a compensation scheme as a separate category, with one exception. I consider a number of factors distinguish HBV from HCV."

Then there are four bullet points there sets out. The first was that:

"- Generally, the effects of HBV -- while it may be a long lasting infection -- are mild or even non-existent, so far as the impact on the quality of

life of the infected is concerned. Compensation in such cases would be likely to be low and it is possible the costs of processing claims for it would be disproportionate.

"- There is available effective treatment which is likely to suppress the disease and avoid the more serious consequences with regard to the liver.

"- Many cases where there are more serious consequences are likely to be where there is HBV/HCV or HBV/HIV co-infection."

Then your last bullet point:

"- In the absence of the more serious infections it may be difficult to establish causation."

Then your exception is set out in 4.85, those:

"... who develop a chronic infection with serious symptoms who require treatment to prevent cirrhosis, or who have actually contracted cirrhosis."

So is it right to understand that those who fall within paragraph 4.85 you would recommend they are compensated within the framework of the scheme?

A. Yes.

Q. Then I think only fair to you to point out that in 4.86 you say the Inquiry will have been able to consider more evidence than you have and you would recommend your conclusion be reviewed in light of the

Inquiry's findings.

A. Can I also say, and particularly because I looked again at the expert evidence or the report, and it seems to me, and I may be wrong about this, that no one has actually asked the experts to distinguish -- they describe things but they haven't actually done an exercise of distinguishing one from the other. And I think that makes what I have said here even more conditional in effect.

And obviously what I have said here is on the basis of what I have read and my understanding. I have -- no doubt I could have -- but thought it -- but in the time available, it would have been difficult, I sought no independent expert advice of my own, and I actually thought it would probably confuse things if I did.

Q. Just before we look a little more at hepatitis B, and I'm just going to ask you to look at some passages in the Inquiry's hepatitis expert group report that Core Participants have asked me to flag up, before we do that, can we just go back to page 17 of the report.

It is just to pick up a potential omission in the executive summary. So bottom of the page, 2.13:

"The conditions for eligibility for the directly infected should be ..."

There we have the reference to hepatitis C and HIV but not hepatitis B.

Should we understand that hepatitis B of the more serious character should be included here?

A. Yes, I had picked that up myself, actually it is an omission, it should be there.

Q. Then, did you have available to you when you were considering the issue of hepatitis B any evidence on the psychological impacts that may be associated with infection with hepatitis B?

A. Only insofar as it was mentioned in the -- that there is a psychological -- psychosocial expert report.

Q. Then if we can look at just a handful of passages in the --

A. Can I --

Q. Yes.

A. Of course, what I didn't have was, as I say in the report, none of the people I met actually brought forward hepatitis B as something to consider. It didn't mean I wasn't going to consider it but I thought that was noteworthy.

Q. And, again, perhaps feeds into your suggestion that the Inquiry --

A. Yes.

Q. -- which will have had more evidence, may be able to

deal with it in more detail.

If I might just ask you to look at just a handful of passages in the Expert Report to the Inquiry from the hepatitis group.

It is EXPG0000001, please. Sir Robert, I know you have read this. I'm just going to highlight a handful of passages --

A. Of course.

Q. -- which Core Participants have asked me to raise and then just ask you a couple of further questions.

If we go to page 3, please. Just above question 15.2 we see there:

"[HBV] and [HCV] are the most important causes of viral hepatitis globally. Each can range in severity from very mild, where an individual has no symptoms and no long-term consequence, to being so severe that the liver can no longer carry out its essential functions and fails with a high risk of death, sometimes necessitating transplantation. The key concern with long term HBV or HCV infection is progressive scarring of the liver (fibrosis, leading to cirrhosis) and an increased risk of liver cancer (hepatocellular carcinoma, HCC)."

Then the second paragraph is -- if we pick it up at page 64, bottom of the page. This identifies some

information about hepatitis B that the expert group said should be provided to newly infected individuals.

So:

"Basic information on what [hepatitis B] is, the different stages of infection and what effect it can have on health (including increased risk of liver scarring and liver cancer ...)."

So I'm asked to flag that up.

Then, over the page, the transmissibility of hepatitis B is a point I'm asked to identify.

Then, I think it is five bullet points down:

"The fact there is no cure, but that long-term medications are available and might be recommended."

Then the penultimate bullet point:

"The need for regular attendance at clinics to monitor infection ..."

Then if we go to page 66 -- sorry, no, over the page, sorry, Lawrence. If we can go to the next page.

So, again, we see under the reference "HBV" there, the reference to the risks of sexual transmission.

Then, if we go to, I think it is, page 73. We've got there, at the bottom of the page, this is impact, for example, on fertility. So:

"For those living with [hepatitis B] and

[hepatitis C] who develop advance fibrosis/cirrhosis, fertility is reduced and pregnancy is uncommon."

Then there is further discussion of that. I don't think I propose to read those aloud.

Then, page 80. So, under the heading "Supplemental Question 26", the first paragraph which begins "The details of individual treatments", so that refers to tenofovir (TDF) as the "first line treatment":

"In discussions with patients as to the need for follow-up and monitoring, it would be expected to include consideration of potential toxicity to the kidneys, and the need for blood and urine monitoring."

At the bottom of the page there is a question about guidelines for infection control, and I am asked to flag up to you that the precautions in terms of transmission apply to both hepatitis B and hepatitis C.

So those are some of the points in relation to hepatitis B, Sir Robert, that I have been asked to draw to your attention.

Before I ask you further about hepatitis B, it is also right, I think, to note that, in terms of that sense of injustice that you refer to as part of the moral case, those infected with hepatitis B have never

been part of any scheme thus far, so they've not had any of the payments that those infected with hepatitis C or HIV have had.

I'm asked to suggest to you, Sir Robert, that the differences between hepatitis B and hepatitis C that it might be said your report reflects are more -- are illusory, that essentially hepatitis B should not be regarded as something which is quintessentially a much milder or less alarming condition to suffer from.

A. Well, I understand entirely what you say. I mean, I would point out that in relation to cirrhosis, fibrosis and liver failure and so on, those are very much the cases in which I envisaged there would be an exception. I must say I did take into account the fact that there had been no previous coverage for hepatitis B and, therefore, what I said about a moral case in relation to past statements and so on and the public reflection of a moral case for HCV and HIV doesn't seem to have been perceived before.

Now, I think all I can say is at the end of the day a value judgment has to be made. If you go down the route of a moral case, which is what I am suggesting should happen, and the issues you raise could result in including hepatitis B, if it is felt,

and maybe that's something the expert panel could be asked about, there is in fact no realistic distinction between the two. It is simply my reading of the evidence that I read was that there did seem to be the distinctions I identified. If that's not the view that is generally taken, then maybe that needs considering.

What I would point out is that to set up a compensation scheme to remedy injustice is an exceptional measure requiring -- and what I'm suggesting here is a significant broadening from what would be legal liabilities and, therefore, a judgment has to be made whether there is a boundary around that in terms of proportionality. I sought to suggest there might be a case where that is so but clearly my view is not determinative of that issue.

Q. Can I then pick up on vCJD. If we go back to your report, please, at page 63. You say there, at paragraph 4.89, this:

"A number of infected persons have received written warnings that there is a risk of there having contracted vCJD. However, the distress and suffering caused by being informed of the risk of contracting this disease is not compensatable under the vCJD scheme: this is a risk shared with all those who have

received all relevant blood products, whether or not they have been infected with the principal infections with which my terms of reference are concerned. Therefore, I suggest that, apart from the extent to which the general concern about the risk of vCJD applies to all infected persons otherwise eligible for compensation, this disease is left out of account in this scheme."

Can I explore with you exactly what's meant there?

Somebody who is not infected with hepatitis C, not infected with HIV, not infected with hepatitis B, but has -- has acquired no actual infection but has been informed that they might be at risk of developing vCJD, that category of person you asked not recommended for inclusion within the compensation scheme.

A. No.

Q. But if you have someone who has been infected with hepatitis C or HIV, or the more serious category of hepatitis B that you do bring within the scheme, so they have a real experience of the trauma, the suffering that comes with infection, if that is being compounded, particularly in psychological terms, by being told that they are at risk of vCJD -- I should

say the Inquiry has heard evidence of those who have been significantly psychologically affected by that additional burden of the knowledge of risk of vCJD on top of everything else -- is that a factor that could form part and parcel of the assessment of the injury award?

A. Well, I think so. I think I start from the point -- and, of course, I may be completely wrong about this -- that the actual risks of contracting vCJD are very small indeed, but that's not to say, of course, being advised of the risk of it is not in itself a concerning issue bearing in mind the gravity of CJD. But if we're talking -- I'm not sure if you are suggesting that I ought to consider those compensation schemes to everyone who has received a blood transfusion because there is that risk, because that would seem to be -- if you did ask me that I would suggest that was disproportionate.

But in relation to those who have one of the eligible diseases, and let's leave the issue about hepatitis B out of that for a moment, then I think that the added information about vCJD could be taken into account because whether you look at it as an exacerbation of the suffering caused by the -- you are actually looking at it as a relevant factor which

makes the distress of having a concatenation of the infection greater, and that is part of a personal circumstance.

But I would treat that with some degree of caution because -- again, I could be completely wrong, people may have received warnings about that risk, but it strikes -- it would appear to me that that risk must be extremely small indeed. So objectively, whatever the distress has been caused, these people are vanishingly unlikely to get that disease, particularly now. But I may be -- that could be misinformation -- a misunderstanding on my part.

Q. Yes, and it is right to know that the Inquiry has obviously had the benefit of hearing from a number of individuals about the impact upon them as infected individuals or on their family members as infected individuals of having this --

A. No. And I would suggest that any assessments of, as it were, additional compensation to be paid for that does need to take into account whether that advice ought to be given and the terms in which it's been given. If it is correct advice, of course, that's one thing, in which case, has everyone received that advice and if not why not? If it is wrong advice, then I wonder whether that is something that's so specific that it

shouldn't be talked about in the scheme. It is a complication, it seems to me, which probably requires more information than I have access to.

SIR BRIAN LANGSTAFF: I just want to observe that this is rather a different sort of risk in this sense, sometimes a clinician may say to a patient, "If you take this, then there is this risk to you". The risk of contracting vCJD is retrospective, rather than prospective. It is telling people, "Because of the treatment you have already had, you are now at risk". So there is that difference, which it may well be that I feel I should take into account.

Your suggestion would be, well, this is something which aggravates the other conditions which they suffer from?

A. Yes, that's my position. I appreciate this is a struggle and there is a balance, but there needs to be a distinction between something which is different for those who have been infected and those who have no infection but may still have been exposed, albeit retrospectively, as it were, that comes to light, to that risk of vCJD, and one is a very large group of people indeed and the other may be a very small one.

MS RICHARDS: Then, if we could just -- just going back to hepatitis B in terms again I think of something that

might need a mild correction in the report. If you go to page 69 and paragraph 6.6. I think there it says:

"... I have concluded that none of HBV, HDV, or vCJD should be separate categories of eligibility."

That I think doesn't entirely reflect your category of serious hepatitis B?

A. I think that's probably right, although there is a qualification in the following sentence which partly deals with one part of that.

Q. Yes. Can I then turn now --

A. Actually, yes, I think that's right.

The difficulty about the HBV it seems to me is there may be a case for including it, certainly where there is a co-infection, but also where there are particularly severe cases, and that latter bit is not included in that sentence and should have been, yes.

Q. Yes. Can we then turn next to "Recommendation 3". Can we go to page 33, first of all, please. So we can see "Recommendation 3". The first is just to point out what I think is a typo in 3(a). It says:

"they have been diagnosed" --

A. Yes, sorry.

Q. "... as being infected with one or more of HCV, HCV, or HBV ..."

So it should be HIV.

A. Yes, my apologies.

Q. Now, I want to just explore a handful of issues relating to the conditions of eligibility for those infected.

Could we start by going back to the report to paragraph 2.15, which is page 18. You say this in paragraph 2.15:

"Where possible, eligibility should be automatic for those who have already been accepted as eligible for regular support by one of the existing support schemes, or any of the preceding schemes."

Then you go on to talk about how eligibility may be assessed for those for whom it is not automatic.

It is the qualification "where possible". If someone has already been accepted onto a scheme, whether for regular support or otherwise, should they not be automatically passported onto any new scheme?

A. I think that's what I'm saying.

Q. So the words "where possible" --

A. I'm not entirely clear whether everyone who has been -- whether it is entirely clear, for instance, with someone who has died in the past whether they were accepted on the scheme or not. And those -- we know, don't we, that there is an archive of information, which is released only with some difficulty, from which

things can be established.

So "where possible", I mean where it is possible to establish that they have been considered to be eligible. That's all.

Q. So anybody who has previously been accepted as qualifying, whether it is under the Macfarlane Trust or the Eileen Trust or the Skipton or any of the devolved schemes, that should effectively be sufficient for establishing eligibility?

A. For eligibility, yes.

Q. Would you -- I'm sorry, the suggestion in paragraph 2.15 in the second line seems to suggest that this automatic eligibility should be for those who have been "accepted as eligible for regular support by one of the existing support schemes, or any of the preceding schemes".

The point I have been asked to raise with you, Sir Robert, is that that might be unnecessarily narrow because it would exclude automatic entry for, for example, the bereaved who'd received a lump sum payment but no regular support, because regular support is not an option under the current scheme for them.

I wonder whether it was meant to refer to regular support or not?

A. Forgive me, this paragraph I think comes under a section about eligibility for the infected.
Q. Yes.
A. So that is what this is referring to not the affected.
Q. If someone -- if we've got a claim on behalf of an estate, then --
A. Yes. Well, that comes under the eligibility for the infected.
Q. So if we go to page 70. The point emerges because of what looked like a difference in wording between paragraphs 2.15 and 6.13. That's the reason why I was asked to raise it with you, Sir Robert.
Here you say:
"Entry to the compensation scheme should be made as easy as possible for all those infected persons who have been accepted as eligible for support by one of the existing or past support schemes."
A. Yes.
Q. So there is no requirement there that they had been eligible for regular support. If you had someone who had been accepted -- who only ever sought a one-off payment --
A. Yes.
Q. -- and not sought regular support, they would still be passported onto the --

A. I think so. That would be subject, I think, to a bit more analysis than I've conducted into what the eligibility for these schemes was, but I've assumed that in effect eligibility to those schemes was the equivalent to the tests that I've set out.
Q. Would it be right to understand that you are not suggesting that anybody who has previously been found eligible under any of the existing schemes should now be regarded as ineligible?
A. As long as I've got the negatives right, yes, I agree with you.
Q. Would you also agree that as much as possible in terms of the process of application, that it is important to avoid people having to repeat and redo past applications --
A. Yes.
Q. -- which may exacerbate health issues?
A. I think it is essential that all the material that has been collected in the past is made available and taken into account by the new scheme absolutely. Inevitably, I think because -- whether my recommendations are accepted about impact awards and so on or not, it is possible that a wider range of information will be required from people to assess the gravity of what they have gone through in a way which probably isn't

necessary for what's happening as a regular payment, regardless of whether you would be moderate severe or less severe.
Q. If we then go to page 68, please. We have got the heading there "Eligibility Criteria", and then the conditions are set out at the bottom of the page and going over to the next page.
A. Position 1 needs a correction again.
Q. Yes, for the serious cases of HBV.
It's really condition 3 I wanted to ask you a little more about, which is paragraph 6.8.
First of all, would it be right to understand, in light of what you have said about those previously eligible being essentially automatically onto the new scheme, that in terms of applying condition 3 that's really only going to be relevant to new applicants?
A. I think so.
Q. I mean, either completely new or those who previously applied and were rejected?
A. Yes.
Q. Then in the penultimate bullet point on the page, you have referred there to:
"[A] defined period ... during which the administration of the infected blood or blood products was avoidable, whether in the light of the knowledge

of the time or retrospectively, subject to the relevant technology or science being available at the time."
Then you say this:
"It is difficult to identify such a strong moral case for compensation for treatments received before, for example, HCV or HIV were known to exist."
Firstly, the reference to HCV would presumably include, would it, previous descriptors such as non-A, non-B hepatitis or non-B hepatitis or --
A. Yes.
Q. -- serial hepatitis?
A. Yes.
Q. And HIV would include AIDs, HTLV-III or --
A. And all those definitions, yes.
SIR BRIAN LANGSTAFF: There was a period of time in which there was a body of infections known as serum hepatitis which later identification of the viruses which formed part of it showed to be a mix of largely what is now known as hepatitis B and what is now known as hepatitis C. There may have been other viruses as well but they have not featured to any great extent.
So am I to read this as representing the -- if it were known the serum hepatitis, that is hepatitis transmissible by blood and blood products, was known,

let us suppose from 1944 onwards at least, that then would meet this test?

A. That is one part of the test, sir, because the other part is -- it is one thing to know that the disease exists, it is another to have a means of screening for it --

SIR BRIAN LANGSTAFF: Yes.

A. -- in samples, which might be a different issue. So it's the two together, I would think.

SIR BRIAN LANGSTAFF: I see.

MS RICHARDS: More broadly, the idea introduced in that bullet point of avoidability, how in practice do you envisage that as a criterion being --

A. Well, I think the Inquiry has received evidence, which I don't pretend to have analysed, about when different screening technologies came in and how effective they were and the ability, therefore, through testing either of donors or of blood or blood products one could detect an infection.

Q. So is it then --

A. So -- I'm sorry -- the principle behind what I'm saying is that -- is to avoid looking at whether there was a step someone knew about but didn't take at the time, as in negligence, and whether there was a technique available which could have uncovered this but didn't.

Q. Just looking at condition 3 as set out in paragraph 6.8 as a whole. Is condition 3 really concerned with what are the dates within which someone would need to show they had been treated?

A. Yes. Yes. Not by relation to what was the practice at the time but from what we now know but in terms of what was available at the time could have been used and could have resulted in the infection being detected.

Q. And --

A. But you're right, that results in an identification that they don't, which is probably going to be artificially precise.

Q. Is it right again to understand that you are not suggesting by talking about avoidability, which is a phrase that appears here in a couple of other places, you are not suggesting, as I understand it, that individual applicants have to show an individual case of avoidability?

A. No, not at all. No, this is one of those things that needs to be determined in advance to apply to a whole scheme.

Q. So it is really just what are the dates within which the scheme operates?

A. And it may be for all I know that the dates of the current scheme, of the EIBSS, are roughly right, but --

which I identify in the first bullet point but it is actually belt and braces because obviously this Inquiry have more information than I would have had in setting those dates.

Q. I think I'm asked to point out that you are absolutely right in relation to the September 1991 date for hepatitis C but my understanding is there isn't a cut-off date in relation to HIV. There certainly wasn't for the Macfarlane Trust or the Eileen Trust to the extent that there was a relevant date for Macfarlane Trust it was tied to the making of claims rather than treatment. My understanding is that there isn't a cut-off date operated by EIBSS or I think the other devolved schemes in relation to HIV.

A. In that case, I apologise for the error. But it seems to me a date needs to be fixed.

Q. Can we then -- we may need to come back to that in due course, but can we then pick up on recommendation 4.

If we go to page 33 again, I think, Lawrence. 34, thank you. You are ahead of me.

So recommendation 4 is about how to prove eligibility, in a nutshell.

A. Yes.

Q. Your recommendation there is:

"... avoid legalistic and adversarial concepts

of the burden and standard of proof; establishing eligibility under the scheme should be either:

"a) automatic in the case of infected persons already accepted for eligibility under the support schemes;

"or

"b) a collaborative process in which:

"- the applicant is sympathetically supported by the scheme in obtaining any required information and documentation;

"- in general a presumption is applied that statements of fact made by an applicant are correct;

"- applicants are not required to repeat information already provided to the support schemes.

"- eligibility is accepted if the information available points towards eligibility and there is no strongly persuasive evidence which contraindicates eligibility."

The process you there describe for those not already accepted as eligible, is that in part designed to avoid the difficulty that may be created by an absence of medical records and this an inability on the part of an individual to point to a record and say, "Look, I had a transfusion on such-and-such a date"?

A. Absolutely, yes. So obviously there are going to be cases where that is the case and inferences are going to have to be drawn from circumstance. The scheme has to start from a point that a lot of people may have great difficulty in getting information together.

I should say that I was particularly impressed by what I was told about the Scottish support scheme and how, in certain respects, in effect, they simply would accept what the applicant tells them. While that might be surprising to some lawyers and some people in government perhaps, it seems to work very well, so they told me, and there is no instance of fraud. People genuinely tell them the truth.

The trouble with so many schemes, frankly, is that the battle people have to persuade the grant-giving authority, if you like, that they come within it makes the damage even worse. So that is what I was impressed by and that's what I tried to reflect here.

Q. If we go back to paragraph 2.15 which was your summary in the executive summary on your proof of eligibility, page 18.

If we zoom in on paragraph 2.15 again, if I pick it up a little further down from where I previously read, so the end of the fourth line:

"The search for supportive evidence should be proactively conducted by the scheme administration in collaboration with the applicant. Where possible, existing medical information should be relied on and assumptions made in favour of the applicant from surrounding information where direct evidence on a relevant matter is absent."

Then this:

"Generally, the recollections of the applicant should be accepted as true, unless there is overwhelming evidence to contradict them. Rejection of eligibility by a support scheme, or absence of symptoms during any particular period, should not automatically exclude an applicant."

The starting point, is this right, if an applicant is infected with one of the eligible conditions, let's take hepatitis C for present purposes, and they have a recollection of treatment within whatever the eligible window of period may be, your suggested approach would be the starting point is, well, believe them --

A. Yes.

Q. -- unless there is some positive other evidence to suggest that that's --

A. I'm not suggesting that when someone comes forward with

their recollection that the scheme should be debarred from looking at the medical records that exist and other matters. But what I was seeking to suggest is that the scheme itself needs to be proactive in looking for relevant information and should be starting from the presumption that what they are being told is true, and so uncertainties, of which there will be many, should at the end of the day be resolved in favour of the applicant.

Q. The Inquiry has heard evidence about historical blood use policy and practice to suggest, for example, that there were practices of topping up patients with small blood transfusions which might not be clinically necessary and certainly wouldn't be given by current standards. Would you agree that whoever is undertaking the assessment on behalf of the scheme must look at that historical clinical practice rather than contemporary clinical evidence?

A. Contemporary?

Q. What the Inquiry has seen some evidence of, particularly in relation to the Skipton Fund, is someone coming along, they don't have medical records because through no fault of their own those records have been lost or destroyed, they said they have a recollection of a procedure in which they had

a transfusion, and there may be some evidence of the procedure but often none of the transfusion, and clinicians looking at it now say, "Oh, we don't give transfusions for that kind of condition or that kind of procedure", that wouldn't necessarily be the right way --

A. No, certainly not. No, the reference obviously has to be by way of what is known about what the practice was then.

Q. Can I ask you to look at -- it is paragraph 2.13, so top of this page I think it should be. Yes. It is the reference in the summary here of condition 3. Sorry, top of the next page.

In the paragraph numbered 3 at the top of the page:

"The applicant received the relevant treatment within - or from stocks created within - the periods of eligibility employed by the current support schemes."

In relation to the evidence from stocks created within, what is it you had in mind there?

A. Well, what I was told was that there are some people, possibly a small group, who believe that they have received treatment, as it were, after what might otherwise be a cut-off date from stocks which are left

over from a period within -- that's what I was getting at, and I appreciate trying to find that out might in some cases be very difficult indeed.

Q. So that might again be a kind of example of where, first of all, the schemes should be proactive in trying to find what kind of supporting evidence might be available whether from the transfusion service or the hospital. But assuming that that kind of evidence couldn't be gleaned, that might be the kind of scenario in which that would be appropriate, as it were, to give the benefit of the doubt to the applicant?

A. Yes. I mean, I imagine the period was relatively small, I don't know, but I imagine stocks aren't kept on an indefinite basis, but I don't know that.

Q. Then, just going back to the issue of cut-off dates, is it right to understand you are not advancing any specific cut-off date because you haven't analysed the evidence in relation to that --

A. No.

Q. -- you are simply saying -- referring to the fact that at least insofar as hepatitis C is concerned, there is a cut-off date in the schemes and a decision will have to be taken whether informed by the finding of the Inquiry or otherwise as to whether there should be

a cut-off date for the scheme you propose and if so what it should be?

A. Yes, my reading -- and, of course, it's limited by the qualifications I have given many times -- is that there is a time after which, if I can put it broadly, when screening techniques and general knowledge and practice was such that the risks of infections had become vanishingly small, thank goodness.

Q. We can take that down. Thank you.

The next question I wanted to ask you about is a category of those infected with hepatitis C who clear the virus within a period of time, you haven't excluded what are sometimes referred to as natural clearers from the scheme?

A. Certainly not. I mean, the fact they cleared obviously is good news but it is realistically likely to lead to a smaller sum by way of compensation than someone who has a lifetime of suffering.

Q. So the way in which you would envisage their circumstances being catered for is they are within the scheme but obviously in terms of the applicable tariff and the kind of compensation that might be payable, it may be significantly different from those who have had a lifetime of treatment?

A. Yes.

Q. Then just dealing a little more with issues about the extent to which applicants have to prove matters and this isn't -- this line of questioning is not limited to questions of eligibility but if we are looking, for example, at proof of loss, proof of causation, does that collaborative approach which you described, that supportive approach, not automatically disbelieving applicants that you described in relation to eligibility decisions, would you carry those principles through to when, whoever it is who is doing the assessment, is looking at the losses that individuals have suffered?

A. Yes. Clearly there are going to be areas where generally you might expect the applicant to be able to produce more information than others, I'm thinking about there is a claim for loss of earnings for instance or loss of career prospects. You could start from a blank sheet of paper but it would obviously be helpful and reasonable for an applicant to come forward with some information and some chapter and verse about that, if they have had an employment history for instance.

On the other hand, if you are talking about the effects of stigma and social impact and so on, it seems to me almost inevitable you will rely to a large

extent on what you are told by the applicant and their immediate family about what happened to them.

Q. If someone, for example, describes, as so many witnesses have described to this Inquiry, the horrific side effects of treatment, whether it was some of the HIV treatments or interferon in relation to hepatitis C, you wouldn't expect individuals to have to go away and get their own individual expert medical report --

A. No.

Q. -- and present it to say that this person did indeed suffer --

A. No, no.

Q. -- those consequences?

A. I was thinking, as I hope is clear, to ensure that the scheme, as far as possible, avoids the need of applicants to have to produce the things like expert evidence and legal submissions or whatever. Having said that, clearly some fairly expert questioning might be needed -- this is where the pro-activity comes in -- of the scheme in terms of asking the right sort of questions to elicit things like what the side effects have been for a particular person and then to set what the description is against what the medical panel has described as included in the known side effects of

particular forms of treatment, which, the way I have read it, can be terrible.

Q. Can we then turn to recommendation 5. We will just look at the text of that first, on page 34 of the report.

So recommendation 5, bottom half of the page, we are now looking here at the eligibility of affected persons, and we looked at the categories earlier on.

For the avoidance of doubt, because I do not think it is necessarily clear from the terms of recommendation 5(a), although I think it becomes clear later, that includes divorced and former spouses.

A. Yes, it does. It could have been made clearer but, I mean, clearly the implication is there. But it definitely -- I intended it to include former spouses.

Q. Yes. It is, I think, clear in what you say in paragraph 6.19 of the report, but I have just been asked to check that with you.

Then, the other question I'm asked to raise in relation to recommendation 5(a) is the reference "for at least one year", and the question is: at what point in time would that year have to have happened?

A. Well, the purpose of having indirectly affected people is that it would have to be during a time where there is an effect, so if there was a co-habitee, for

instance, who co-habited before any treatment was given, they would not qualify. And that's true of spouses and civil partners. It is the suffering everyone has shared from the point at which that suffering begins.

Q. Then in relation to the reference to children in recommendation 5(b), I'm asked to check this with you again for clarity, that encompasses those who were the children of an infected parent and are now adults?

A. Yes. I think my qualification is they needed to be children at the time.

Q. And why is that?

A. Because I believe children have a particular -- children, by which I mean people under the age of 18, are likely to be affected in a very particular way by living with or having a parent who is infected in this way. And I have heard stories about that. But obviously they can be adults now and be claiming for what happened when they were children.

Q. Recommendation 5(c):

"parents of eligible infected persons whose eligibility started in childhood."

The question is this: why do parents only qualify in the event of the eligibility of the infection starting in childhood?

A. Rather the same as with children. The parent of a child who has got -- who contracts one of these terrible diseases has a responsibility for the child which the parent of an adult doesn't. Of course they have another and -- a close relationship and distress, they may well come within one of the other categories in that respect, but there is a particular reason, it seems to me, for parents, given their burdensome responsibilities, the -- one of which will almost inevitably be a sense of responsibility, often completely misplaced, that they in some way are responsible for submitting their child to the treatment in the first place.

So there are all sorts of reasons why the parent of a child who has received treatment and then been affected will be affected in a somewhat different way to the understandable issues that a parent of a grown-up might have, when actually they may feel a close relationship and so on but it is not as close as that that I have just described.

Q. Then two further points arising out of that. If a child was infected before turning 18 but that infection was not detected or symptoms did not develop until after 18, would parents be eligible for compensation in this category?

A. I don't see why not.

Q. I'm asked to point out that in some cases it may not be possible to detect the batch or treatment that infected the child and the date of infection of hepatitis C or HIV may be unavailable. Again, that would be a question of perhaps looking to see what was --

A. That is a question of proof and evidence. All I can possibly say, bearing in mind what I just said about the reason for parents and children being in this category, is that it would seem to me the later in childhood all this happened, particularly if during childhood there was no evident infection or issue, then we might not be looking very much by way of compensation should they actually be eligible for it.

Q. Then recommendation 5(d):

"siblings living, while under the age of 18, as a family with an eligible infected person."

I'm asked to double check with you, under the age of 18, does that refer to the infected sibling or to both the affected sibling and the infected sibling?

A. The age refers to the sibling living with the infected person. The reason -- I heard stories about the effect on siblings of children living in a family where a brother or a sister has been infected in this way,

the impact that has both socially and psychologically on them as children.

Q. You've not included within those who are eligible as affected persons by reason of relationship, grandparents or grandchildren; why is that?

A. Putting it bluntly, I felt a line has to be drawn somewhere in terms of actual automatic categories. It could be that such people might come within (f) but they would have had to show that.

Some would argue that I have been stretching the envelope of eligibility quite a long way anyway, and I come back all the time to where is there a strong moral case. In terms of damages, as you say, well, no, we do not as a matter of law award damages to people who are considered to be too remote from the problem that's caused and some would argue that line is sometimes too strictly drawn. But clearly there has to be a line somewhere or otherwise we might say, for example, we ought to compensate someone who reads about the suffering people in a newspaper, which probably we wouldn't actually want to happen.

So it is always -- there was always going to be a line beyond which it's not proportionate to -- in terms of the moral case or the case about responsibility to bring people within it, and I have

sought to draw that line as widely as I can, but I do feel that the mere status of being a grandparent or grandchild is probably not sufficient, but that doesn't mean that you wouldn't necessarily qualify under (f) if you can prove that effect.

Q. Or presumably potentially (e) as well, as a provider of care?

A. Yes, of course.

Q. So, for example, a grandparent who effectively stood in loco parentis perhaps not formally as such but effectively was the person bringing up the child would be more likely to fall within (f)?

A. Yes.

Q. A grandchild forming caring responsibilities might well come within --

A. And the limiting factor I did put in was they did in fact suffer a mental or physical injury.

Q. And then in relation to that limiting factor, the suffering a mental or physical injury as a result, what is it that you are suggesting would have to be demonstrated in that regard in terms of a mental injury? Would there have to be a mental condition as recognised in one of the diagnostic manuals or would it include those who have suffered degrees of anxiety, unhappiness, depression that don't qualify as fully

recognised psychiatric disorders?

A. I think both anxiety and depression probably do appear -- (overspeaking) -- as it happens.

Q. But it is a question of degree --

A. I would -- it is obviously a moot point and open to debate. Clearly anything that is diagnosable, whether it be depression or anxiety of that nature, would be included. But I was impressed by what I read in the psychosocial -- I can't remember the full name of it, but the psychosocial expert report, which seemed to be -- very graphically to describe a whole range of suffering, of distress, around which it is quite difficult, frankly, to draw a definition. But I would personally be prepared to see -- if there was some mental injury that was diagnosable, then I would certainly suggest you take into account the psychosocial impact more generally and the distress.

Q. Then, in terms of category (e):

"providers of care to an eligible infected person, as a result of the infection."

I'm asked to ask you what level of care would require to be established for a person to fall within that?

A. I think under the care section I actually describe that, and perhaps one might be able go to that in due

course, but I'm talking about definitely care that would not be necessary for a person who did not have an infection. So, for instance, a parent will always have obligations towards a child but would probably not have nursing care obligations in the way you might have towards someone who has one of these infections or the side effects from treatment. So that's what I mean.

But one has to take account of the fact that parents in particular that may be, in other circumstances, grandparents may have caring responsibilities of a general nature.

Q. If we just pick that last point up over the page -- sorry, page 73. The heading "Carers" there. If we go to 6.24, under "Eligibility". So:

"- A person who has provided personal care or support to an infected person;

"- The care and support provided has been over and above that which they would have been reasonably expected to provide to the infected person but for the infection and its consequences;

"- The care and support provided has been without remuneration (except for reimbursement of reasonable expenses incurred in the provision of the care or support); and

"- The care and support provided was reasonably

necessary to mitigate the effects or consequences of the infection on the infected person."

Is it right to understand there is not a minimum number of hours that have to be established or --

A. No --

Q. It is a more commonsense and holistic approach?

A. It is that and it's -- clearly there is a de minimis.

Q. Yes.

A. I mean, if perhaps you are giving someone a lift to the hospital on one occasion, I would rather hope the scheme wouldn't be troubled with that, but certainly anything that is of substance -- and that could be an hour a day or a couple of hours a week -- I don't see why that shouldn't be compensated for it, if necessary, in accordance with that sort of scheme -- sort of test, rather.

MS RICHARDS: Sir, I note the time. I'm moving on to the next recommendations, so perhaps we can do that after lunch.

SIR BRIAN LANGSTAFF: Okay. We will take a break now until 2 o'clock. Not everyone will have heard me say to you at the end of the earlier sessions, so I will say it for everyone to hear now: you are giving evidence, you know, of course, you must not discuss the evidence you have given with anyone nor for that

matter anything which you think you may yet be asked about. That goes for discussions with anyone but you can talk about anything else you like.

A. I will do that with delight, sir.

(1.02 pm)

(The short adjournment)

(2.00 pm)

MS RICHARDS: Just to go back briefly to the discussion we had before lunch about siblings and parents, I just wanted to give an example that I have been given just to check that there's no confusion about what the position is.

So if you have someone who is infected, say, at the age of ten, obviously now an adult but their parents elderly adults now, but the infection took place when the child was ten years old, the parent would qualify or parents would qualify as eligible affected adults?

A. So they are the parents of a ten-year-old child?

Q. At the time of the infection they were the parents of a ten-year-old child, yes?

A. Yes.

Q. And a sibling who, say, was an elder sibling going through A levels, 17 years old, would also qualify --

A. Yes.

Q. It might be said that by reason of the fact of when that sibling's birthday was they turned 18 in the course of that year, they might end up not qualifying because they have just turned 18 at the point at which the infection takes place but may have suffered in exactly the same way, impact upon education and so on, is there any answer to that?

A. The answer is you need to draw a line somewhere. We draw a line for all sorts of reasons about childhood finishing at 18. It used to be 21, but now it's 18, so maybe you could change that.

I repeat that if you don't qualify by reason of your status, then you can potentially qualify under one of the other heads. It's about the connection, and clearly it is not an area where there could only be one reasonable view taken but that was my view.

Q. Then, can I just ask you to deal with the position of those who are both infected and affected. So, for example, where you have someone who because of the hereditary nature of haemophilia may themselves have been infected but may also have lost or cared for other family members, how would you envisage a scheme reflecting that?

A. Well, clearly they would be potentially eligible under both parts of the scheme.

Q. Yes.

A. You would have to take into account the award under one -- the totality of the award, so that you were being -- receiving an award for the actuality of your experience rather than -- I mean, putting it simply, if you've got a certain sum for an impact of your injury as an infected person, you couldn't double that up by having the same again as an affected person if the symptoms you are talking about are the same. So you would need to look at the totality of the event.

So it is no coincidence the categories of award I have suggested, in terms of description of category, are fairly similar whether it's -- I mean, there are more for the affected for reasons that are specific -- but you would in effect end up with an impact award for the totality of your experience. I think that's what would be what would have to happen. So if you had a matrix, then you would have take -- to adjust the figures to take that into account, but it would be very difficult -- I accept to do that by way of some algorithm you would have to have judgment as to what was fair in those circumstances.

Q. So you would potentially assess that individual in their own right as an infected individual?

A. Yes.

Q. But then there would need to be a judgement as to whether additional compensation was warranted to reflect what they had lost as an affected --
A. Yes, that would be -- personally, the way I would do it would be to start off with the impact of -- the direct impact of the infection, and then the added impact, the aggravation if you like, of being an affected person as well. One could imagine that could be very significant.
Q. Can I then just explore with you a little some issues that might arise in relation to claims brought on behalf of estates or some form of quasi Fatal Accidents Act claim.
A. Mm.
Q. It has been pointed out to me, not least because of the fact that so many years have passed, in many instances, since an individual's case, that that may be all sorts of practical complications. There may be cases where there was no grant of probate, there may be difficulties in unravelling who would be the right individuals to bring claims. I'm not going to list all the various different permutations that have been drawn to my attention.
But I'm asked to explore this with you, in fatal accidents at litigation, there would be one claim

brought on behalf of the estate identifying the potential beneficiaries. Would you agree that that should in principle be the same for claims under the compensation scheme?
A. As far as possible, yes. Of course, that doesn't preclude direct claims from an affected person who has been affected by the infection of the deceased.
I accept, of course, with something going a long way back there could be complications which need to be looked at but it is possible to appoint a personal representative or an administrator to bring claims, but it is important that there is such a person. We can't have, I'm afraid, just everyone -- you have to have a system by which there is a claim brought on behalf of the estate and then a mechanism for distributing any money that's received.
Q. So there may need to be a practical mechanism under the scheme to try and ensure that potential beneficiaries are notified?
A. Yes.
Q. And then potentially a method of allocation?
A. Yes. One can see there may be difficulties in --
I mean, someone at some point has to identify the fact that the deceased person died of -- or may have died as a result of this. And the issue of a claim to be

raised, and I'm not sure whether it is practical for the scheme itself to go hunting for people, it may be, but I would have thought it is more likely that enquiries should be encouraged from the relatives of a deceased person and through publicity and other means, but the scheme should certainly be in a position to provide proactive help to people to come forward to navigate what is undoubtedly a complicated situation.
Q. Yes. I should say, I'm not asked to put forward to you any specific mechanism but just to identify that it's an issue that would warrant careful consideration?
A. Yes. Well, it's not -- for that reason, it's not one I've actually gone into detail about, because I think that's slightly premature until one has actually sort of seen the overall structure of the scheme generally.
Q. Relatedly, the next point I'm asked to explore with you is this, there will be, potentially, a not insignificant number of cases in which families will not have formally sorted out their estate, perhaps because there was so little in them at the time, and they will have to now go back and formalise the position many years after the event, with the prospect, now, potentially, of more substantial sums being payable.

If those substantial sums take the estate into the territory where tax might have been payable, do you agree there should be specific provision to ensure that they are disregarded for estate or inheritance tax?
A. I think I've read a recommendation about inheritance tax generally, haven't I?
Q. Yes.
A. That should be the position. It is a difficult -- not an area free from controversy, but -- because if the compensation being received by the estate is for the injury to the deceased person, it might be argued there is no particular reason why that money should not be subject to inheritance tax, whereas money that is received under, as it were under, the Fatal Accidents provision, the dependency clearly wouldn't I think be under the Fatal Accidents Act, so shouldn't be in this sort of claim.
But I think there is a potential issue around inheritance tax for, as it were, the compensation for the suffering the deceased has gone through, because if a living deceased -- sorry, a living victim receives compensation for their injury as a when -- if they were to die the following day, that money would be the subject of inheritance tax if it was of

a sufficient quantity. So there needs to be parity there somewhere.

Q. Would you agree that consistent with the principles that you identified as the broad principles for the scheme, and the importance of making it something that can be navigated by individual applicants, would you agree that there ought to be some form of appropriate legal assistance or support available whether it is from the scheme or otherwise?

A. I think I have said that in effect but perhaps in general terms but where there are complexities around estates, for instance, most people would not be able to navigate that without assistance and the Inquiry should be able to provide that.

Q. The scheme should be able to provide that?

A. Absolutely. Not the Inquiry. The Inquiry does many things but that's not one of them. No, I mean the scheme.

SIR BRIAN LANGSTAFF: Could I just clarify through you for the benefit of those who are listening, the current legal position on a death may be a claim of one of two kinds; is that right? One of the Law Reform (Miscellaneous Provisions) Act, a long title, but basically that is a claim for the estate in respect of various events which may have happened during the

lifetime of the deceased where the deceased had an entitlement; is that correct?

A. That is correct.

SIR BRIAN LANGSTAFF: That is different from a claim under the Fatal Accidents Act, which is where some fatality, whether it be the consequence of an accident or a disease, has caused in whole or in part the death of the deceased.

A. Yes.

SIR BRIAN LANGSTAFF: In which case the claim is not for the estate it is for the dependents of the deceased.

A. Yes.

SIR BRIAN LANGSTAFF: And what they get awarded in Common Law terms or statutory terms is a bereavement award, which you have said earlier is set at a statutory figure which may not satisfy everyone because it is neither so little that it is derisory, at least that's the theory, certainly isn't generous in most people's perception, I suspect, plus the extent to which the survivors, the dependents who can claim were financially dependent upon the deceased.

A. Yes.

SIR BRIAN LANGSTAFF: Your scheme, as it were, cuts across both by giving them a recognition of the suffering they will have had as -- these are the dependents --

the suffering that they will or may have had during the lifetime of the person who has died from an illness such as HIV/AIDS or hepatitis C?

A. Yes.

Q. Plus the costs of care, plus the costs of -- the losses they have suffered as a result and the losses that the deceased suffered during his lifetime?

A. Yes.

Q. I say "his"?

A. It might be "her".

What I sought to do, I think, is to not replicate but try to provide the equivalent of exactly what you described in the scheme, so that there is the estate's claim and a dependents' claim, and a mechanism for doing that, but by reference to the -- generally speaking, to the categories of award that I've suggested should be made.

SIR BRIAN LANGSTAFF: Yes.

A. There was one other qualification. Obviously in relation to your deceased person, one of the complications could well be some people will have provided for an inheritance in a will, others will not, and they will be intestate and there could be all sorts of potential complications coming out of those approaches because, as has been pointed out, a person

who has made a will without any expectation of compensation may have made and entirely different provision to what they would have done if they had.

I'm afraid the law has means of sorting that out. None of that is simple and I do not think there is anything I could do to make things less complicated.

SIR BRIAN LANGSTAFF: If there had been a Fatal Accidents Act and liability settlement in court there could only be room for one claim --

A. Yes.

SIR BRIAN LANGSTAFF: -- albeit the claim is brought on behalf of the number of claimants.

A. Yes.

SIR BRIAN LANGSTAFF: And that is to cut down the number of legal claims which may be brought. Would you envisage with the claims here, those who might come within the categories of parent, siblings, et cetera, that they will be separate, divisible claims or would they all have to be brought at one and the same time, in effect, by coming to the --

A. I think what I have suggested is that if at all possible they should be brought as one claim in the same way, but each affected person who is eligible will have their own separate right anyway. But clearly

I envisage it would be better for the scheme and indeed everyone involved, if the claims of a family group, if I can put it loosely, were all brought at the same time and dealt with together because there is likely to be an interdependence between some aspects of those claims.

SIR BRIAN LANGSTAFF: Yes, thank you.

MS RICHARDS: I want to ask you a little more about recommendation 6 now. Recommendation 6 was the categories with defined degrees of severity and the role of the medical or clinical advisory panel and the legal panel.

Can I just ask you, first of all, about your thoughts on how the medical expert panel might be appointed? Would you agree that there should be a clearly independent and transparent process separate from government if the membership of the panel is to earn and retain the confidence and trust of those who might be affected by its divisions?

A. What I think I envisage is the arm's length body that I suggested should be created, and obviously in the way of things that would have a board which would be an independent board, and I would envisage that one of their first tasks would be to appoint the panel or panels.

A. Yes.

Q. I'm asked to put forward the suggestion for your comment that perhaps approaching the editorial board of the Judicial College Guidelines for the assessment of general damages, the JSB guidelines, for nomination might be a good starting point?

A. I'm not sure the editorial boards or the judicial guidelines would necessarily thank me for that, but the Judicial College more generally might be a start, although obviously they know more about judges than they may do about the legal profession. Frankly, it would be, I anticipate, much easier to populate the legal panel than it will be the medical panel because there are a wide range of professionals both at the Bar and amongst solicitors who deal with personal injury work of the type which would qualify them to make this sort of assessment.

Q. Do you think it might be helpful to have on the legal panel at least one member familiar with either the Inquiry or the detail of the suffering endured by the infected and affected so that they're not having to reinvent the wheel?

A. Possibly, but I don't think I would want to legislate for that. I mean, there is -- clearly in both the medical and the legal side, in order to make sure these

Q. In relation to the medical panel, the clinical panel, would you agree that there would need to be robust conflict of interest safeguards in place, so, for example, doctors who may in the past have themselves been implicated in their decision-making which has caused harm should not be included on the panel?

A. There would certainly need to be a conflict of interest process. I am, from my professional experience, aware that there are certain areas, and I don't know if this is one, where actually the expertise is so confined that actually you have to take the expert where you can find them and take into account the fact that they have had experiences which are relevant to what you think about their judgment. But clearly in principle, experts, whether legal or medical, should be independent and not have had anything to do with the history. But how possible that is, bearing in mind you are looking for real experts, I don't know.

This Inquiry, if I may say so, seems to have found a panel of independent experts so it is not impossible.

Q. In terms of the appointments to the legal panel, again should be an independent and transparent process, so on your model would be undertaken by the arm's length body rather than appointments by government?

processes happen expeditiously it would be an advantage to have access to the learning of this Inquiry, whether it is part of the report or not.

Q. I have been asked to explore with you the possible detriment of multiple assessments of individual applicants, bearing in mind what they have previously experienced. It may be that question is based upon a misconception as to how the process would work but I just wanted to tease that out with you.

Let's say the medical panel have fixed their categories of mild, moderate, severe, the legal panel have filled the grid with a range of figures.

A. Yes.

Q. In terms of the person or people who then decide where an individual application fits within that grid, I think you said earlier it could potentially be a lawyer, it could be someone trained by the arm's length body, you weren't I think prescribing who the assessors might be. What information about the individual would you expect the assessor or assessors to have available to know where to place the individual in those categories?

A. I suppose the easy but perhaps unhelpful answer would be as much as possible. I don't see this as being a process which you will probably find in some social

security application to everything being reduced to a common form of two or three pages. I can see the job of assessment being quite onerous and actually will need an examination of all the material the applicant would want to be taken into account and anything else the scheme of its own abilities been able to find. I don't see any way of avoiding that process.

If possible, one would hope the administration of the scheme would manage to collect the information in a way which may be in a standard form in the end but which would be more easily accessible by the assessor. But it is a good reason I think why this is a process that needs to be undertaken by lawyers and I know I hark back to it a lot but the 9/11 scheme had lawyers who did that, and they did interact with the claimant. In that case obviously the claimants were sadly the people who had died, but interacted with claimants who would interview them where necessary. So I see that as being a potential route to find out information that the assessor themselves would and probably should have personal contact with the claimants but not in the formal sense of a court hearing but actually more of an interview. And actually I think it is probably important in order to develop that competence and trust the claimants would

need in the system.

Q. So that there is no misconception then, this process does not involve the medical panel undertaking individual assessments of the applicants?

A. No.

Q. That's not their role?

A. No. I would like to think that the assessment will be possible on the back of the information available about the medical history. The point of the medical panel counsel to provide, as it were, a medical framework within which the assessor could place the information that is there.

I would foresee that clearly assessors should have access to medical advice if there's something they didn't understand or some gap that needed to be filled, and indeed this, in one sense, has to be a developing process and a learning process, which is why I recommended that obviously the scheme needs to be kept under review as it develops experience, and it needs to, of course -- and publish reports from time to time which make that clear to the world at large.

Q. So it may be, in an individual case, that the assessor might have all the information they need from the existing medical and other data that had been submitted to Skipton Fund or one of the devolved

schemes?

A. Yes, but clearly in such a case one would hope that they would then seek to confirm that, in terms of its accuracy, with the applicants and any other relevant people. And the scheme then would need to be alive to, as it were, the absence of information and how to fill gaps.

Q. So is it right to understand you are describing a relatively flexible approach in terms of the kind of information/evidence that might be looked at?

A. Yes.

Q. An individual who has provided a witness statement to this Inquiry, that statement might itself provide ample evidence --

A. I would foresee see this Inquiry having fulfilled, amongst its many other valuable functions, a collection of a lot of information individuals might need to pursue their own claim.

SIR BRIAN LANGSTAFF: May I ask a question. The process which you are describing is essentially this, is it, that at the very start there is a lot of work for the medical panel to do to work out what qualifies under the various headings severe, moderate, mild, whatever the levels are? Once they have done that, those levels may need some adjustments but essentially the

hard work has been done?

A. Yes.

SIR BRIAN LANGSTAFF: The legal panel will look at the categories and work out how much.

A. Yes.

SIR BRIAN LANGSTAFF: Again, once that's been done, there may be a bit of tinkering later on, but essentially the hard work's been done. So that's a bit of, if you like, front loading in terms of the personnel and the time. The assessment has to be done by people who know the field enough to make a proper assessment, have sufficient training or background to be able to do it, by nature it is going to be a relatively limited class, particularly if it is going to carry confidence of those who are subject to the scheme.

But their process is not a quick one individually and if -- I'm just thinking to myself, suppose the Inquiry did recommend a scheme such as yours and at day one invite applications. Now, there might be 3,000, 4,000, 5,000 applications, all of which would demand a degree of time, flexibly applied to each of them and yet the system has to be quick for the very reasons that you have described. How do you address that in terms of staging of this sudden rush as it were to get through the doors? Later on it is

much easier because by then the great number who already have well-recognised, well-recorded claims will have been dealt with, it is the new claims wherever they may come from that have to be analysed and looked at and assessed. How do you cope with the rush?

A. Well, again, there's almost certainly, in this exercise, got to be some front loading. Because, as you say, there will be -- the bulk people who think they have a claim already know they think they have the claim, and they will be waiting there anxiously from day one to put their claim in.

Obviously the efficacy of the scheme will depend on whether sufficient funding is put in and resource put in to enable a sufficient panel of assessors to be recruited, and I do envisage, I would envisage, that, sensibly, at the start it may be slower dealing with an individual case than it becomes later on when it is more used to you.

But I do point to the fact that it is not impossible. The 9/11 scheme dealt with all 3,000, 4,000 claims in two years, beginning to end. I admit that some of that might have been a stretch, sadly, more simple, because they weren't talking about lengthy and varying medical conditions in a way that

these assessors would, but I'm rather assuming, I hope rightly, that once the understanding of the range of medical experience is described, that it should become quite easier for actually the individuals themselves to seek to fit themselves into categories and for the information they produce to be designed to that end and assistance to be devised so that the information can be processed relatively quickly. But -- depending on the nature of the case.

A lot will depend upon collaboration, the willingness of people perhaps to accept something that is a little bit more broad brush than they would do in a court-based system. But I would be confident that -- I mean, obviously there has to be a prioritisation of cases, and you either take first come, first served, which is probably the fair thing to do, or you look at urgent need, you might want to do that, but I have assumed -- I would assume that my recommendation about an interim payment has been made, which would relieve the pressure, and if you don't have an interim payment of sufficient substance, and the figure I put in is clearly just a potential figure, but of sufficient substance to allay people's fears that they might not actually be getting a fair compensation, then I would see it as a problem. But

if that's provided then the pressure is a little bit off in terms of how long things take.

SIR BRIAN LANGSTAFF: I was going to ask if this were, in itself, a reason for thinking that there may be something to support the interim payment scheme.

A. Yes. Part of my thinking about it was that the interim payment itself should be of sufficient substance that actually it might reflect at least the substantial part of quite a lot of people's claims. I put it no better than that. There are clearly going to be claims which are way in excess of that, but if the figure is one which some people might actually be satisfied as being actually that's all they need or want or whatever, then that in itself would relieve some of the pressures. That is one of my reasons for recommending an interim payment.

SIR BRIAN LANGSTAFF: Thank you very much.

MS RICHARDS: You referred this morning to the approach to self assessment in the Scottish scheme.

A. Yes.

Q. Again, building on the principles you identified, collaboration, ideas of trust and so on, is there something to be said for having self assessment at least as a significant feature of the scheme or a starting point for the process?

A. I think actually self assessment is almost an essential part of the process, in that it is the beginning of a conversation, isn't it, as to what people regard as their position within this framework. I'm assuming that the framework is described in language that people can understand, they know what their own experience has been, and they can put it in.

What impressed me about the Scottish scheme was that, as lawyers are sometimes accused of being cynical and sceptical and so on, a lawyer of such mind might have thought that everyone would claim the maximum and say, "We are the not severe cases", that's not been the Scottish experience.

So, of course, it is a starting point, and no scheme could possibly just accept the self assessment without question. But it is the beginning of a conversation and a reference point. So, yes.

Q. Again, picking up on that idea of a conversation, would you anticipate, ideally at least, the conversation continuing, with the assessor saying -- either having looked at the material, having helped the individual gather any additional extra material -- "My assessment is the same as yours", or, "My assessment is different and here are some thoughts", but do that as a staging point in the conversation.

So before getting to any formal final decision and then formal review or right of appeal, that the assessor might say, "I think you are in this category for these reasons, what do you think?"

Because obviously if that can be resolved by agreement, dialogue, discussion, that reduces the burden on the individual and reduces the burden on the scheme.

A. Yes, ideally that's what should happen, and that's why I'm very keen that this should not become an adversarial process as between a scheme that is trying to save every penny it can and a claimant who, dare I say it, backed by -- or supported and represented by some lawyer, is claiming the maximum theoretically possible. But both sides are seeking to come to a reasonable solution around the circumstances of the case. That's a much better way of producing a satisfactory outcome than an adversarial system which produces an analogue answer "yes" or "no" or this figure or that figure.

Q. Can I then ask you a little about recommendation 7. Could we have the report back on screen 35, please.

Recommendation 7, bottom of the page, refers to aggravated and exemplary damages, and you say in the recommendation (a) the scheme should allow as part of

the autonomy award the eligible infected persons an award equivalent to aggravated damages for the aggravated distress caused by interferences and their autonomy in private life such as lack of informed consent, information about the risks of treatment and about diagnosis, treatment and testing, and (b) the issue of exemplary damages be reviewed in the light of the findings of the Inquiry.

Now, again, just really for the benefit of those listening, and you have explained the terms in your report, but could you just briefly explain what aggravated damages are and what exemplary damages are.

A. Yes, I will do my best. The idea of -- I can deal with the exemplary damages first, is it is a punitive award. So it is an award in a court system of the court's disapproval of the conduct, usually of a state body but it may be others, and the misconduct as opposed to a value of the injury that's being suffered. So it is a bit like a fine but it is one that goes to the claimant.

There are other jurisdictions where exemplary damages are awarded by juries in the US in millions of dollars a lot of the time. It is a much less common feature of claims in this country. The Republic of Ireland compensation scheme, from memory, allows for

exemplary damages and indeed has a special fund for that.

I didn't feel qualified on what I knew to say yay or nay to exemplary damages. All I would say about it is that it would undoubtedly introduce an adversarial element to what would otherwise I hope be a more consensual collaborative scheme, and a way of dealing with exemplary damages would be to say, well, if that's what you want try your luck in court because it is not compensation in reality, it is a punitive element.

Aggravated damages, on the other hand, to my mind could play a part, which is where the injury has been aggravated by conduct or something else that's unacceptable. And in the case here, it seemed to me from what I was hearing and what I read that one of the things that a number of people -- many people are complaining about has been an interference with in effect their human rights. Interference with family life, interference with their autonomy in terms of consent and other ways, which they would say has been completely wrong, and that has aggravated in a real sense that the injury they have suffered and in some cases in itself caused serious psychological distress and sometimes mental illness, and it was for that

reason I thought that that was something that could be reflected actually in the autonomy award. That's really the purpose of having something over and above the social impact award which was about the direct effect of stigma and other things which exists regardless actually of the conduct of this type. These are concepts which are quite difficult to be expressed but I think much easier to understand when looking at the stories that I heard and are available to the Inquiry.

Q. So in relation to exemplary damages, is this right, the -- or a key reason why you have not made a recommendation is because in your view it would essentially turn on findings of misconduct --

A. Yes.

Q. -- pejorative critical findings about the role of the state, and that's the job of the Inquiry rather than you?

A. It is, and it also fits, in my view, rather uneasily into a scheme which is meant to be about compensation and a scheme which is meant to take the place of -- because it is broader than in some ways litigation. So in one sense you might say that the need for exemplary damages is at least reduced whatever the findings of the Inquiry by the fact that there is this scheme in

existence to remedy what has gone before. That would be one thing.

But I think it fits -- it is quite a difficult thing to fit into a collaborative scheme where you have got assessors looking at medical history and all the rest of it and then suddenly having to switch into deciding on what degree of culpability is involved and what any individuals had happen to them is so bad that the state should be punished by giving extra money to this particular individual as opposed to all the other victims of this particular disaster. That's my problem.

Q. Just before we move to aggravated damages, do you know what kind of circumstances have triggered an award of exemplary damages in the Irish scheme?

A. I'm afraid I don't. I have looked at a number of reported cases because they don't report the actual Tribunal cases. If they do I couldn't find them. They do report the appeals to the court and I think some of those have been about aggravated damages, but I'm afraid I don't have a sufficient understanding to be helpful to you on that.

What I do understand from the system is there is a separate fund for it and I think there is a separate process of determining it. So it undoubtedly adds

complexity to an already complex system.

Q. In terms of the aggravated damages as part of the autonomy award, what's your suggestion or expectation as to how the scheme might go about calculating the level of aggravated damages?

A. I think it is difficult because it is not -- these are damages which aren't -- are related to the interference with a right, or a failure to protect, if you like, is another way of putting it, rather than any actual sort of physical or mental injury. So it's rather like if you brought a claim for a breach of human rights under the Human Rights Act for a breach of the right to privacy or inhumane or degrading treatment, there would be a level of award for that, which is assessed in part by reference and how much longer that will be possible but at the moment is assessed in part by reference to court cases in the European Court of Human Rights and where awards are made just for the very fact that a right has been broken.

The awards I have to say tend to be relatively modest most people would say, I don't say that's right or wrong, because as with so many things there's no right or wrong answer, but I would envisage these would be relatively modest awards because they would be on top of awards for things that actually do not

sound in damages in law in this country at the moment. So we are already suggesting that people should be compensated for psychological injury in circumstances where they probably wouldn't get that in litigation. That might be said to be another way of reflecting aggravation which wouldn't conventionally be seen. So I would envisage relatively modest awards here, bearing in mind everything else that such a person with such a claim would have.

Q. When you are again talking about relatively modest, is it right to understand, and I have in mind here the kind of awards that are made in Strasbourg, on occasion are --

A. Yes.

Q. -- made in these courts, you are talking about something more than in the hundreds of pounds but something less than in the tens of thousands of pounds usually?

A. It might be in the tens of thousands of pounds. It certainly wouldn't be in the hundreds of thousands of pounds, no. Nothing is certain obviously, is it? But that would be my vision of it, yes.

Q. In terms of the kind of items that might trigger it, lack of informed consent, lack of information about risks of treatment, being tested without consent,

would you envisage potentially -- or would you recommend a tariff for that, X thousand pounds for testing without consent, X thousand for being involved in research without consent or would you envisage a slightly more flexible holistic assessment?

A. I think it would probably be fairer or more manageable anyway to set an overall range. This wouldn't be a matter for the medical panel. It would be a matter for the legal panel I think. I mean, after all, there would need be a difference, it would seem to me, between someone who on one occasion had not been offered informed consent, from someone who'd spent years of being subjected to testing or experimental treatment without being told about it. So there is a scale of aggravation.

And I think some of this anyway would -- because these circumstances would have given rise to additional distress caused by the suffering from either the injury -- the infection itself or the treatment from it, we would still be talking about relatively modest sums but I think there would be a scale and it would be something which would have to be worked out in practice over a period of time.

My reservation about it as a whole is that I could see it giving rise to a lot of dispute over

a relatively small proportion of what would otherwise be a significant award, but we would have to see. I see the case for it.

Q. Then we talked about the significance and the problems created by missing medical records in the context of establishing eligibility. The same kind of issues might arise in the context here of establishing testing when a patient wasn't informed and so on. Would you, again in broad terms, envisage a similar kind of approach as previously? So the assessor would not be sitting as a tribunal of fact, would not be interrogating the medical records, would not be calling for evidence from the clinicians, but there would be essentially an extent of having regard to the findings of this Inquiry on the broader issues and then perhaps taking on trust having regard to the credibility of what's advanced, the applicant's account of having been tested without consent or not given information?

A. Very much that I think. I would expect that the evidence that this Inquiry would be such as -- evidence before this Inquiry to be such as to establish patterns which could be taken into account. I think also it might be relevant to note whether or not any individual had been tested without their consent. If it was the

circumstances are such that everyone might fear that without knowing that that in itself might need to be reflected in an award. Obviously, if it were possible to show these specific insults in a technical sense had occurred then that would make for a stronger case.

Q. Can I turn then to consider, next, recommendation 8.

So if we go over to the next page, please, Lawrence.

So we are now looking at the heads of damage or heads of award, I should say, for those who were infected.

A. Yes.

Q. We have the five components there set out.

In relation to the impact injury award, you have already explained how you envisage that happening with the role of the medical panel and the legal panel and the creation of the tariff and the grids.

Would you envisage the same in relation to the social impact award?

A. I would, but the difference would be -- clearly, social impact is not a medical matter, although clearly if clinicians, and we can see that from the expert reports, are well versed in noting some of these impacts, there is also the psychosocial evidence, I see this as an area where it would be appropriate to come

up with a standard figure, by which I mean not the same amount is given to everyone but there is a standard sum which refers in part to a length of time that an individual has suffered from the impact. Because it is one thing to -- for an individual to have suffered one year of stigma and then died, I don't wish to be cruel about this but that may be some cases, whereas others we are talking about a lifetime, 40, 50 years of this. So there would have to be a reflection of time and so on.

But I would think that it is as area where perhaps less regard should be paid to individual circumstances, and I say that for this reason. I believe from what I have seen that the stigma and, to some extent, general social consequences of these diseases is such that everyone who has contracted them will have suffered them. How they suffer them will differ from case to case. So on one extreme people may have lost friends, lost family, lost jobs and so on. At the other end, none of those things have happened because they kept everything quiet and to themselves. It seems to me to distinguish in money terms the value of one various from the other would be artificial. It seems to me the way in which these things are received, in a sense matters less than how

long they have been received for.

But, again, there will be potential grades in this because -- or could be, but I think essentially we are talking about a standard figure that everyone would get and would know what it is they get referable to the length of time they have suffered from this from.

Q. Can I just ask you about the table on page 107 of the report. Again, so that there's no confusion about what the significance of this table is.

A. Yes.

Q. So just before we look at the text above it, the table itself says:

"Illustrative periodic figure for the impact of stigma and social [exclusion]"

A. Yes.

Q. This table envisages that there might be different social exclusion stigma awards for different infections.

A. Possibly.

Q. Certainly for different periods of time. And you have explained the rationale for that.

A. Yes.

Q. In relation to different infections --

A. The reason I have not been more specific is that

I, frankly, didn't feel able, from what I saw, to work out for myself whether HIV was a "worse" category than hepatitis C or much the same, and so I think that would be an area perhaps someone would need to look into.

Q. That is really the purpose of going to this. You are not positively advocating that there should be distinctions based upon the different disease?

A. No.

Q. You say in terms in paragraph 9.48 that would have to be something that is decided by the expert panels.

A. My instinct was there might be a difference. It was also my instinct that if you had both, there was a co-infection, that might be worse, but I wasn't sure about that.

Q. If we go back to the table, again, this is an illustrative table. This suggests that the impact of stigma and social isolation could mirror the categorisation of mild, moderate and severe. Does that necessarily follow? You may have had -- that the stigmatising impact of whether it's HIV or hepatitis B or hepatitis C may not depend upon the severity of the underlying condition and the other experiences that the individual might have suffered in terms of side effects of treatment and so on?

A. Well, maybe, but on the other hand, someone who has had

15 years of symptom-free life, for instance, followed by a period where these things come to life or a period post-infection of an undiagnosed and symptom-free period, he's unlikely to have suffered as much stigma, in fact none, until later on. So I think there is a case for saying there will be different degrees of severity.

Q. But does that suggest that the length of time may be more significant than the course that the illness has taken?

A. It's both. If it's a mild case of hepatitis C, if there is such a thing, and you may tell me there isn't, but if there is such a case then there will be a level of stigma, particularly if there are long periods of no symptoms where life could be relatively normal, but if we are talking about as opposed to someone who is visibly very ill from these awful diseases. So I just put that forward as a possible way forward.

It may be there aren't very many cases at the mild end. But it does seem to me one needs the option there, but I do think the length of time suffered for is a significant impact.

Q. Yes. Just going back then to the injury impact award, where you do envisage the categorisation potentially into mild, moderate, severe, did you have any expert

or other advice available to you about the feasibility of constructing that kind of tariff system?

A. No, only what I -- no -- in terms of these particular diseases?

Q. Yes.

A. No, not. It is not a question which was answered obviously by the evidence that I saw, unless I missed something. But it does seem to me from what I read that there are some cases that are more serious than others. Obviously, there are people who happily do not develop liver problems, there are many who don't get cancer, there are many who had a relatively symptom-free time, albeit with worry maybe and treatment and so on, whereas others had terrible symptoms from a long period of time. So there are degrees of severity.

The extent to which they can be classified and described, if you ask me that, no, I have had no expert advice on that. But, frankly, we -- certainly as lawyers we spend our whole time looking at conditions like asbestosis or pneumoconiosis, which may be one condition but affects different people in different ways and evaluating that in coming to different values. All I am seeking to do here is try to collect and classify -- or get cases classified

into more categories so that it is easier and quicker to make awards than it would otherwise be.

Q. Would it be right to understand, drawing on your broader experience of how compensation is assessed more widely, it may not be easy to describe those categories but it ought to be possible to do so?

A. Yes. Insofar as this may actually not be exclusively a medical matter, and I think say somewhere, probably not prominently enough, I don't necessarily see the medical and legal panels operating in isolation all the time, I can see there being an interchange between them. So as would happen in a court case, the lawyers and the judge would be consulting the medics about the nature of the condition in a way which makes their evidence relevant to damages, so I wouldn't necessarily expect the medical panel to be able to could come up with this without dialogue with the legal panel.

Q. Again, I'm very conscious that you are trying to describe a scheme that doesn't take forever to get up and running, but would there also be a role on this really very important issue of how you categorise cases, a role for consultation with those infected --

A. Definitely, it is absolutely essential, and indeed you would probably expect me to say this as Chair of Healthwatch and the president of the Patients

Association, they should be involved in the creative process. This is not an area where I would be terribly happy with two panels going away in private and coming back six months later with a proposed solution and having a six-week consultation over the summer holidays to produce a result. You need some real involvement. As with everything else, but this scheme in particular, it needs to carry the trust of the people who are most deeply affected by it.

Q. I was going to come on later to the issue of a final award or provisional damages but it might be sensible to address it now.

You referred to someone who -- on the topic of how you might distinguish between different categories of cases, there may be somebody who doesn't currently have cirrhosis or has cirrhosis but hasn't developed cancer or hasn't required a liver transplant. If you take hepatitis C as an example, the same may well be true of the other conditions with which we are concerned, there are significant elements of uncertainty about future prognosis, as sadly too many here in this room will know. So somebody may have a level of cirrhosis now that may develop in a number of years to cancer, how does that fit with a final scheme rather than provisional?

A. I come back to that, there is a choice to be made here. In the court situation, in litigation, until a provisional award of damages became possible it was always the case that the court had to make a once-and-for-all assessment at the point of the case about an injury, including the prognosis for the future. So damages would be awarded for in effect the risks of deteriorations in the future, which, you know, a degree of those risks would obviously depend on the medical evidence.

So by definition, a one-off payment is never right because, firstly, if it is a lump sum there is an issue about how long people live and so no one lives precisely to their statistical expectancy and, secondly, some people will develop the risk and some won't, so some people will be over-compensated but some will be under compensated. The advantage you get in return, though, for that uncertainty and broad-brush approach is you have finality and you know where you are, and you don't have to keep on revisiting these things. The strong message I was getting from people is that a lot of them want that finality.

The choice of having a provisional award is that -- which exists in the court system now is you

can have an award which assumes the best in effect and then defines certain deteriorations which would allow you to come back for more. Of course, a compensation scheme could do that. The reason I have not suggested it but, of course, it could be done if you have a powerful enough view about it is that it adds complexity, it adds costs, it means that the individuals can never let go of the system because they will always be thinking, "We might need to go back for more", so they've got to retain records, they've got to retain the ability to make good their case, however collaborative the system is.

And then you ask the question how often can they come back? Do you have a series of provisional awards? Now, again, the Republic of Ireland system does allow, I think, for awards of that nature. I think the figures are available in their reports as to how often that happens. I think it is a minority of cases. But you could do that.

The life expectancy issue is taken away in relation to anything you award a periodical payment award. So you can now precisely compensate someone for the length of their life because that's what a periodical payment does. But there is a choice to be made, and to put provisional damages as -- sorry,

provisional compensation in as a thing would mean that people remained a member of a scheme which actually they prefer not to be. I mean, people like the support payments because they carry on getting them, they don't have to do anything more about it, and I thought that's what would attract people. But, of course, you could have that option in there if you wanted. It would be a burden on the scheme. It would, therefore, cost the scheme more money and the issue is whether it would deliver more by way of justice to people and that's open to debate. But that's my reason for it anyway.

Q. In your report, if we could go back, please, to page 103, so we have got a table here at the bottom:

"Illustrative grid for an impact award by categories of severity."

So this is the injury impact element of your recommendations.

Again, important to understand these are not the figures that you are positively asserting should be used by the scheme. This is for the purpose of illustration as to how it might work; is that right?

A. Yes. Where I have a little more confidence in these as figures would be the upper end of it, in the sense that I sought to reflect what seemed to me to be the

reference point, being the maximum payments you are likely ever to get for pain and suffering, loss of amenity, as an award in a personal injuries case, and then, coming back a bit because, serious though these injuries undoubtedly are, they're not -- I'm afraid they are not the really, really most serious injuries. I mean, it is difficult to conceive, but they are not.

So one has to put that in the scale, because it does seem to me that whatever is awarded here should bear comparison with what, in this particular category, people might expect to get in litigation.

So that is the reference point. But the figures overall are illustrative rather than recommendations. As it has to be because I'm not judging it against any particular case.

Q. No. And on your model it would be the legal panel who would work out what the figure ranges should be in each of these categories?

A. Yes.

Q. One of the sources that you have suggested that they might wish to draw on are the Judicial College Guidelines?

A. Yes.

Q. Could we go to page 151, please.

First of all, could you just explain for the

benefit of those listening what the Judicial College Guidelines are.

A. Yes. Well, the Judicial College, as its name implies, is an organisation which trains judges. There was a time when it was thought judges were born to be judges and needed no training whatsoever. Fortunately we are now better advised than that and every judge has to go through some training.

But one of the College's functions it now performs, through a committee of experienced judges and lawyers, is to offer guidelines as to the amount of damages to be awarded for injury, and they do that by reference to decided cases, what the guidelines said before, and when new things come up they look at those, and then they set a range for each injury, as is described, and then that gets uprated for inflation every year until they look at it again.

So, on the bench, any judge who is trying a personal injury case would have a Judicial College Guidelines. They will be referred to other reference points as well but, by and large, it is the bold judge who goes outside the Guidelines for an injury that is mentioned in these Guidelines.

Now, of course, they don't cover every circumstance, as is illustrated by the sad facts we

have here, they don't deal with these particular injuries, but what lawyers do is, when it is a case like that, they look at something that probably produces a similar type of suffering and then they put that together. But one thing that doesn't happen is that if you have one accident, you have a broken knee and a broken hip and you look at the Guidelines, you don't necessarily -- you just add them up and get the total, because the suffering from the two, as we all know, if you have a pain from your knee and in your hip it all tends to end up as one pain, so you get a figure for the both together. So that is how it works.

Q. If we just take an example, if we go to page 160.

This is mesothelioma and then -- sorry, if we pick it up in the previous page just to make sense of it.

So we have "Asbestos related disease". There is then a description of the range of diseases that might be due to asbestos.

If we go over the page, we can see there, just in relation to the top half of the page, there is a range given there of just under £60,000 to £107,410. So would it be right to understand that the way in which these kind of guidelines might be used in the

assessment of damages, those representing the parties would look at them, the court would look at them and would then do their best to identify where within that range the individual case fell?

A. Exactly. By the way, the bold print is mine not the guidance, it is just I occasionally saw stuff that I thought would be worth drawing attention to.

The reason for including mesothelioma is it is a long lifetime condition with severe consequences, including death, but also producing the need for surgery, chemotherapy and radiotherapy and, therefore, is comparable to some of the treatment needed in our cases. As you see, the maximum there is 100 -- the figures are very peculiar and specific because they are the result of uprating for inflation. At some point it started off as a round figure and has now become artificially precise many might say.

Q. If you just go back to page 151. You have referred here to the 15th edition, 2021 edition of the Judicial College Guidelines. Now, you weren't, as I understand it, using this prescriptively in any event --

A. No.

Q. -- but I'm asked to explore with you because of the use of the figures made in your report and this, presumably whether it is the government looking at

your recommendations, the arm's length body setting up its scheme if one is commissioned, the panels looking at it or individual assessors they should guide themselves to the extent that they are going to look at the Judicial College Guidelines as a source and only one source, they should look at the most recent version?

A. Certainly. I'm not sure if the 2022 edition hasn't already come out.

Q. It has --

A. I think it came out more or less as I signed off this report, must to my --

Q. It came out in May, in fact, so a few weeks after your report.

A. You've got to stop somewhere. But you are absolutely right, we have to use -- or they should use the up-to-date editions. And indeed the figures -- where occasionally in these Guidelines a significant change is made other than the rate of inflation because there has been some case that has seen a different perception in something, and that would be one reason why any figures they come up with probably need to be kept under review.

Q. Would it also be right to understand that again, looking at it from the perspective of a court, for

present purposes being the principal user of these guidelines, that a judge, when deciding on the equivalent of the injury impact award, the general damages for pain, suffering and loss of immunity, will potentially increase further by reference to the current RPI?

A. Yes, I'm sorry. My pause is whether it is still the RPI or now something else, the CPI, the Consumer Prices Index. I think it depends.

Q. So the important --

A. But there is a rate -- clearly the rate of inflation -- we uprate these figures and we are now, unhappily, back in times of inflation being more than minimal, so this would be paid attention to in some detail in a court case, yes.

Q. And probably should be something that the scheme or the panel would themselves have in mind --

A. Yes, it probably would be possible to have in the rules of the scheme that it would automatically uprate things by that, by reference to whatever index they referred to.

MS RICHARDS: Sir, I note the time, perhaps a good moment for the afternoon break.

SIR BRIAN LANGSTAFF: Yes, that is a good point at which to break. 3.45 pm.

(3.14 pm)

(A short break)

(3.45 pm)

MS RICHARDS: Lawrence, could we have back on screen the report and go again to page 151.

This is just a follow-up to the discussion we were having on the Judicial College Guidelines, Sir Robert.

The footnote at the bottom of the page says this:

"The figures given in the table are those without the 10% uplift required in court based litigation to reflect the costs incurred by litigants in entering conditional fee arrangements, which are no longer recoverable as part of the costs of successful litigation. I suggest it is not appropriate in a scheme which is not intended to rely on unfunded legal representation to add such an uplift. If, on the other hand, it is accepted that in general legal representation comparable to that used in court proceedings will be required, then an uplift might have to be considered."

I just wanted to deconstruct that, if I may. As I understand it, and this is based upon information provided to me rather than my own knowledge, that's

something called the Simmons v Castle uplift.

A. I think you are right about that.

Q. That reflects a whole process undertaken by Rupert Jackson -- not just Rupert Jackson -- and others to deal with the way costs might be recoverable in personal injury claims.

A. Yes.

Q. I do not think we need to go into the detail of it. There was a rough and ready 10% uplift on general damages to reflect the possibility that solicitors may take a success fee from their clients' damages.

A. Yes.

Q. I'm told by those far more experienced in this particular issue than I am, it is not now the general experience that solicitors take such success fees out of their clients' damages, and that's now being reflected in the most recent edition of the Judicial Studies Board's Guidelines, the 16th edition, where the column which omits the 10% uplift has been removed because there are effectively now no longer any cases running under those old condition fee arrangements. The current -- the more recent Judicial Studies Board Guidelines figures treat as the normal general damages figure the figure which includes the 10% uplift.

A. It includes the figure?

Q. Yes, that's what I'm told. It may be that you --
A. I'm sorry, I perhaps should declare for the sake of transparency that I actually retired from full-time practice two years ago, so for that reason rather gladly I have not kept as up to date as I might, but -- and I certainly haven't looked in detail at the 2022 figures. If, in fact, solicitors no longer take costs which were intended to be reflected in the 10% uplift, then I would expect that uplift to go rather than be included in whatever the figures are left.
Q. I can perhaps pick it up over night by checking the 2022 guidelines and see if the position is clear.
A. Maybe I can do the same.
SIR BRIAN LANGSTAFF: Yes, I mean, there's an option which is that I think we have in the room somebody who is part of the panel which compiled the damages, and if so I would certainly give permission for him to talk to Sir Robert and Sir Robert to talk to him if that were thought advisable over the break.
MS RICHARDS: It may not surprise you to know, sir, that it is Mr Snowden who asked me to raise this point.
SIR BRIAN LANGSTAFF: In which case he might be the appropriate person to -- (overspeaking) --
MS RICHARDS: The short point being that effectively, in addition to the RPI and taking the figures from the

most recent Judicial Studies Board Guidelines, the suggestion is that essentially the figures should have the additional 10%.

Perhaps I can put that out there as the point that I have been asked by Mr Snowden(?) to ventilate publicly and we can come back to it if necessary, if Sir Robert and I are, respectively, better informed in the morning.

Can I just come again briefly to the social impact award.
A. Yes.
Q. If we go to the report, page 108. I asked you some questions earlier about the way in which the social impact award might be approached. I just wanted to flag up, again really just so that those following can understand, that your recommendation is that two matters to be reflected in the social impact award is interference with the ability to form a marriage, partnership or equivalent long-term relationship and then, over the page, the loss of chance to have children?
A. Yes. I should say, on re-reading this, the report is not as clear as it could be on whether that should be part of the social impact or the autonomy award, but there is a potential, I think, for overlap there. But

I think -- and you could put some of these in either but maybe more accurately they are social impact, which is where they are in this section.
Q. But either way, again, when -- on your model, when the legal panel is identifying the range of tariffs, your suggestion is that there should be reflected --
A. Yes.
Q. -- these losses.
A. And again, these are figures which no one would see -- claim -- reflect the reality of people suffering that are nominal, that -- and it would seem to me there is no case for them being very different from that which you get in a court hearing.
Q. Can I then, if we go to the bottom of the page, just pick it up with the care award. So, again, this is an element of the award that could be claimed by an infected person.

If we go over the page top of the next page. Page 110, please. You identify in paragraph 9.62 that the need an incidence of the care required may be very variable. So this isn't a one-size-fits-all type of award, some people might have had very extensive needs, some might have had comparatively limited needs for care.

Then you have set out below how the court would

approach a damages claim. I just wanted to pick it up at the bottom of that page, 9.65, read that and read over the page and then I'll ask you perhaps if you could explain a little more of what's set out here and why you make the recommendations you do.

So you have said here:

"In deciding how to approach the issue of compensation for care given, it is relevant to note the complexity involved in calculating such an award in court proceedings. As an examination of the AA case will show, it is common practice for care experts, often qualified nurses or occupational therapists who run care agencies, to be instructed to interview the injured person and their family and to obtain highly detailed accounts of the history of their needs over time. They will then analyse that evidence, which can be extraordinarily detailed, to identify separate periods of differing need. Sometimes they will go into minute detail, for example considering the month following a spell in hospital, or a period when the injured was away at school. Then, in respect of each such period, the expert will calculate the type of care required (eg nursing, gardening, DIY), the number of hours, and the appropriate commercial rate. The rate may differ

according to whether the care is daytime or night care, itself divided into 'sleeping' or 'non-sleeping' care, or for 'unsocial' hours such as when care is required at weekends or public holidays. The exercise is then repeated for the predicted future needs of the insured person."

Just pausing there. In a large personal injury claim in court, is it right to understand there would be potentially rival care experts, each performing the task that you've described here, hugely long reports, schedules, itemising every aspect of care and seeking to quantify it, and then the expert on the other side tries to chisel away at that and suggests, "You don't need that number of hours", and, "You don't need that degree of qualification", and so on?

A. Absolutely. And one the reasons for that, putting it bluntly, is that often in catastrophic injury cases the claim for care is the biggest item of the claim, and I can envisage cases in this field where that could be the case. But you are right, it has always been a surprise to me that after many years of practice we still have experts giving evidence to the claimant, another one giving expert evidence for the defence, both looking at the same set of facts, one would have thought, and both coming up with radically different

figures on absolutely every aspect: how many hours there should be, what the rate should be, what grade of nurse is required and so on.

Having undertaken that exercise, and this is perhaps the cynical lawyer coming in, you would be surprised at how often the figures come out rather the same in every case because the judges take a view, as they have to when expert evidence is provided, and a great deal of resource is undertaken and I think often at some distress to the families I have represented because the intrusion into their lives by two experts poking around, putting it bluntly, into every aspect of what they do and why and when can be in itself distressing when, as I have suggested here, I think for a scheme like this it ought to be possible, again with the exception -- I know I'm loading a lot on the medical panel here -- but may be extended to this purpose -- the care need of people with a particular condition should be capable of a fairly standardised approach, I would say, even if that means people don't get such a detailed assessment but it might not be quite as much -- some people might get more than they would expect but it is an area classically which shows why we need a compensation payment scheme which has a slightly -- has

a broad-brush approach to the thing rather than a detailed bespoke assessment for each individual.

Q. The advantage of the more broad-brush approach that you've go on to outline the following two perhaps, which I will read in a moment, is speed --

A. Yes.

Q. -- it is a quicker approach than having someone minutely analyse what could be decades of care and produce a report in relation to it?

A. I wouldn't by any means wish to compare it, but just as an indication if you went right to the other extreme you could adopt an approach similar to what social security does about attendance allowance. So broadly speaking there is a rate for someone who needs care during the day and another one if you need care during the night or if you have a mobility issue or not. Now, I'm not for a moment suggest something those are the figures, but it is a way of compensating people for those needs, and I would have thought -- my suggestion is that a similar -- you know, a more bespoke approach to this particular disease or these two diseases could be taken or different stages in the disease.

Q. If we just look at what you say in 9.66 and 9.67:

"It is suggested that to conduct such an exercise in the case of each applicant infected

under a compensation scheme would defeat the ambition of most to have a scheme which is simple to understand, and prompt in its determinations. It is necessary to devise a method of offering a fair, if broad brush, reflection in any award of the need for care generally experienced by the infected both in the past and present. An option could be made available enabling an applicant to choose between accepting the broad brush sum, or undertaking a more detailed application as would take place in a civil action. Alternatively, it may be felt that settling a maximum applying to all within the scheme - except for the truly exceptionally severe cases - would promote equity/parity among the infected in this scheme.

"9.67 Whatever approach is taken, this is an area where the advantages of avoiding a demanding process involving detailed evidence and expert support suggest that a high degree of self assessment should be encouraged, but limited by reference to expert based standardised presumptions with regard to care needs and costs."

A. I say that because it is an area where, with appropriate questioning by appropriate people in the scheme, this as part of a collaborative approach, people on the whole are able to have an assessment

about how much extra time has been spent looking after an individual, how much they need by way of care, and what type of person, a qualified nurse or someone doing the cleaning, whatever it is, and then it should be possible to apply to that a standardised rate.

Now, I appreciate if you live in the south of England, probably care costs more than if you live in the north of England but somewhere it seems to me you need to take averages and some will do better than others but, on the whole, you are recognising a concept, bearing in mind whichever approach you take it is somebody's estimate, so even when you've got these sophisticated experts claiming a minute precision, that's their opinion, it's not necessarily what will happen in real life or will happen in the future.

Q. Can we look at it in this way, there might be three broad terms of information that would be required.

A. Yes.

Q. There would be an understanding that the scheme would have based on evidence, what evidence it could gather about the costs of care over the relevant decades.

A. Yes.

Q. There would be potentially based upon perhaps some advice from either the clinical panel or perhaps the

scheme itself getting just some general advice about care needs.

A. Yes.

Q. There would be an understanding in broad terms of the kind of tasks that might have to be performed for somebody who had -- somebody who was being nursed at home having had a liver transplant or somebody in the last stages of AIDS or with pneumonia or whatever. So you would have that kind of information and then you'd have the individual's account saying, "My partner in those periods of years looked after me", you know, "day in day out or would look after me for a couple of afternoons a week", or whatever it might be --

A. Yes.

Q. -- and you could bring those three together in a hopefully practical and straightforward way?

A. Yes. And, if I may say so, that's something that lawyers in these cases do all the time but it would be much quicker to do if you have that sort of information but largely standardised information to go on to which you apply the individual circumstances of the claim.

Q. It's a bit rough and ready. It's a bit broad brush but the advantage is it's potentially quicker, it's potentially more straightforward and it's less intrusive.

A. And I can imagine -- the reason I put in -- this is options -- it does seem to me there could be cases of very severe cases indeed where it would be unjust to limit the claim, as it were, in this sort of way and someone who, for instance, needed 24-hour specialist nursing care with equipment in the house and so on that that was being provided by a member of the family, the only proper way of compensating that might be thought to be this more detailed bespoke system. But I think there would need to be -- the scheme would probably need to be persuaded that was the just thing to do in that particular case. I mean, it would certainly be, unless I misunderstood entirely the situation here, the minority of cases.

SIR BRIAN LANGSTAFF: You would have to have some ability to deal with those cases who had residential or a degree of care.

A. Yes.

SIR BRIAN LANGSTAFF: And probably several more cases where the existing carer needed respite.

A. Yes. Well, a lot of that would come under the financial loss because that would be what the claimant would actually need to pay for in some shape or form. So this care that I'm talking about here is not the care that has been paid for, that is a separate claim,

but the care is provided by relatives and so forth gratuitously.

Unhappily, my experience is relatives are often having to provide care which would be much better done by a professional. But that's the nature of what they are seeking to compensate people for, yes.

MS RICHARDS: Can I then turn to what is probably the final topic of today, the financial losses for those infected?

If we could go to page 114, please. Again, I'm not going to read out the section but you talk in this next section of the report about the status of support payments, and you refer to many of those who you spoke to wanting the support payments to continue.

How would you propose that working in practice?

A. Well, what I'm suggesting is that the support payments, with some adjustments, would continue as they are at the moment, as support payments, and they would be guaranteed for the lifetime of the applicant.

I do that because there was a very strong representation to me that people did not want to lose that security and certainty. So I could have said, and I obviously thought about saying: stop the support payment, everyone is now going to get compensation which would cover the sorts of things that the support

payment might be expected to cover, remembering that of all the -- there are -- various reasons have been given for them, and part one of them is about lifting people out of poverty and presumably an element of care, but there is this general payment there.

It was a principle of mine, which I think was called for as well, clearly people do not want support -- sorry, the compensation scheme to leave them in a worse position than they were before. So it seemed to me that a starting point had to be that we carried on with the support payments as they were made. However, it did seem to me that whatever might be the position about taking account of the support payments that remained in the past that the other side of the coin, to carry them on in perpetuity for the future would be that they should be taken account of against any claim for financial loss -- future financial loss, and it might well be that in a lot of cases that would mean there would be no further claim, although the case Sir Brian was talking about where there was a need for a care home or permanent care that might well not be the case, there might be significant sums in excess of that.

So basically there would be a continuation with a base line of this is to cover the financial losses

in the future, not I should say to be taken away from -- it wouldn't be taken off against a personal injury claim, as it were, the impact loss, but would be taken account of in that way.

And as far as the past was concerned, for reasons I have set out here, it seemed to me it would be wrong to seek to take credit for payment -- support payments that have been made in the past whether it would be under -- since 2017 or the rather more sporadic payments made before then.

Q. If we just deal with future payments for the moment, and again although your report sets this out, it's a matter of such importance for those listening --

A. Sure.

Q. -- it's sometimes helpful to -- just to ensure that the position is clearly understood.

A person making an application under the scheme would, as an infected person, receive the injury award that we have talked about --

A. Yes.

Q. -- the social stigma award, may or may not have a care award depending on their particular circumstances, the loss of autonomy award. Those awards would be payable as lump sums and would be for the individual to apply as they saw fit.

They would then -- under the scheme that you are proposing, in terms of things going forward into the future, they would continue to receive the existing support payments.

You have recommended, I think, an uplift to those in paragraph 9.88 of your statement. It may be that would then, in terms of future losses, future financial losses be all that an individual receives, the ongoing support payments, but that you then identify that an individual might -- would be able to opt to bring a future loss of earnings claim essentially if that was going to exceed the support payments?

A. Yes, and maybe for other financial losses.

Q. Yes, absolutely. There might be other items of financial loss, of course.

If we just look at the bottom of page 116, please. Under the heading "Additional claims for loss of earnings", you say this, and here you are dealing with both past and future losses:

"It should be open to an infected person to claim for past and future loss of earnings, over and above the tariff sums described above, if they can prove an actual loss of earnings, net of tax, caused by an inability to work due to the infection, or

an illness or disability caused by the infection. If the evidence is available, the actual loss could be calculated and awarded. In respect of past loss of earnings calculate odd this basis, a lump sum should be awarded assessed on the actual loss incurred."

So the first question then would be for the assessor to form the view that there had, as a matter of fact, been a degree of loss of earnings, an individual has been significantly incapacitated and unable to work because of their infection, that presumably shouldn't be too great a hurdle to overcome?

A. No.

Q. Then it is the question of how you quantify that, and then you go on to deal with that in paragraph 9.95.

A. Yes.

Q. "In the absence of an employment record sufficient to make an assessment of the past loss of earnings, where an infected applicant can show persuasively that they have been unable to work, or have had a reduced earning capacity because of infection, reference should be made to relevant statistics, for example the national average earnings for that class of employment. Where the relevant category of employment for that applicant cannot be shown, or working out a

probably career path is speculative or disproportionately complex, to assess there should be a presumption that the applicant has lost income equivalent to the national median earnings."

Then you refer to data available from the office of national statistics.

Does that reflect in broad terms the approach that would be taken by a court assessing damages?

A. Yes. As is the case with care costs, cases can descend into extraordinary detail, can involve the employment of employment experts, who I think are now increasingly frowned upon, not as people or experts but their actual need to be in cases because there are pretty good figures out there as to what people can expect to earn in particular occupations, and sometimes it is possible to make that calculation on the basis of payslips people produce and they've got a consistent history and it's quite easy to see what has happened.

Obviously in other cases that is less so, so people will say, "I have been working in a particular managerial position but I lost a promotion because of my illness and if I'd got the promotion I would have earned so much more", so there is that sort of evidence, and then if there is uncertainty, of course, according to the case. Again, if we choose to you can

get as precise as you like about it or it is possible on the evidence but, again, my approach here has been to seek to encourage a scheme to approach things on a rather broader basis so people can get a swift solution without the need for hugely complicated figures and all the rest of it.

Q. Would there again be an element of choice that an individual might, for example, say, "When I was diagnosed with HIV and became ill or ill from my condition from the treatments I was receiving for it I had to give up my work as a teacher" --

A. Yes.

Q. -- and they can provide an indication of the income they were on, they can describe what they thought their career path would have been, probably with a degree of straightforwardness, and the calculation of past loss of earnings could be on the basis of what they have lost in those terms?

A. Yes.

Q. Alternatively, an individual could either not feel able to say exactly what would have happened, perhaps particularly for those infected when younger and before an employment and they could still bring their past loss of earnings claim but it would be assessed most likely in the way you have described here?

A. I think I dealt with that elsewhere, and certainly in the case of children who have no career history and so they have no period of their life with a working history not affected by their illness, then one almost certainly has to resort to some sort of overall average. The reason being that while -- you know, the children of Goldman Sachs bank don't necessarily end up as Goldman Sachs bankers, many of them go the very opposite way and become conscientious social workers. And rather less, likewise the children of social workers might become bankers, so you can't speculate about these things, you just have to take averages, and as with all such approaches it overcompensates some people and undercompensates others, but they at least get recognition for that particular loss, but that's true of the Common Law system as much as it would be here.

Q. Again, you have made this clear in your report and in your earlier evidence, but you would not propose past support payments to be deducted from those sums --

A. No. And I have set the reasons out for that. Principally because of the nature and the way in which these were described and formulated at the time, and if they are meant to be charitable payments, well, they are charitable payments.

Q. I have been asked to ask you about your use of the word "persuasively" in the second paragraph of 9.95. Does that suggest some higher burden or more cogent evidence that's required?

A. I think what I mean is that I would go back to the fact that I wouldn't suggest that there is a formal burden or standard of proof set out, which leads to legal complexity. But I would suggest that -- and I'm deliberately trying not to use legal language -- that an infected person should be able to show -- be persuasively assessed that they have been unable to work or had reduced earning capacity. Which, frankly, I don't think would be difficult in most cases.

But there will be cases of difficulty, where middle-aged adults have been unemployed for years for all sorts of different reasons and, you know, what would -- if they come along and suddenly say that they were going to be earning hundreds of thousands of year as an entrepreneur, it might be possible -- it would only be right for the scheme to question that.

What I'm trying to say is of course you should start off by listening carefully with respect to what the applicant says, but this is slightly different from an applicant coming forward with a history of what has happened as a matter of fact as opposed to

what this is, which would be expressing their opinion as to how well or otherwise they would have done. And to be quite honest, most of us probably had a slightly rosier-coloured view of our prospects in life than maybe others might think. Not all of us.

Q. You have talked here about the important role of the assessor --

A. Yes.

Q. -- and the need for a degree of proactivity, sympathy, understanding and the like, but in terms of what you are describing for the individual to make out a case as to why they are in category 1 rather than category 2 for the injury award or to explain why they might be entitled to the loss of relationship element of the social impact award, or to make out a claim for past gratuitous care provided by family members or loss of earnings, they're going to -- a lot of individuals are going to require help to do that, aren't they?

A. Yes. Well, I would hope, firstly, that the assessment system would be supportive and would be within it doing its best, as it were, to produce the case for and with the applicant. You are right, this is not necessarily easy stuff, you know, any more than filling in your tax return is easy stuff for all people, but guided through

a process it seems to me that most people should be able to do that.

Now, obviously, there will be cases of significant complexity where some form of outside help -- and I have advised or recommended that there should be a sort of advocacy support system and, of course, some people will have their own legal representatives, but I'm deliberately trying to suggest that this should be as least legalistic as is possible, but I don't think we can avoid it in all cases. And some cases people's circumstances vary significantly, but some people's cases in financial terms are much simpler than others. So it is not necessarily everyone who will need outside support but most people, I would accept, will need internal support from the scheme about putting their claim together, and it can't just be a matter of asking someone to fill in a form online at home and hope for the best. I just don't think that's going to work. You need a process of interview, collaboration and conversation, all taking time but one would hope less time than having to repeat that umpteen times, which is what would happen in litigation.

MS RICHARDS: Sir, I'm going to move to another topic and I'm going to suggest, therefore, that we do that in

the morning when everyone is fresh and hopefully the room might be a bit cooler.

SIR BRIAN LANGSTAFF: Yes, well, it has been a very warm day for lots of us. So let's break now and come back at 10.00 am. So 10.00 am tomorrow for the next set of questions. 10 o'clock.

(4.22 pm)

(The Inquiry adjourned until 10.00 am on Tuesday, 12 July 2022)

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