

1 **Monday, 11 July 2022**

2 **(10.00 am)**

3 **SIR BRIAN LANGSTAFF:** Good morning, Sir Robert.

4 **THE WITNESS:** Good morning, sir.

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

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

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

18 So, much for today. We all know it is hot  
19 today. The hearing room is deliberately set at  
20 a fairly low temperature to allow people to  
21 concentrate all the better, but it may well be that  
22 you may wish to go out and bring in water and drink it  
23 in the room. That's entirely acceptable. Please feel  
24 free to do that. The last thing I would want is  
25 anyone to feel that the heat was in any way affecting

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1 NHS in England.

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

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

5 **A.** Yes.

6 **Q.** And you are Chair of Healthwatch England.

7 **A.** Yes.

8 **Q.** What is that exactly?

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

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

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

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

25 **A.** Yes.

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1 them. If you do so, please do avoid disturbing your  
2 neighbour, it is important for evidence like this that  
3 everyone should be able to concentrate and so bear in  
4 mind that. If you feel the need to talk to your  
5 neighbour, do so, please if you can in a way that  
6 doesn't disturb the concentration of those around you.  
7 That's enough of the headmaster from me. So Mary.

8 **SIR ROBERT ANTHONY FRANCIS (sworn)**

9 **Examination-in-chief by MS RICHARDS**

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

13 **A.** Yes.

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

15 **A.** Yes.

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

19 **A.** That is correct.

20 **Q.** You chaired the public Inquiry into Mid Staffordshire  
21 NHS Foundation Trust, which I think began in around  
22 2010 and reported in 2013.

23 **A.** Yes.

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

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

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

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

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

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

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1 Inquiry, or cut across the Inquiry's findings. The  
 2 study shall provide the Paymaster General with advice  
 3 on potential compensation framework design and  
 4 solutions which can be ready to implement upon the  
 5 conclusion of the Inquiry should the Inquiry's  
 6 findings and recommendations require it.  
 7 "The name of the independent reviewer will be  
 8 announced shortly."  
 9 That is the initial statement and that is  
 10 a broad description of what it is you then became the  
 11 independent reviewer to undertake.  
 12 A. Yes. I should say, at the time of this announcement,  
 13 I frankly paid little attention to it and I certainly  
 14 haven't been contacted at that point.  
 15 Q. Then if we go to RLIT0001138. I don't need to read it  
 16 aloud, but it is just to give us a date. This is  
 17 an announcement on 20 May 2021 and this announced your  
 18 appointment to undertake the study that had been  
 19 described in the Paymaster General's previous  
 20 statement?  
 21 A. Yes.  
 22 Q. Now the terms of reference for your study are at  
 23 RLIT0001125. I'm not going to read them aloud, I'm  
 24 just going to identify the headings. So:  
 25 "Rationale for compensation."

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1 Paymaster General, all of which, from recollection,  
 2 were accepted and were in this document.  
 3 Q. So these terms of reference built on an initial draft  
 4 produced by the Paymaster General --  
 5 A. Yes.  
 6 Q. -- but reflect your own thinking --  
 7 A. Yes.  
 8 Q. -- and the input of those during the consultation?  
 9 A. Yes.  
 10 Q. Then if we then can just pick up a subsequent key  
 11 dates and course of events. First of all at  
 12 RLIT0001132, please.  
 13 This is a statement made on 23 September 2021 by  
 14 Ms Mordaunt's successor as Paymaster General,  
 15 Michael Ellis.  
 16 We can see if we go a little further down the  
 17 page, under the heading "Statement", I'm not going to  
 18 read this aloud, but it describes the process of  
 19 formulating the terms of reference, and explains in  
 20 the third paragraph that the Paymaster General is  
 21 happy to accept Sir Robert's recommendations in full  
 22 as to what the terms of reference should be.  
 23 Then, if we just go to the third page, please,  
 24 Lawrence, to pick up the last paragraph of the  
 25 statement, the Paymaster General says this:

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1 "Independent advice to Government.  
 2 "Scope of compensation.  
 3 "Categories of injury and loss.  
 4 "Types of award and method of assessment."  
 5 Over the page:  
 6 "Measures for compensation.  
 7 "Relationship with current schemes.  
 8 "Options for administering the scheme.  
 9 "Other issues.  
 10 "Reporting to the Government by February 2022",  
 11 which I think was subsequently put back by two weeks  
 12 to the middle of March 2022.  
 13 A. Yes.  
 14 Q. So those were your terms of reference. How were those  
 15 terms of reference drawn up?  
 16 A. Well, the Paymaster General issued some, as it were,  
 17 draft terms of reference for consultation, and the idea  
 18 was that I should hold a consultation and then make  
 19 recommendations about the final terms of reference.  
 20 That I did.  
 21 It is fair to say that the time for consultation  
 22 was relatively short because the job appeared to be  
 23 urgent but I did receive a number of representations  
 24 from Core Participants at this Inquiry and others, as  
 25 a result of which I made recommendations to the

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1 "I, like my predecessor, am deeply committed to  
 2 ensuring that Sir Brian Langstaff's Independent public  
 3 inquiry has all the resources it needs to complete its  
 4 work; in Sir Brian's words, 'as quickly as  
 5 thoroughness permits'. The infected blood scandal  
 6 continues to claim the lives of infected people, and  
 7 those directly affected have waited too long for  
 8 answers, and for justice."  
 9 So that is the statement made as at  
 10 23 September 2021. You then embarked upon your work.  
 11 Just so that there is no doubt or misconception about  
 12 your role. You undertook your work entirely  
 13 independent of Government?  
 14 A. I did.  
 15 Q. You were essentially asked as an experienced lawyer to  
 16 come up with a review of what might be a fair and  
 17 proper compensation scheme?  
 18 A. Yes. Obviously one of the challenges being that it was  
 19 very dependent upon the findings of this Inquiry,  
 20 which, of course, it was a bit of egg before chicken,  
 21 if that's the right expression, about it.  
 22 Q. The aim of doing that way, as I understand public  
 23 statements, and please correct me if this is not your  
 24 understanding, is to try and ensure that essentially  
 25 as soon as the Inquiry has reported, if the Inquiry's

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1 recommendations and conclusions essentially invite  
 2 compensation, that the work would already have been  
 3 done to then enable that to be established as soon as  
 4 possible.  
 5 A. Yes. I think it fair to say I regarded my task as to  
 6 try and produce a framework of compensation independent  
 7 of this Inquiry and I think the text of my report  
 8 probably shows that. But, yes, you are correct.  
 9 Q. To what extent did financial or economic factors for  
 10 affordability play any part in your decision-making?  
 11 A. Only in very broad terms. I deliberately did not go  
 12 into detail into figures. I sought to have regard to  
 13 proportionality in relation to balancing the perceived  
 14 wrongs and injuries inflicted on people and to have  
 15 regard to other forms of compensation. But I did not  
 16 take -- look at, as it were, physical issues as to what  
 17 might or might not be affordable by the government.  
 18 Q. Is it right to understand you weren't given any sum or  
 19 cap with which to work by the government?  
 20 A. No, I was given a blank piece of paper.  
 21 Q. Then, in broad terms, can you explain how you set  
 22 about your task?  
 23 A. Well, I thought, first and foremost, it was extremely  
 24 important to have regard to the -- this is what I do in  
 25 Healthwatch England is having regard to the lived

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1 Care or anyone else in government as to what your  
 2 recommendations should be?  
 3 A. None at all. That is not to say there weren't  
 4 communications, as I think is clear from the report.  
 5 I did meet officials in the Department of Health, NHS  
 6 resolution and organisations like that in order to  
 7 establish what was happening and what had happened in  
 8 the past.  
 9 Q. Were there any representations from any of the  
 10 devolved governments as to what your recommendation  
 11 should be?  
 12 A. No, except to the extent that there was an anxiety  
 13 expressed, at least some of them to be involved, if  
 14 I can put it in that way. They recognised that I was  
 15 principally looking at the situation in England but  
 16 they wanted what was happening in the devolved  
 17 administrations taken into account. But certainly  
 18 there were no suggestions made to me as to what my  
 19 recommendations should be.  
 20 Q. Can we then just pick up a further few dates.  
 21 You delivered your report on 14 March 2022 to  
 22 the Paymaster General.  
 23 A. Yes.  
 24 Q. Then if we look at RLIT0001137. This is a statement  
 25 made by Mr Ellis, the Paymaster General and minister

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

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

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

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

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

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

14 I will just look at a handful of documents with  
 15 you, Sir Robert, and then just pick up on the issue of  
 16 government response. So that is a statement on  
 17 15 March.

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

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

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1 our response. That work is already underway.  
 2 "I recognise how important it is for the Inquiry  
 3 and its core participants to have sufficient time to  
 4 consider the study before Sir Robert gives evidence to  
 5 the Inquiry. It is my intention to publish the study  
 6 alongside the Government's response as soon as  
 7 possible."  
 8 So that is 22 March.  
 9 If we then pick it up at RLIT0001134. This is  
 10 27 April, bottom of the page. It is in response to  
 11 a question from Ian Lavery MP. It is the same message  
 12 on 27 April:  
 13 "Ongoing funding of the Infected Blood support  
 14 scheme payments is a matter for the Department of  
 15 Health and Social Care.  
 16 "I recognise how important it is that the views  
 17 of infected and affected people are reflected in  
 18 Sir Robert's study."  
 19 Then there is reference to consultation for  
 20 those infected and affected.  
 21 Then the last sentence:  
 22 "It is my intention to publish the Study and the  
 23 Government response, in time for the Inquiry and its  
 24 core participants to consider them before Sir Robert  
 25 gives evidence to the Inquiry."  
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1 it before it was formally produced at this hearing  
 2 today. So there was a sort of outside time limit for  
 3 it. You would have to ask the Government about the  
 4 detail of what happened in the immediate time. I only  
 5 have sort of third-hand hearsay about that.  
 6 Q. We will. Just to bring it up to date, RLIT0001135.  
 7 This is again Mr Ellis, if we go to the bottom of the  
 8 page. This is in response to a question from  
 9 Lisa Nandy MP. This is on 20 June 2022. There is  
 10 reference to you giving evidence in the second  
 11 paragraph and then it says:  
 12 "The Government is considering Sir Robert's  
 13 recommendations and it is most important that the  
 14 government is able to reflect upon Sir Robert's  
 15 evidence and the evidence of others to the Inquiry as  
 16 part of that consideration."  
 17 So it appears that, as between the end of April  
 18 and this date in June, the Government's position has  
 19 shifted from publishing the response as well as your  
 20 study in time for you to give evidence to simply  
 21 publishing your study. Have you had discussions with  
 22 Cabinet Office or anyone else in Government that would  
 23 throw any light on why the Government has decided to  
 24 take that course?  
 25 A. No, the only meeting I've had with Mr Ellis was on the  
 15

1 So that is the position as at the end of April.  
 2 Now, your report was ultimately published on or  
 3 around the second week of June of this year, so some  
 4 weeks after the report had been provided by you to the  
 5 Cabinet Office. As I understand it, the published  
 6 report is in the same form as the report which you  
 7 submitted. There are some minor textual matters about  
 8 referencing and watermarks and so on --  
 9 A. Yes.  
 10 Q. -- but the content of the report is the same.  
 11 A. It is, and I have to say, given more time  
 12 retrospective -- having read it again for today, there  
 13 are no substantive changes I would make, but the  
 14 presentation wasn't as good in terms of headings as it  
 15 might have been, for which I apologise.  
 16 Q. Do you have any understanding or knowledge as to why  
 17 you having delivered the report in the middle of  
 18 March 2022 the Cabinet Office didn't publish it until  
 19 June 2022?  
 20 A. It was always intended I think that the Government  
 21 would take time to consider the report and publish  
 22 a response at the same time as they published the  
 23 report. I think that -- and in terms of how long that  
 24 was going to take, it was clear that the report had to  
 25 be published in time for interested parties to consider  
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1 day I handed in the report, at which point, obviously,  
 2 he had nothing to say about it, apart from thanking us.  
 3 Q. Then the most recent I think communication of the  
 4 Government's position, and this is really just to  
 5 complete the chronology of events and put matters into  
 6 the open, rather than the focus of any question for  
 7 you, Sir Robert, but it is JEVA0000129.  
 8 This is a letter from Mr Ellis to Factor VIII  
 9 campaigning organisation. We have seen I think  
 10 letters in similar terms around this time to others,  
 11 but this happens to be dated 30 June and the second  
 12 report reads:  
 13 "I would like to emphasise that there is a great  
 14 deal of complexity to the issues covered in  
 15 Sir Robert's study. At present, officials from across  
 16 Government are conducting a thorough analysis of the  
 17 report and its recommendations; that analysis requires  
 18 careful and diligent work given the very many factors  
 19 that must be taken into account. I should note that  
 20 Sir Robert is due to give evidence to the Inquiry on  
 21 11 and 12 July. Following his appearance at the  
 22 Inquiry, officials will also need to factor in his  
 23 oral evidence as well as the recall evidence of others  
 24 appearing at the Inquiry."  
 25 Sir Robert, do you know -- I suspect the answer  
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1 to this is probably "no", in light of your earlier  
 2 answers, but do you know what oral evidence of others  
 3 is thought by the Cabinet Office to be particularly  
 4 relevant to their consideration of your report?  
 5 A. No, I'm afraid I don't.  
 6 Q. In terms of those with whom you have dealt at the  
 7 Cabinet Office, I think your statement tells us you  
 8 met Ms Mordaunt once and Mr Ellis once; is that right?  
 9 A. Before the publication of the report and then there was  
 10 our meeting with Mr Ellis on the presentation of the  
 11 report, which was obviously afterwards, after the  
 12 report was prepared.  
 13 Q. Again in terms of the question of what your  
 14 recommendations should be or might be, have you had  
 15 any dealings with any civil servants within the  
 16 Cabinet Office as to what the content of your report  
 17 should be?  
 18 A. No, the only contact I have had with the Cabinet  
 19 Office, including senior officials in the Cabinet  
 20 Office, has been about administrative matters.  
 21 Q. I just want to pick up on the question of your  
 22 recommendation for interim payments.  
 23 A. Yes.  
 24 Q. We will come back to some detailed issues relating to  
 25 the scope of that recommendation at a later stage.

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1 Then if we turn to page 29, please. Top of the  
 2 page, paragraph 2.69 you say:  
 3 "There is a compelling case for awarding interim  
 4 payments as soon as possible to the infected who have  
 5 already been accepted as eligible for the support  
 6 schemes. Many wish to be able to settle their affairs  
 7 before they die. Challenging though it is to do this  
 8 before the scheme has been set up and is fully  
 9 operational, and before the conclusions of the Inquiry  
 10 are available, I suggest that such a payment should be  
 11 made now reflecting the minimum any infected person  
 12 could be expected to receive under the scheme. I have  
 13 suggested this is unlikely to be less than £100,000 in  
 14 any case. Naturally, any such payment would be on  
 15 account of any final award, and may suffice for some  
 16 who might not wish to proceed further."  
 17 Then if we go to page 122. Under the heading  
 18 "Interim payments" you set out, in paragraphs 9.128  
 19 through to 9.137, in a little more detail your  
 20 thinking about the issue of an interim payment, and  
 21 referring, in particular in paragraph 9.128, the fear  
 22 of many that they have not got long to live.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 A. Yes.

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

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

23

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

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

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

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

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

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

22

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

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

6 A. Yes.

7 Q. Likewise hepatitis D which is --

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

9 Q. Yes.

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

11 Q. You then did not include vCJD.

12 A. No.

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

16 A. Yes.

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

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

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

24

1 with at the bottom of this page -- I'm so sorry, next  
 2 page.  
 3 So you set out -- paragraph 2.13 -- four  
 4 "conditions for eligibility for the directly  
 5 infected": diagnosis with hepatitis C or HIV.  
 6 Over the page, condition 2 is:  
 7 "the applicant received one or more blood  
 8 transfusions or blood products known to be capable of  
 9 transmitting one or more of the relevant diseases ..."  
 10 3 is:  
 11 "the applicant received the relevant treatment  
 12 within - or from stocks created within - the periods  
 13 of eligibility employed by the current support  
 14 schemes,  
 15 "OR ..."  
 16 As an alternative, a different period.  
 17 I will come back to that again, Sir Robert, in  
 18 due course.  
 19 Then, 4:  
 20 "the applicant's infection was likely to have  
 21 been caused by the administration of a relevant  
 22 treatment."  
 23 So those are the four conditions for eligibility  
 24 if directly infected.  
 25 Then paragraph 2.14 deals with "Indirectly

25

1 Q. You also recommend that carers may be able to make  
 2 a claim. That is paragraph 2.18. Again, we will  
 3 unpick the detail of that in due course.  
 4 Then at 2.19 you have suggested, is this right,  
 5 a residual discretion to the scheme to make awards to  
 6 other categories of affected individuals who don't  
 7 fall within those that you listed above?  
 8 A. Yes, the trouble with any definition of eligibility is  
 9 that there are likely to be cases that come out,  
 10 particularly in -- where there are complex social and  
 11 family situations. And it calls -- it is a potential  
 12 extension because probably at Common Law many people in  
 13 this category who suffered a mental injury wouldn't be  
 14 able to claim damages, for instance for negligence, but  
 15 it struck me that there were people, both in the more  
 16 clear eligible categories and this rather inchoate  
 17 category for whom there was a strong moral case for  
 18 compensation.  
 19 Q. In terms then of the types of awards, if we go to  
 20 page 23. So an infected individual or their estate  
 21 who is eligible, you have identified in paragraph 2.36  
 22 five components to the compensation: injury impact  
 23 award, and that's to reflect both physical and mental  
 24 suffering.  
 25 A. Past and future.

27

1 infected persons", so they would be those, for  
 2 example, who were infected through a sexual  
 3 relationship --  
 4 A. Yes.  
 5 Q. -- by a partner.  
 6 Then, in terms of proof of eligibility, we will  
 7 come back to that, but you have urged a sympathetic  
 8 and sensitive attitude without rigid adherence to  
 9 legal concepts of proof.  
 10 If we go then further down the page. You  
 11 anticipate at 2.16 that the "Estates of deceased  
 12 infected persons" may be able to claim.  
 13 A. Yes.  
 14 Q. Then "Eligibility for affected persons". Is it right  
 15 to understand, you have recommended widening the  
 16 categories of those who may currently claim?  
 17 If we go over the page, you suggest  
 18 an entitlement to claim to those in a marital or  
 19 comparable relationship, children of infected persons,  
 20 parents of an infected person and siblings of  
 21 an infected persons.  
 22 There are some qualifications in relation to  
 23 those, which I will come back to, but in broad terms,  
 24 those are the principal categories of the affected.  
 25 A. Yes.

26

1 Q. "A social impact award for past and future stigma and  
 2 social consequences;  
 3 "A care award for past and future paid and  
 4 unpaid care ...  
 5 "An autonomy award for the aggravation of the  
 6 distress and suffering caused by the direct physical  
 7 and mental impact, through interference and family and  
 8 private life and autonomy;  
 9 "A financial loss award for past and future  
 10 financial losses."  
 11 A. Yes.  
 12 Q. Now, again, obviously we will look at these in a lot  
 13 more detail in due course, but would it be right to  
 14 understand that the social impact award and the  
 15 autonomy award are not regular features of damages  
 16 payments in a claim, for example, for negligence?  
 17 A. No, exactly, and they may, as defined in this report,  
 18 to some extent overlap --  
 19 Q. Yes.  
 20 A. -- a little bit with each other and there may need to  
 21 be, I think looking at this, further work done about  
 22 how you define this. But it seemed to me that to be  
 23 bound by the categories of damages recognised in Harvey  
 24 McGregor's law of damages would be too limiting, and --  
 25 but if there's to be a compensation scheme, that there

28

1 was an opportunity to look at things in a slightly  
 2 different way to reflect the real injuries that people  
 3 were telling me they were suffering from.  
 4 Q. Then, in terms of those who are affected, the eligible  
 5 affected, the components of the awards for that  
 6 category would be:  
 7 "An injury impact award for past and future  
 8 physical and mental injury caused by their experience  
 9 of the relevant infection, its consequences and/or the  
 10 death of the infected person, where a recognised  
 11 consequence of a close and established association  
 12 with the infected person ..."  
 13 So would it be right to understand that that's  
 14 not going to necessarily be an award that's payable to  
 15 every affected person? Does it require --  
 16 A. No, it wouldn't.  
 17 Q. So it would require evidence of some --  
 18 A. It requires proof of some injury in that category, yes.  
 19 Q. Again, we'll --  
 20 A. Yes.  
 21 Q. -- unpick that in due course. But the "social impact  
 22 award for stigma and social consequences", you  
 23 identify for the affected.  
 24 A. Yes.  
 25 Q. A "family care award", and that would be as

29

1 takes it as a lump sum or a periodical payment, that  
 2 should be a choice for applicants.  
 3 Again, for those who may not be familiar with  
 4 the terms, periodical payments are what?  
 5 A. Periodical payments are instead of receiving a lump  
 6 sum, which reflects both past and future losses, it is  
 7 a payment by definition to recover future losses which  
 8 on the whole are thought to be regular, and they have  
 9 to be ordered by the court in a damages claim but they  
 10 are these days in serious cases very frequently used to  
 11 spread the payments over a period of time. They are  
 12 always uplifted for inflation. They are guaranteed for  
 13 life. It has the advantage of regularity of income and  
 14 it also has the advantage of assurance of security of  
 15 the payment, which, of course, a lump sum doesn't  
 16 because if you have a lump sum, then you have to work  
 17 out how to invest it, and anyone looking at the  
 18 newspapers in the last few weeks will understand how  
 19 risky that can be.  
 20 Q. But, importantly, would it be right to understand one  
 21 of the reasons you say this should be a choice for the  
 22 applicants is, in a sense, caught up with the idea  
 23 again of autonomy --  
 24 A. Yes.  
 25 Q. -- for those for whom they perhaps have been given

31

1 an alternative to the care award claimed by the  
 2 infected person?  
 3 A. Yes, and also instead of, I suppose, the separate award  
 4 for care that might be for someone who wasn't otherwise  
 5 eligible but had provided care.  
 6 Q. "A bereavement award payable to defined family  
 7 members ..."  
 8 A. Yes.  
 9 Q. And:  
 10 "A bereaved family loss award to redress loss of  
 11 dependency."  
 12 Now, again, I'll need to come back to this in  
 13 more detail, but just so those listening can  
 14 understand the term there, what do you have in mind  
 15 where you refer to "loss of dependency"?  
 16 A. The bereavement award was intended by me to be the  
 17 equivalent of what is awarded under the Fatal Accidents  
 18 Act as a nominal and, some people would say, unduly  
 19 small sum of money, but it reflects the fact of the  
 20 loss and bereavement. The family loss award was more  
 21 about, in effect, the financial losses families will  
 22 suffer because of the death of the infected person.  
 23 Q. If we just go over the page, in terms of some other  
 24 elements of the scheme that you are recommending. You  
 25 suggested that, in terms of whether the individual

30

1 little choice over decades this is something where  
 2 they could exercise a degree of autonomy?  
 3 A. Yes. That will have to be subject, I think, to some  
 4 definition around what periodical payments can be for,  
 5 because it is not every item in a damages claim that  
 6 would qualify for a periodical payment, but, yes,  
 7 that's correct.  
 8 SIR BRIAN LANGSTAFF: I think, am I right in thinking,  
 9 that in making this recommendation you are looking at  
 10 the nature of the award which reflect losses which are  
 11 periodic in their nature?  
 12 A. Yes.  
 13 SIR BRIAN LANGSTAFF: So it is not simply a choice of  
 14 either having a lump or your money spread over time,  
 15 you will get, as you do in Common Law damages, a lump  
 16 sum for whatever a lump sum is appropriate for and the  
 17 losses which would otherwise come over a period, every  
 18 week you would get earning which you don't get, every  
 19 week you pay out for a carer which you wouldn't have  
 20 to pay, for treatment which you wouldn't have to pay  
 21 and so on, those losses are periodic in their nature  
 22 and they may be either brought together in one payment  
 23 in advance, if you like, which may be higher, may be  
 24 lower than what it actually costs or you may get it  
 25 over time uprated for the appropriate rate of

32

1 inflation?

2 A. Yes, sir, and I think it's probably worth also worth

3 making it clear that the assessment of the entitlement

4 is a once-and-for-all assessment.

5 **SIR BRIAN LANGSTAFF:** Yes.

6 A. That's the difference between that and a provisional

7 award, it's not revisited at a later date, but you know

8 at the date of the assessment you are going to receive

9 X pounds per year uprated for inflation for the rest of

10 your life. Or sometimes it is divided into periods.

11 The classic example would be in relation to care costs

12 where it's known as you get older or more disabled you

13 will need more care, so might be periods -- uplifts of

14 the actual amount over a period but that will all be

15 determined at the date of the first assessment rather

16 than constantly being revisited, so you get finality

17 but security.

18 **SIR BRIAN LANGSTAFF:** Picking up that point on finality,

19 the lump sum. For instance, let us suppose a lump sum

20 had been awarded in 1980 --

21 A. Yes.

22 **SIR BRIAN LANGSTAFF:** -- to someone, there would be no

23 opportunity, no right for the individual to come back

24 in 2020 and say, "That was 40 years ago" --

25 A. No.

33

1 below that you have suggested that a past waiver of

2 litigation rights shouldn't be a barrier to

3 compensation and that there shouldn't be a waiver of

4 litigation rights required to claim compensation.

5 I'll come back to what you say the interrelationship

6 might be between awards under this scheme, court

7 awards and indeed what account might need to be taken

8 of previous payments, current payments and benefits in

9 due course.

10 So that's the basic architecture of the

11 structure of compensation.

12 In terms of the scheme that would deliver it,

13 you considered a number of other schemes, and we will

14 look at some of them, but you considered the bespoke

15 individual assessment model that's used, for example,

16 in the Republic of Ireland under the Tribunal

17 established there --

18 A. Yes.

19 Q. -- and rejected that. Briefly, what was the reason

20 for rejecting that as the model?

21 A. Well, I come back to the message that was continually

22 given to me by those I spoke to and wrote to me, which

23 was the need for something that would happen quickly,

24 as quickly as possible. As I think I said somewhere in

25 the report, there was the conflicting demand, as it

35

1 **SIR BRIAN LANGSTAFF:** -- "it is a pittance compared to

2 what that sum would be worth now, please can I have

3 some more?" You can't do that?

4 A. No. Well, the theory in damages is that the recipient

5 of the damages invests wisely and, therefore, the money

6 keeps up with inflation but not necessarily changes in

7 circumstances, that's correct. That's the rough

8 justice, if you like, that the system of damages gives

9 us.

10 **SIR BRIAN LANGSTAFF:** As you pointed out, one advantage it

11 is said of periodical payments is that the risk of

12 a bad investment is shifted to the person who is

13 making the payment --

14 A. Yes.

15 **SIR BRIAN LANGSTAFF:** -- and it doesn't lie, as it

16 otherwise would, on the shoulders of the person who

17 has the money --

18 A. Yes.

19 **SIR BRIAN LANGSTAFF:** And may need to invest it wisely.

20 A. Yes, and my professional experience would be that

21 families who are in receipt of large lump sums worry

22 a great deal about that very fact and it is the

23 periodical -- therefore, they welcome the periodical

24 payments as a solution to that particular issue.

25 **MS RICHARDS:** We can see from the paragraph immediately

34

1 were, for something that was quick and easy to do but

2 also as detailed in terms of the recognition of the

3 individual as possible, and unfortunately the two

4 aren't necessarily compatible. The more detail the

5 best scheme is required to look into in relation to

6 individual circumstances, the longer it will take, the

7 more information that's required, the more evidence and

8 argument there can be.

9 Unfortunately, as is apparent, I was unable to

10 avoid all complexity. That's just impossible but the

11 idea was to try and produce something which had more

12 easily understandable categories into which you could

13 slot a case with perhaps the descriptions already

14 available about a particular individual but perhaps

15 leaving the choice in some areas that someone who

16 wanted a more bespoke assessment, say in relation to

17 financial loss, could proceed to get it, but penalty,

18 as it were, for that or the burden of that being it

19 was going to take longer, it would be more complicated

20 and their final determination by definition would take

21 a longer time.

22 Q. So the model you came up with is what you described as

23 a more standardised tariff-based model?

24 A. Yes.

25 Q. Again, just really by way of overview, you envisaged

36

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

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

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

19 A. Yes.

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

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

37

1 Q. -- assessed at large?

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

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

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

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

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

21 A. Yes.

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

25 A. Yes.

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

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

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

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

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

40

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

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

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

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

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

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

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

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

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

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

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

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

25 Happily, or perhaps happily in a way, there are

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1 particular purpose.

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

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

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

13 A. Yes.

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

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

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1 quickly as possible, and the more you become involved  
 2 in a legal process the less chance you have of doing  
 3 that.  
 4 Q. And your suggestion is that this scheme should  
 5 essentially be administered by an arm's length body?  
 6 A. Yes.  
 7 Q. So a body distinct from any government department?  
 8 A. Yes. Arm's length bodies hold -- I should say they are  
 9 not politically popular in all quarters because it is  
 10 another bureaucracy, it costs money to set up. It  
 11 seemed to me that the need of this particularly group  
 12 of people were such and the need for independence from  
 13 government was such that an independent body was  
 14 needed, which, of course, is funded by the government  
 15 and ultimately there is a form of government oversight  
 16 of it, but legally they are responsible for their own  
 17 decisions and run things in their own way.  
 18 One of the issues that became very clear to me,  
 19 certainly from the people I met and from the  
 20 correspondence we had, was that there is no --  
 21 a complete absence of trust on the part of many  
 22 infected and affected people of the government because  
 23 of their experience over many years, and if they are  
 24 to have trust in a system of compensation they would  
 25 require it to be independent. The sort of pragmatic  
 45

1 conditions of eligibility for those -- sorry,  
 2 recommendation 4 is about the process of establishing  
 3 eligibility, I should say.  
 4 A. Yes.  
 5 Q. I will want to unpick a number of those points.  
 6 Recommendation 5 is eligibility for those who  
 7 were affected.  
 8 Recommendation 6 then, is this right, captures  
 9 your idea about there being these tariffs --  
 10 A. Yes.  
 11 Q. -- with input from a medical panel and a legal panel?  
 12 A. Yes.  
 13 Q. Recommendation 7 relates to aggravated and exemplary  
 14 damages. We will come back to those concepts in  
 15 a while.  
 16 Over the page, recommendation 8 then sets out  
 17 the five heads of awards that you recommend for those  
 18 who were infected, so: the injury impact, social  
 19 impact, care, autonomy and financial loss awards.  
 20 Recommendation 9 sets out your recommendations  
 21 for heads of award for those who were affected.  
 22 Recommendation 10 is essentially, although you  
 23 avoided giving figures, as I understand it, you were  
 24 suggesting that the rate should broadly reflect Common  
 25 Law damages and other compensation schemes.  
 47

1 need for that is that unless the victims -- and I call  
 2 them victims for this purpose, people who might make  
 3 a claim -- are confident in the system that's offered  
 4 to them, they won't go down that route, they will  
 5 still want to litigate, if they can, and, of course,  
 6 there may be obstacles in the way of that, but it will  
 7 mean this is not -- this issue is not solved.  
 8 Q. In terms of your recommendation, you have made 19  
 9 recommendations.  
 10 If we turn to page 33 of the report. I'm not  
 11 going to read them aloud, I'm going to deal briefly  
 12 with each of them, I'm going to come back to each of  
 13 them in the course of the day.  
 14 Recommendation 1 was a recommendation that the  
 15 Government accepts the "strong moral case for  
 16 a publicly funded scheme", "irrespective of the  
 17 findings of the Inquiry".  
 18 I wanted to ask you about that once we've looked  
 19 at the recommendations.  
 20 Recommendation 2 concerns the diseases that  
 21 would be covered, so hepatitis C, HIV, defined serious  
 22 cases of hepatitis B.  
 23 Recommendation 3 are the conditions of  
 24 eligibility for those who were infected.  
 25 If we go over the page, recommendation 4 is the  
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1 A. I thought it necessary to provide some guidance for  
 2 that and for there to be a relationship between the  
 3 compensation under this scheme and the Common Law in  
 4 order to promote proportionality and -- and fairness,  
 5 to be honest.  
 6 Q. Recommendation 11 concerns the interrelationship  
 7 between awards and past or contemplated legal claims.  
 8 Recommendation 12 deals with awards being final.  
 9 That's final with no provisional element.  
 10 A. Yes.  
 11 Q. Again, we will come back to that. Then the lump sum  
 12 or periodical payment that you have already described.  
 13 Over the page, recommendation 13 is concerned  
 14 with issues of interest or uplifts for inflation.  
 15 Recommendation 14 is the immediate consideration  
 16 of substantial interim payment.  
 17 Recommendation 15 deals with matters such as  
 18 interrelationship with benefits, taxation and the  
 19 like. Again, I will have some further questions in  
 20 relation to that.  
 21 Then over the page, recommendation 16 is the  
 22 establishment of the arm's length body accountable to  
 23 Parliament, and with independence from Government.  
 24 Recommendation 17 was that the scheme should  
 25 include certain support services including advocacy  
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1 and advice and other matters. Again, we will come  
 2 back to that.  
 3 Recommendation 18 was a degree of local delivery  
 4 within each devolved nation. Again, I want to come  
 5 back to that.  
 6 Then recommendation 19 was that these proposals:  
 7 "... should be reviewed by the Government in  
 8 light of the findings and recommendations of the  
 9 Inquiry, and thereafter, on a periodic basis and  
 10 reported on to Parliament."  
 11 Again, we will come back to that, but those are  
 12 the recommendations for when I, in due course, ask you  
 13 about recommendation 4 or 9 or the like. I will, as  
 14 I do so, remind those listening of what the  
 15 recommendation is, because it is not otherwise  
 16 necessarily easy to follow.  
 17 Before we look at any of the individual  
 18 recommendations in terms of mechanics, I just wanted  
 19 to go back to the issue touched on in recommendation  
 20 1, this issue of the moral case.  
 21 A. Yes.  
 22 Q. And, indeed, a moral case in which you describe as  
 23 strong and arising irrespective of the findings of the  
 24 Inquiry. What was it that led you to that conclusion?  
 25 A. Well, I hope I've set it out reasonably clearly in the

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1 was in effect trying to do the very opposite to put  
 2 that right. And when people have suffered, as people  
 3 have here, their entire lives, which is another  
 4 exceptional feature of this case, then putting that  
 5 right is not just a matter of an apology, sympathy  
 6 and, one would hope, perhaps that's not always  
 7 happened either, proper material support in relation  
 8 to medical help and so on, that it can only be put  
 9 right by -- insofar as anything can be -- by money,  
 10 and that is a measure of the gravity with which the  
 11 public, represented by the government, see this  
 12 particular issue.  
 13 So those are, in overall terms it seems to me,  
 14 the grounds I felt produced a strong moral case and  
 15 I have cited and I've looked in some detail in the  
 16 report at the pronouncements made in the past about  
 17 this by government figures and trying to look at what  
 18 the rationale was behind the support schemes, which  
 19 hasn't -- I don't think I'm pre-judging anything  
 20 here -- always been entirely coherent. But what it  
 21 reflects was this instinct, both political but also  
 22 human, that these were a very unfortunate group of  
 23 people who had been damaged by the state, that it  
 24 probably had been avoidable and they needed to be put  
 25 in as far as possible back to where they would have

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1 first chapter of this report but, but it is not in --  
 2 when there is a disaster in which people are injured  
 3 through no fault of their own, in many cases, even if  
 4 there's no one else to blame at all, the state will  
 5 move in and intervene in some way or another, and in  
 6 this case, albeit many people were telling me it was  
 7 unsatisfactory, successive governments have done so in  
 8 relation to this particular tragedy.  
 9 In my view, one of the special features of this  
 10 case is that whatever it can be said about fault or no  
 11 fault, the injuries that have been inflicted on  
 12 people, firstly have been inflicted on them by the  
 13 state, putting it bluntly. The state-delivered Health  
 14 Service has done this to people.  
 15 It seemed to me, and without wishing to  
 16 pre-judge this Inquiry, that much of what happened,  
 17 and it is not for me to make the judgment, was in  
 18 retrospect avoidable. In other words, if we look back  
 19 on things from now it could be avoided for many if not  
 20 all cases.  
 21 And while we do not have a law in this country  
 22 which promotes legal liability on that basis, it seems  
 23 to me that where there is such a widespread disaster  
 24 as this, there can be a strong moral obligation on the  
 25 state which inflicted harm on people when the state

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1 been if this had been avoided. So for those reasons,  
 2 I considered there was a strong moral case.  
 3 And if I may also say one of the reasons  
 4 I looked at was -- and there has been evidence given  
 5 about it recently -- that a lot of the decisions that  
 6 seem to have been taken about support seemed to have  
 7 been around a wish to avoid accepting a legal  
 8 liability when actually what needed to be looked at  
 9 was the moral case for looking after people.  
 10 Q. And you referred in your report, amongst other  
 11 governmental pronouncements over the years, to the  
 12 then Prime Minister, Mr Cameron, identifying this as  
 13 something that should not have happened.  
 14 A. Yes.  
 15 Q. And it is perhaps also worthy of note, before we  
 16 break, that the Department of Health in its opening  
 17 submissions to this Inquiry said this:  
 18 "This acceptance that this should not have  
 19 happened is an acceptance that things went wrong,  
 20 things happened that should not have happened."  
 21 And what was said to be an unreserved apology  
 22 was offered:  
 23 "I say unreservedly we are sorry. We are sorry  
 24 this should be so, that this happened when it should  
 25 not have done."

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1 That is also, I think, from your report  
 2 an element of this --  
 3 A. Yes.  
 4 Q. -- moral case?  
 5 A. Just a personal -- and it is a personal view, but I'm  
 6 an independent reviewer and asked to put a review  
 7 forward, that to bedevil this area with legal -- strict  
 8 legal position about negligence is to overcomplicate  
 9 things, and I appreciate when Government ministers say  
 10 this should not have happened, that is a very high  
 11 level almost -- not superficial, but it is a high level  
 12 undetailed examination of what is a very complicated  
 13 picture. But if the general feeling is this is  
 14 something that should not have happened and in  
 15 retrospect there were ways of stopping it happening,  
 16 then it seems to me that in itself is a strong moral  
 17 case for compensation.  
 18 Q. And you have set out in your report, I'm not going to  
 19 go through them but it is paragraphs 4.64 through to  
 20 4.74, and for those who are following the report  
 21 itself it is pages 58 to 59, but you have set out  
 22 a number of factors that --  
 23 A. Yes.  
 24 Q. -- seem to you to be significant in identifying the  
 25 strength of the moral case --

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1 A. Yes.  
 2 SIR BRIAN LANGSTAFF: None of which make for the justice  
 3 which appeals to you.  
 4 One of the dangers with an arm's length body  
 5 may -- and it may be that I have representations about  
 6 this in respect of the various bodies which were set  
 7 up at some length from the government, though quite  
 8 what length it was is a matter for my determination,  
 9 but Macfarlane, Eileen, Caxton, Skipton -- the -- that  
 10 they may not, because of their size, have been  
 11 adequately staffed or equipped to deal with everything  
 12 which arose.  
 13 Was it part of your consideration whether  
 14 a tribunal within the tribunal service might be the  
 15 arm's length body -- as part of the tribunal service  
 16 it would be what is increasingly recognised as part of  
 17 the court system but not a court. So the advantages  
 18 of informality, speed, experienced chairman and  
 19 independence, plus the clout and oversight that comes  
 20 to reinforce that independence by being part of  
 21 a system with the senior president of tribunals,  
 22 a very senior judge, at its head. Had that crossed  
 23 your thinking?  
 24 A. It is not in the report, sir, but I did consider that.  
 25 I think the attraction to me of an arm's length body --

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1 A. Yes.  
 2 Q. -- including all the matters that you have just  
 3 summarised in your answer, Sir Robert, but also you  
 4 have referred to what I think you describe as  
 5 a rollercoaster of raised and dashed expectations, and  
 6 you have looked at how over the years the state has  
 7 responded or not responded to the plight of those  
 8 infected --  
 9 A. Yes.  
 10 Q. -- and drawn that into part of the moral case as well.  
 11 A. Yes.  
 12 MS RICHARDS: Sir, I note the time. Perhaps a convenient  
 13 moment for the morning break.  
 14 SIR BRIAN LANGSTAFF: Yes, it is. Before we do that, let  
 15 me just ask one question which arises out of your  
 16 discussion with counsel about the arm's length body.  
 17 The reason why I think you would prefer a body  
 18 independent of government but not court is that if it  
 19 were a court, there would be the delays caused by the  
 20 formality caused by process, the probable need to  
 21 involve lawyers, you didn't say that but I think it is  
 22 at the back of it --  
 23 A. Definitely.  
 24 SIR BRIAN LANGSTAFF: -- and the costs necessarily  
 25 involved and the time?

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1 and I should hasten to add I don't see an arm's length  
 2 body being comparable to something like the  
 3 Macfarlane Trust, I see it being more comparable to  
 4 something like, but obviously not as large, as the  
 5 General Medical Council, that sort of arm's length  
 6 body -- is that there will be a degree -- we need  
 7 administrative flexibility in this. We also need, it  
 8 seems to me, the direct oversight and accountability to  
 9 Parliament for the administration of this scheme and  
 10 its funding.  
 11 I wouldn't have been -- I don't think I would be  
 12 persuaded that a tribunal service in itself would be  
 13 able to provide the support actually required to  
 14 the claimants, the expertise required, because it is  
 15 not just an expertise sitting on a tribunal, it is  
 16 an expertise of maybe investigating some things but  
 17 looking into things. There are a whole range of  
 18 functions which, it seems to me, would be better done  
 19 by an arm's length body in terms of, say,  
 20 administering advocacy, support, communications of  
 21 a supportive nature with claimants and a wider  
 22 community, which don't sit, to my mind, happily within  
 23 the tribunal service.  
 24 I can see the tribunal service being a route of  
 25 appeal and having oversight in that way, but I just

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1 feel there are -- there's too much going on or will be  
2 going on for the tribunal service itself to accept.  
3 And also I would not like to see, in terms of  
4 the funding of the administration of this, that to be  
5 diluted with or competing with the other  
6 considerations of the budget of the  
7 Ministry of Justice, if I can put that fairly bluntly.

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

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

11 **(11.21 am)**

12 **(A short break)**

13 **(11.50 am)**

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

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

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

22 "Remedial ...

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

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

5 Then:

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

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

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

25 It is a very particular feature of what I was

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

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

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

11 I'll come back to that

12 "Inclusive ...

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

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

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

20 Then:

21 "Broad ...

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

25 Then, over the page:

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

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

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

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

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

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

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

23 A. Yes.

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

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

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

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

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

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1 principles you apply would be in relation to Scotland.

2 A. Yes.

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

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

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

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

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

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

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

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

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1 obviously don't intend to ask you about the inclusion  
 2 of those -- and then defined serious cases of  
 3 hepatitis B. I just want to ask you a little more  
 4 about hepatitis B.  
 5 If we go to page 62, please. Under the heading  
 6 "Conclusions on Coverage" you explain your reasons for  
 7 approaching hepatitis B in the way that you did. So  
 8 you said:  
 9 "Of necessity, this very generalised view of the  
 10 impact HBV can have is based on a reading largely of  
 11 the expert evidence to the Inquiry. It was not  
 12 a subject which the infected raised at our meetings,  
 13 although I have been pressed in written submissions to  
 14 include HBV infections as a category of eligibility.  
 15 "4.84 On the basis of the description of HBV  
 16 and its effects, which I hope is a fair one, I am  
 17 unable to recommend that this infection be included in  
 18 a compensation scheme as a separate category, with one  
 19 exception. I consider a number of factors distinguish  
 20 HBV from HCV."  
 21 Then there are four bullet points there sets  
 22 out. The first was that:  
 23 "- Generally, the effects of HBV -- while it may  
 24 be a long lasting infection -- are mild or even  
 25 non-existent, so far as the impact on the quality of

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1 Inquiry's findings.  
 2 A. Can I also say, and particularly because I looked again  
 3 at the expert evidence or the report, and it seems to  
 4 me, and I may be wrong about this, that no one has  
 5 actually asked the experts to distinguish -- they  
 6 describe things but they haven't actually done  
 7 an exercise of distinguishing one from the other. And  
 8 I think that makes what I have said here even more  
 9 conditional in effect.  
 10 And obviously what I have said here is on the  
 11 basis of what I have read and my understanding.  
 12 I have -- no doubt I could have -- but thought it --  
 13 but in the time available, it would have been  
 14 difficult, I sought no independent expert advice of my  
 15 own, and I actually thought it would probably confuse  
 16 things if I did.  
 17 Q. Just before we look a little more at hepatitis B, and  
 18 I'm just going to ask you to look at some passages in  
 19 the Inquiry's hepatitis expert group report that Core  
 20 Participants have asked me to flag up, before we do  
 21 that, can we just go back to page 17 of the report.  
 22 It is just to pick up a potential omission in  
 23 the executive summary. So bottom of the page, 2.13:  
 24 "The conditions for eligibility for the directly  
 25 infected should be ..."

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1 life of the infected is concerned. Compensation in  
 2 such cases would be likely to be low and it is  
 3 possible the costs of processing claims for it would  
 4 be disproportionate.  
 5 "- There is available effective treatment which  
 6 is likely to suppress the disease and avoid the more  
 7 serious consequences with regard to the liver.  
 8 "- Many cases where there are more serious  
 9 consequences are likely to be where there is HBV/HCV  
 10 or HBV/HIV co-infection."  
 11 Then your last bullet point:  
 12 "- In the absence of the more serious infections  
 13 it may be difficult to establish causation."  
 14 Then your exception is set out in 4.85, those:  
 15 "... who develop a chronic infection with  
 16 serious symptoms who require treatment to prevent  
 17 cirrhosis, or who have actually contracted cirrhosis."  
 18 So is it right to understand that those who fall  
 19 within paragraph 4.85 you would recommend they are  
 20 compensated within the framework of the scheme?  
 21 A. Yes.  
 22 Q. Then I think only fair to you to point out that in  
 23 4.86 you say the Inquiry will have been able to  
 24 consider more evidence than you have and you would  
 25 recommend your conclusion be reviewed in light of the

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1 There we have the reference to hepatitis C and  
 2 HIV but not hepatitis B.  
 3 Should we understand that hepatitis B of the  
 4 more serious character should be included here?  
 5 A. Yes, I had picked that up myself, actually it is  
 6 an omission, it should be there.  
 7 Q. Then, did you have available to you when you were  
 8 considering the issue of hepatitis B any evidence on  
 9 the psychological impacts that may be associated with  
 10 infection with hepatitis B?  
 11 A. Only insofar as it was mentioned in the -- that there  
 12 is a psychological -- psychosocial expert report.  
 13 Q. Then if we can look at just a handful of passages in  
 14 the --  
 15 A. Can I --  
 16 Q. Yes.  
 17 A. Of course, what I didn't have was, as I say in the  
 18 report, none of the people I met actually brought  
 19 forward hepatitis B as something to consider. It  
 20 didn't mean I wasn't going to consider it but I thought  
 21 that was noteworthy.  
 22 Q. And, again, perhaps feeds into your suggestion that  
 23 the Inquiry --  
 24 A. Yes.  
 25 Q. -- which will have had more evidence, may be able to

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1 deal with it in more detail.  
 2 If I might just ask you to look at just  
 3 a handful of passages in the Expert Report to the  
 4 Inquiry from the hepatitis group.  
 5 It is EXPG0000001, please. Sir Robert, I know  
 6 you have read this. I'm just going to highlight  
 7 a handful of passages --  
 8 A. Of course.  
 9 Q. -- which Core Participants have asked me to raise and  
 10 then just ask you a couple of further questions.  
 11 If we go to page 3, please. Just above  
 12 question 15.2 we see there:  
 13 "[HBV] and [HCV] are the most important causes  
 14 of viral hepatitis globally. Each can range in  
 15 severity from very mild, where an individual has no  
 16 symptoms and no long-term consequence, to being so  
 17 severe that the liver can no longer carry out its  
 18 essential functions and fails with a high risk of  
 19 death, sometimes necessitating transplantation. The  
 20 key concern with long term HBV or HCV infection is  
 21 progressive scarring of the liver (fibrosis, leading  
 22 to cirrhosis) and an increased risk of liver cancer  
 23 (hepatocellular carcinoma, HCC)."  
 24 Then the second paragraph is -- if we pick it up  
 25 at page 64, bottom of the page. This identifies some  
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1 [hepatitis C] who develop advance fibrosis/cirrhosis,  
 2 fertility is reduced and pregnancy is uncommon."  
 3 Then there is further discussion of that.  
 4 I don't think I propose to read those aloud.  
 5 Then, page 80. So, under the heading  
 6 "Supplemental Question 26", the first paragraph which  
 7 begins "The details of individual treatments", so that  
 8 refers to tenofovir (TDF) as the "first line  
 9 treatment":  
 10 "In discussions with patients as to the need for  
 11 follow-up and monitoring, it would be expected to  
 12 include consideration of potential toxicity to the  
 13 kidneys, and the need for blood and urine monitoring."  
 14 At the bottom of the page there is a question  
 15 about guidelines for infection control, and I am asked  
 16 to flag up to you that the precautions in terms of  
 17 transmission apply to both hepatitis B and  
 18 hepatitis C.  
 19 So those are some of the points in relation to  
 20 hepatitis B, Sir Robert, that I have been asked to  
 21 draw to your attention.  
 22 Before I ask you further about hepatitis B, it  
 23 is also right, I think, to note that, in terms of that  
 24 sense of injustice that you refer to as part of the  
 25 moral case, those infected with hepatitis B have never  
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1 information about hepatitis B that the expert group  
 2 said should be provided to newly infected individuals.  
 3 So:  
 4 "Basic information on what [hepatitis B] is, the  
 5 different stages of infection and what effect it can  
 6 have on health (including increased risk of liver  
 7 scarring and liver cancer ...)."  
 8 So I'm asked to flag that up.  
 9 Then, over the page, the transmissibility of  
 10 hepatitis B is a point I'm asked to identify.  
 11 Then, I think it is five bullet points down:  
 12 "The fact there is no cure, but that long-term  
 13 medications are available and might be recommended."  
 14 Then the penultimate bullet point:  
 15 "The need for regular attendance at clinics to  
 16 monitor infection ..."  
 17 Then if we go to page 66 -- sorry, no, over the  
 18 page, sorry, Lawrence. If we can go to the next page.  
 19 So, again, we see under the reference "HBV"  
 20 there, the reference to the risks of sexual  
 21 transmission.  
 22 Then, if we go to, I think it is, page 73.  
 23 We've got there, at the bottom of the page, this is  
 24 impact, for example, on fertility. So:  
 25 "For those living with [hepatitis B] and  
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1 been part of any scheme thus far, so they've not had  
 2 any of the payments that those infected with  
 3 hepatitis C or HIV have had.  
 4 I'm asked to suggest to you, Sir Robert, that  
 5 the differences between hepatitis B and hepatitis C  
 6 that it might be said your report reflects are more --  
 7 are illusory, that essentially hepatitis B should not  
 8 be regarded as something which is quintessentially  
 9 a much milder or less alarming condition to suffer  
 10 from.  
 11 A. Well, I understand entirely what you say. I mean,  
 12 I would point out that in relation to cirrhosis,  
 13 fibrosis and liver failure and so on, those are very  
 14 much the cases in which I envisaged there would be  
 15 an exception. I must say I did take into account the  
 16 fact that there had been no previous coverage for  
 17 hepatitis B and, therefore, what I said about a moral  
 18 case in relation to past statements and so on and the  
 19 public reflection of a moral case for HCV and HIV  
 20 doesn't seem to have been perceived before.  
 21 Now, I think all I can say is at the end of the  
 22 day a value judgment has to be made. If you go down  
 23 the route of a moral case, which is what I am  
 24 suggesting should happen, and the issues you raise  
 25 could result in including hepatitis B, if it is felt,  
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1 and maybe that's something the expert panel could be  
2 asked about, there is in fact no realistic distinction  
3 between the two. It is simply my reading of the  
4 evidence that I read was that there did seem to be the  
5 distinctions I identified. If that's not the view  
6 that is generally taken, then maybe that needs  
7 considering.

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

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

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

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

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

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

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

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

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

18 A. No.

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

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

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

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

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

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1 shouldn't be talked about in the scheme. It is  
2 a complication, it seems to me, which probably requires  
3 more information than I have access to.  
4 **SIR BRIAN LANGSTAFF:** I just want to observe that this is  
5 rather a different sort of risk in this sense,  
6 sometimes a clinician may say to a patient, "If you  
7 take this, then there is this risk to you". The risk  
8 of contracting vCJD is retrospective, rather than  
9 prospective. It is telling people, "Because of the  
10 treatment you have already had, you are now at risk".  
11 So there is that difference, which it may well be that  
12 I feel I should take into account.

13 Your suggestion would be, well, this is  
14 something which aggravates the other conditions which  
15 they suffer from?  
16 **A.** Yes, that's my position. I appreciate this is  
17 a struggle and there is a balance, but there needs to  
18 be a distinction between something which is different  
19 for those who have been infected and those who have no  
20 infection but may still have been exposed, albeit  
21 retrospectively, as it were, that comes to light, to  
22 that risk of vCJD, and one is a very large group of  
23 people indeed and the other may be a very small one.  
24 **MS RICHARDS:** Then, if we could just -- just going back to  
25 hepatitis B in terms again I think of something that

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1 **A.** Yes, my apologies.  
2 **Q.** Now, I want to just explore a handful of issues  
3 relating to the conditions of eligibility for those  
4 infected.  
5 Could we start by going back to the report to  
6 paragraph 2.15, which is page 18. You say this in  
7 paragraph 2.15:  
8 "Where possible, eligibility should be automatic  
9 for those who have already been accepted as eligible  
10 for regular support by one of the existing support  
11 schemes, or any of the preceding schemes."  
12 Then you go on to talk about how eligibility may  
13 be assessed for those for whom it is not automatic.  
14 It is the qualification "where possible". If  
15 someone has already been accepted onto a scheme,  
16 whether for regular support or otherwise, should they  
17 not be automatically passported onto any new scheme?  
18 **A.** I think that's what I'm saying.  
19 **Q.** So the words "where possible" --  
20 **A.** I'm not entirely clear whether everyone who has been --  
21 whether it is entirely clear, for instance, with  
22 someone who has died in the past whether they were  
23 accepted on the scheme or not. And those -- we know,  
24 don't we, that there is an archive of information,  
25 which is released only with some difficulty, from which

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1 might need a mild correction in the report. If you go  
2 to page 69 and paragraph 6.6. I think there it says:  
3 "... I have concluded that none of HBV, HDV, or  
4 vCJD should be separate categories of eligibility."  
5 That I think doesn't entirely reflect your  
6 category of serious hepatitis B?  
7 **A.** I think that's probably right, although there is  
8 a qualification in the following sentence which partly  
9 deals with one part of that.  
10 **Q.** Yes. Can I then turn now --  
11 **A.** Actually, yes, I think that's right.  
12 The difficulty about the HBV it seems to me is  
13 there may be a case for including it, certainly where  
14 there is a co-infection, but also where there are  
15 particularly severe cases, and that latter bit is not  
16 included in that sentence and should have been, yes.  
17 **Q.** Yes. Can we then turn next to "Recommendation 3".  
18 Can we go to page 33, first of all, please. So we can  
19 see "Recommendation 3". The first is just to point  
20 out what I think is a typo in 3(a). It says:  
21 "they have been diagnosed" --  
22 **A.** Yes, sorry.  
23 **Q.** "... as being infected with one or more of HCV, HCV,  
24 or HBV ..."  
25 So it should be HIV.

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1 things can be established.  
2 So "where possible", I mean where it is possible  
3 to establish that they have been considered to be  
4 eligible. That's all.  
5 **Q.** So anybody who has previously been accepted as  
6 qualifying, whether it is under the Macfarlane Trust  
7 or the Eileen Trust or the Skipton or any of the  
8 devolved schemes, that should effectively be  
9 sufficient for establishing eligibility?  
10 **A.** For eligibility, yes.  
11 **Q.** Would you -- I'm sorry, the suggestion in  
12 paragraph 2.15 in the second line seems to suggest  
13 that this automatic eligibility should be for those  
14 who have been "accepted as eligible for regular  
15 support by one of the existing support schemes, or any  
16 of the preceding schemes".  
17 The point I have been asked to raise with you,  
18 Sir Robert, is that that might be unnecessarily narrow  
19 because it would exclude automatic entry for, for  
20 example, the bereaved who'd received a lump sum  
21 payment but no regular support, because regular  
22 support is not an option under the current scheme for  
23 them.  
24 I wonder whether it was meant to refer to  
25 regular support or not?

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

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

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

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

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1 let us suppose from 1944 onwards at least, that then  
 2 would meet this test?  
 3 A. That is one part of the test, sir, because the other  
 4 part is -- it is one thing to know that the disease  
 5 exists, it is another to have a means of screening for  
 6 it --  
 7 **SIR BRIAN LANGSTAFF:** Yes.  
 8 A. -- in samples, which might be a different issue. So  
 9 it's the two together, I would think.  
 10 **SIR BRIAN LANGSTAFF:** I see.  
 11 **MS RICHARDS:** More broadly, the idea introduced in that  
 12 bullet point of avoidability, how in practice do you  
 13 envisage that as a criterion being --  
 14 A. Well, I think the Inquiry has received evidence, which  
 15 I don't pretend to have analysed, about when different  
 16 screening technologies came in and how effective they  
 17 were and the ability, therefore, through testing either  
 18 of donors or of blood or blood products one could  
 19 detect an infection.  
 20 Q. So is it then --  
 21 A. So -- I'm sorry -- the principle behind what I'm saying  
 22 is that -- is to avoid looking at whether there was  
 23 a step someone knew about but didn't take at the time,  
 24 as in negligence, and whether there was a technique  
 25 available which could have uncovered this but didn't.

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1 which I identify in the first bullet point but it is  
 2 actually belt and braces because obviously this Inquiry  
 3 have more information than I would have had in setting  
 4 those dates.  
 5 Q. I think I'm asked to point out that you are absolutely  
 6 right in relation to the September 1991 date for  
 7 hepatitis C but my understanding is there isn't  
 8 a cut-off date in relation to HIV. There certainly  
 9 wasn't for the Macfarlane Trust or the Eileen Trust to  
 10 the extent that there was a relevant date for  
 11 Macfarlane Trust it was tied to the making of claims  
 12 rather than treatment. My understanding is that there  
 13 isn't a cut-off date operated by EIBSS or I think the  
 14 other devolved schemes in relation to HIV.  
 15 A. In that case, I apologise for the error. But it seems  
 16 to me a date needs to be fixed.  
 17 Q. Can we then -- we may need to come back to that in due  
 18 course, but can we then pick up on recommendation 4.  
 19 If we go to page 33 again, I think, Lawrence.  
 20 34, thank you. You are ahead of me.  
 21 So recommendation 4 is about how to prove  
 22 eligibility, in a nutshell.  
 23 A. Yes.  
 24 Q. Your recommendation there is:  
 25 "... avoid legalistic and adversarial concepts

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1 Q. Just looking at condition 3 as set out in  
 2 paragraph 6.8 as a whole. Is condition 3 really  
 3 concerned with what are the dates within which someone  
 4 would need to show they had been treated?  
 5 A. Yes. Yes. Not by relation to what was the practice at  
 6 the time but from what we now know but in terms of what  
 7 was available at the time could have been used and  
 8 could have resulted in the infection being detected.  
 9 Q. And --  
 10 A. But you're right, that results in an identification  
 11 that they don't, which is probably going to be  
 12 artificially precise.  
 13 Q. Is it right again to understand that you are not  
 14 suggesting by talking about avoidability, which is  
 15 a phrase that appears here in a couple of other  
 16 places, you are not suggesting, as I understand it,  
 17 that individual applicants have to show an individual  
 18 case of avoidability?  
 19 A. No, not at all. No, this is one of those things that  
 20 needs to be determined in advance to apply to a whole  
 21 scheme.  
 22 Q. So it is really just what are the dates within which  
 23 the scheme operates?  
 24 A. And it may be for all I know that the dates of the  
 25 current scheme, of the EIBSS, are roughly right, but --

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1 of the burden and standard of proof; establishing  
 2 eligibility under the scheme should be either:  
 3 "a) automatic in the case of infected persons  
 4 already accepted for eligibility under the support  
 5 schemes;  
 6 "or  
 7 "b) a collaborative process in which:  
 8 "- the applicant is sympathetically supported by  
 9 the scheme in obtaining any required information and  
 10 documentation;  
 11 "- in general a presumption is applied that  
 12 statements of fact made by an applicant are correct;  
 13 "- applicants are not required to repeat  
 14 information already provided to the support schemes.  
 15 "- eligibility is accepted if the information  
 16 available points towards eligibility and there is no  
 17 strongly persuasive evidence which contraindicates  
 18 eligibility."  
 19 The process you there describe for those not  
 20 already accepted as eligible, is that in part designed  
 21 to avoid the difficulty that may be created by  
 22 an absence of medical records and this an inability on  
 23 the part of an individual to point to a record and  
 24 say, "Look, I had a transfusion on such-and-such  
 25 a date"?

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

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

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

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

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

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

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

19 A. Contemporary?

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

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

8 Then this:

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

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

22 A. Yes.

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

25 A. I'm not suggesting that when someone comes forward with  
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1 a transfusion, and there may be some evidence of the  
2 procedure but often none of the transfusion, and  
3 clinicians looking at it now say, "Oh, we don't give  
4 transfusions for that kind of condition or that kind  
5 of procedure", that wouldn't necessarily be the right  
6 way --

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

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

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

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

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

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

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1 over from a period within -- that's what I was getting  
 2 at, and I appreciate trying to find that out might in  
 3 some cases be very difficult indeed.  
 4 Q. So that might again be a kind of example of where,  
 5 first of all, the schemes should be proactive in  
 6 trying to find what kind of supporting evidence might  
 7 be available whether from the transfusion service or  
 8 the hospital. But assuming that that kind of evidence  
 9 couldn't be gleaned, that might be the kind of  
 10 scenario in which that would be appropriate, as it  
 11 were, to give the benefit of the doubt to the  
 12 applicant?  
 13 A. Yes. I mean, I imagine the period was relatively  
 14 small, I don't know, but I imagine stocks aren't kept  
 15 on an indefinite basis, but I don't know that.  
 16 Q. Then, just going back to the issue of cut-off dates,  
 17 is it right to understand you are not advancing any  
 18 specific cut-off date because you haven't analysed the  
 19 evidence in relation to that --  
 20 A. No.  
 21 Q. -- you are simply saying -- referring to the fact that  
 22 at least insofar as hepatitis C is concerned, there is  
 23 a cut-off date in the schemes and a decision will have  
 24 to be taken whether informed by the finding of the  
 25 Inquiry or otherwise as to whether there should be

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1 Q. Then just dealing a little more with issues about the  
 2 extent to which applicants have to prove matters and  
 3 this isn't -- this line of questioning is not limited  
 4 to questions of eligibility but if we are looking, for  
 5 example, at proof of loss, proof of causation, does  
 6 that collaborative approach which you described, that  
 7 supportive approach, not automatically disbelieving  
 8 applicants that you described in relation to  
 9 eligibility decisions, would you carry those  
 10 principles through to when, whoever it is who is doing  
 11 the assessment, is looking at the losses that  
 12 individuals have suffered?  
 13 A. Yes. Clearly there are going to be areas where  
 14 generally you might expect the applicant to be able to  
 15 produce more information than others, I'm thinking  
 16 about there is a claim for loss of earnings for  
 17 instance or loss of career prospects. You could start  
 18 from a blank sheet of paper but it would obviously be  
 19 helpful and reasonable for an applicant to come forward  
 20 with some information and some chapter and verse about  
 21 that, if they have had an employment history for  
 22 instance.  
 23 On the other hand, if you are talking about the  
 24 effects of stigma and social impact and so on, it  
 25 seems to me almost inevitable you will rely to a large

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1 a cut-off date for the scheme you propose and if so  
 2 what it should be?  
 3 A. Yes, my reading -- and, of course, it's limited by the  
 4 qualifications I have given many times -- is that there  
 5 is a time after which, if I can put it broadly, when  
 6 screening techniques and general knowledge and practice  
 7 was such that the risks of infections had become  
 8 vanishingly small, thank goodness.  
 9 Q. We can take that down. Thank you.  
 10 The next question I wanted to ask you about is  
 11 a category of those infected with hepatitis C who  
 12 clear the virus within a period of time, you haven't  
 13 excluded what are sometimes referred to as natural  
 14 clearers from the scheme?  
 15 A. Certainly not. I mean, the fact they cleared obviously  
 16 is good news but it is realistically likely to lead to  
 17 a smaller sum by way of compensation than someone who  
 18 has a lifetime of suffering.  
 19 Q. So the way in which you would envisage their  
 20 circumstances being catered for is they are within the  
 21 scheme but obviously in terms of the applicable tariff  
 22 and the kind of compensation that might be payable, it  
 23 may be significantly different from those who have had  
 24 a lifetime of treatment?  
 25 A. Yes.

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1 extent on what you are told by the applicant and their  
 2 immediate family about what happened to them.  
 3 Q. If someone, for example, describes, as so many  
 4 witnesses have described to this Inquiry, the horrific  
 5 side effects of treatment, whether it was some of the  
 6 HIV treatments or interferon in relation to  
 7 hepatitis C, you wouldn't expect individuals to have  
 8 to go away and get their own individual expert medical  
 9 report --  
 10 A. No.  
 11 Q. -- and present it to say that this person did indeed  
 12 suffer --  
 13 A. No, no.  
 14 Q. -- those consequences?  
 15 A. I was thinking, as I hope is clear, to ensure that the  
 16 scheme, as far as possible, avoids the need of  
 17 applicants to have to produce the things like expert  
 18 evidence and legal submissions or whatever. Having  
 19 said that, clearly some fairly expert questioning might  
 20 be needed -- this is where the pro-activity comes in --  
 21 of the scheme in terms of asking the right sort of  
 22 questions to elicit things like what the side effects  
 23 have been for a particular person and then to set what  
 24 the description is against what the medical panel has  
 25 described as included in the known side effects of

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1 particular forms of treatment, which, the way I have  
 2 read it, can be terrible.  
 3 Q. Can we then turn to recommendation 5. We will just  
 4 look at the text of that first, on page 34 of the  
 5 report.  
 6 So recommendation 5, bottom half of the page, we  
 7 are now looking here at the eligibility of affected  
 8 persons, and we looked at the categories earlier on.  
 9 For the avoidance of doubt, because I do not  
 10 think it is necessarily clear from the terms of  
 11 recommendation 5(a), although I think it becomes clear  
 12 later, that includes divorced and former spouses.  
 13 A. Yes, it does. It could have been made clearer but, I  
 14 mean, clearly the implication is there. But it  
 15 definitely -- I intended it to include former spouses.  
 16 Q. Yes. It is, I think, clear in what you say in  
 17 paragraph 6.19 of the report, but I have just been  
 18 asked to check that with you.  
 19 Then, the other question I'm asked to raise in  
 20 relation to recommendation 5(a) is the reference "for  
 21 at least one year", and the question is: at what point  
 22 in time would that year have to have happened?  
 23 A. Well, the purpose of having indirectly affected people  
 24 is that it would have to be during a time where there  
 25 is an effect, so if there was a co-habitee, for

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1 A. Rather the same as with children. The parent of  
 2 a child who has got -- who contracts one of these  
 3 terrible diseases has a responsibility for the child  
 4 which the parent of an adult doesn't. Of course they  
 5 have another and -- a close relationship and distress,  
 6 they may well come within one of the other categories  
 7 in that respect, but there is a particular reason, it  
 8 seems to me, for parents, given their burdensome  
 9 responsibilities, the -- one of which will almost  
 10 inevitably be a sense of responsibility, often  
 11 completely misplaced, that they in some way are  
 12 responsible for submitting their child to the treatment  
 13 in the first place.  
 14 So there are all sorts of reasons why the parent  
 15 of a child who has received treatment and then been  
 16 affected will be affected in a somewhat different way  
 17 to the understandable issues that a parent of  
 18 a grown-up might have, when actually they may feel  
 19 a close relationship and so on but it is not as close  
 20 as that that I have just described.  
 21 Q. Then two further points arising out of that. If  
 22 a child was infected before turning 18 but that  
 23 infection was not detected or symptoms did not develop  
 24 until after 18, would parents be eligible for  
 25 compensation in this category?

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1 instance, who co-habited before any treatment was  
 2 given, they would not qualify. And that's true of  
 3 spouses and civil partners. It is the suffering  
 4 everyone has shared from the point at which that  
 5 suffering begins.  
 6 Q. Then in relation to the reference to children in  
 7 recommendation 5(b), I'm asked to check this with you  
 8 again for clarity, that encompasses those who were the  
 9 children of an infected parent and are now adults?  
 10 A. Yes. I think my qualification is they needed to be  
 11 children at the time.  
 12 Q. And why is that?  
 13 A. Because I believe children have a particular --  
 14 children, by which I mean people under the age of 18,  
 15 are likely to be affected in a very particular way by  
 16 living with or having a parent who is infected in this  
 17 way. And I have heard stories about that. But  
 18 obviously they can be adults now and be claiming for  
 19 what happened when they were children.  
 20 Q. Recommendation 5(c):  
 21 "parents of eligible infected persons whose  
 22 eligibility started in childhood."  
 23 The question is this: why do parents only  
 24 qualify in the event of the eligibility of the  
 25 infection starting in childhood?

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1 A. I don't see why not.  
 2 Q. I'm asked to point out that in some cases it may not  
 3 be possible to detect the batch or treatment that  
 4 infected the child and the date of infection of  
 5 hepatitis C or HIV may be unavailable. Again, that  
 6 would be a question of perhaps looking to see what  
 7 was --  
 8 A. That is a question of proof and evidence. All I can  
 9 possibly say, bearing in mind what I just said about  
 10 the reason for parents and children being in this  
 11 category, is that it would seem to me the later in  
 12 childhood all this happened, particularly if during  
 13 childhood there was no evident infection or issue, then  
 14 we might not be looking very much by way of  
 15 compensation should they actually be eligible for it.  
 16 Q. Then recommendation 5(d):  
 17 "siblings living, while under the age of 18, as  
 18 a family with an eligible infected person."  
 19 I'm asked to double check with you, under the  
 20 age of 18, does that refer to the infected sibling or  
 21 to both the affected sibling and the infected sibling?  
 22 A. The age refers to the sibling living with the infected  
 23 person. The reason -- I heard stories about the effect  
 24 on siblings of children living in a family where  
 25 a brother or a sister has been infected in this way,

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1 the impact that has both socially and psychologically  
 2 on them as children.  
 3 Q. You've not included within those who are eligible as  
 4 affected persons by reason of relationship,  
 5 grandparents or grandchildren; why is that?  
 6 A. Putting it bluntly, I felt a line has to be drawn  
 7 somewhere in terms of actual automatic categories. It  
 8 could be that such people might come within (f) but  
 9 they would have had to show that.  
 10 Some would argue that I have been stretching the  
 11 envelope of eligibility quite a long way anyway, and  
 12 I come back all the time to where is there a strong  
 13 moral case. In terms of damages, as you say, well,  
 14 no, we do not as a matter of law award damages to  
 15 people who are considered to be too remote from the  
 16 problem that's caused and some would argue that line  
 17 is sometimes too strictly drawn. But clearly there  
 18 has to be a line somewhere or otherwise we might say,  
 19 for example, we ought to compensate someone who reads  
 20 about the suffering people in a newspaper, which  
 21 probably we wouldn't actually want to happen.  
 22 So it is always -- there was always going to be  
 23 a line beyond which it's not proportionate to -- in  
 24 terms of the moral case or the case about  
 25 responsibility to bring people within it, and I have

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1 recognised psychiatric disorders?  
 2 A. I think both anxiety and depression probably do appear  
 3 -- (overspeaking) -- as it happens.  
 4 Q. But it is a question of degree --  
 5 A. I would -- it is obviously a moot point and open to  
 6 debate. Clearly anything that is diagnosable, whether  
 7 it be depression or anxiety of that nature, would be  
 8 included. But I was impressed by what I read in the  
 9 psychosocial -- I can't remember the full name of it,  
 10 but the psychosocial expert report, which seemed to  
 11 be -- very graphically to describe a whole range of  
 12 suffering, of distress, around which it is quite  
 13 difficult, frankly, to draw a definition. But I would  
 14 personally be prepared to see -- if there was some  
 15 mental injury that was diagnosable, then I would  
 16 certainly suggest you take into account the  
 17 psychosocial impact more generally and the distress.  
 18 Q. Then, in terms of category (e):  
 19 "providers of care to an eligible infected  
 20 person, as a result of the infection."  
 21 I'm asked to ask you what level of care would  
 22 require to be established for a person to fall within  
 23 that?  
 24 A. I think under the care section I actually describe  
 25 that, and perhaps one might be able to go to that in due

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1 sought to draw that line as widely as I can, but I do  
 2 feel that the mere status of being a grandparent or  
 3 grandchild is probably not sufficient, but that  
 4 doesn't mean that you wouldn't necessarily qualify  
 5 under (f) if you can prove that effect.  
 6 Q. Or presumably potentially (e) as well, as a provider  
 7 of care?  
 8 A. Yes, of course.  
 9 Q. So, for example, a grandparent who effectively stood  
 10 in loco parentis perhaps not formally as such but  
 11 effectively was the person bringing up the child would  
 12 be more likely to fall within (f)?  
 13 A. Yes.  
 14 Q. A grandchild forming caring responsibilities might  
 15 well come within --  
 16 A. And the limiting factor I did put in was they did in  
 17 fact suffer a mental or physical injury.  
 18 Q. And then in relation to that limiting factor, the  
 19 suffering a mental or physical injury as a result,  
 20 what is it that you are suggesting would have to be  
 21 demonstrated in that regard in terms of a mental  
 22 injury? Would there have to be a mental condition as  
 23 recognised in one of the diagnostic manuals or would  
 24 it include those who have suffered degrees of anxiety,  
 25 unhappiness, depression that don't qualify as fully

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1 course, but I'm talking about definitely care that  
 2 would not be necessary for a person who did not have  
 3 an infection. So, for instance, a parent will always  
 4 have obligations towards a child but would probably not  
 5 have nursing care obligations in the way you might have  
 6 towards someone who has one of these infections or the  
 7 side effects from treatment. So that's what I mean.  
 8 But one has to take account of the fact that  
 9 parents in particular that may be, in other  
 10 circumstances, grandparents may have caring  
 11 responsibilities of a general nature.  
 12 Q. If we just pick that last point up over the page --  
 13 sorry, page 73. The heading "Carers" there. If we go  
 14 to 6.24, under "Eligibility". So:  
 15 "- A person who has provided personal care or  
 16 support to an infected person;  
 17 "- The care and support provided has been over  
 18 and above that which they would have been reasonably  
 19 expected to provide to the infected person but for the  
 20 infection and its consequences;  
 21 "- The care and support provided has been  
 22 without remuneration (except for reimbursement of  
 23 reasonable expenses incurred in the provision of the  
 24 care or support); and  
 25 "- The care and support provided was reasonably

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

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

5 A. No --

6 Q. It is a more commonsense and holistic approach?

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

8 Q. Yes.

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

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

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

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

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

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

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

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

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

4 A. I will do that with delight, sir.

5 (1.02 pm)

(The short adjournment)

7 (2.00 pm)

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

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

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

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

22 A. Yes.

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

25 A. Yes.

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1 Q. Yes.

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

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

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

25 A. Yes.

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

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

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

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

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

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

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

15 Q. The scheme should be able to provide that?

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

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

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

4 A. Yes.

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

8 A. Yes.

9 Q. I say "his"?

10 A. It might be "her".

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

18 SIR BRIAN LANGSTAFF: Yes.

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

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

3 A. That is correct.

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

9 A. Yes.

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

12 A. Yes.

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

22 A. Yes.

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

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

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

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

11 A. Yes.

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

14 A. Yes.

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

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

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

7 **SIR BRIAN LANGSTAFF:** Yes, thank you.

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

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

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

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1 **A.** Yes.

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

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

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

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

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

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

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

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

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

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

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

13 **A.** Yes.

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

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

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

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

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1 schemes?

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

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

11 **A.** Yes.

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

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

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

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1 need in the system.

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

5 **A.** No.

6 **Q.** That's not their role?

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

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

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

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1 hard work has been done?

2 **A.** Yes.

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

5 **A.** Yes.

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

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

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

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

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

20 But I do point to the fact that it is not  
21 impossible. The 9/11 scheme dealt with all 3,000,  
22 4,000 claims in two years, beginning to end. I admit  
23 that some of that might have been a stretch, sadly,  
24 more simple, because they weren't talking about  
25 lengthy and varying medical conditions in a way that

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

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

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

17 **SIR BRIAN LANGSTAFF:** Thank you very much.

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

20 **A.** Yes.

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

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

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

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

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

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

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

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1 So before getting to any formal final decision and  
 2 then formal review or right of appeal, that the  
 3 assessor might say, "I think you are in this category  
 4 for these reasons, what do you think?"  
 5 Because obviously if that can be resolved by  
 6 agreement, dialogue, discussion, that reduces the  
 7 burden on the individual and reduces the burden on the  
 8 scheme.  
 9 A. Yes, ideally that's what should happen, and that's why  
 10 I'm very keen that this should not become  
 11 an adversarial process as between a scheme that is  
 12 trying to save every penny it can and a claimant who,  
 13 dare I say it, backed by -- or supported and  
 14 represented by some lawyer, is claiming the maximum  
 15 theoretically possible. But both sides are seeking to  
 16 come to a reasonable solution around the circumstances  
 17 of the case. That's a much better way of producing  
 18 a satisfactory outcome than an adversarial system which  
 19 produces an analogue answer "yes" or "no" or this  
 20 figure or that figure.  
 21 Q. Can I then ask you a little about recommendation 7.  
 22 Could we have the report back on screen 35, please.  
 23 Recommendation 7, bottom of the page, refers to  
 24 aggravated and exemplary damages, and you say in the  
 25 recommendation (a) the scheme should allow as part of

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1 exemplary damages and indeed has a special fund for  
 2 that.  
 3 I didn't feel qualified on what I knew to say  
 4 yay or nay to exemplary damages. All I would say  
 5 about it is that it would undoubtedly introduce an  
 6 adversarial element to what would otherwise I hope be  
 7 a more consensual collaborative scheme, and a way of  
 8 dealing with exemplary damages would be to say, well,  
 9 if that's what you want try your luck in court because  
 10 it is not compensation in reality, it is a punitive  
 11 element.  
 12 Aggravated damages, on the other hand, to my  
 13 mind could play a part, which is where the injury has  
 14 been aggravated by conduct or something else that's  
 15 unacceptable. And in the case here, it seemed to me  
 16 from what I was hearing and what I read that one of  
 17 the things that a number of people -- many people are  
 18 complaining about has been an interference with in  
 19 effect their human rights. Interference with family  
 20 life, interference with their autonomy in terms of  
 21 consent and other ways, which they would say has been  
 22 completely wrong, and that has aggravated in a real  
 23 sense that the injury they have suffered and in some  
 24 cases in itself caused serious psychological distress  
 25 and sometimes mental illness, and it was for that

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1 the autonomy award the eligible infected persons an  
 2 award equivalent to aggravated damages for the  
 3 aggravated distress caused by interferences and their  
 4 autonomy in private life such as lack of informed  
 5 consent, information about the risks of treatment and  
 6 about diagnosis, treatment and testing, and (b) the  
 7 issue of exemplary damages be reviewed in the light of  
 8 the findings of the Inquiry.  
 9 Now, again, just really for the benefit of those  
 10 listening, and you have explained the terms in your  
 11 report, but could you just briefly explain what  
 12 aggravated damages are and what exemplary damages are.  
 13 A. Yes, I will do my best. The idea of -- I can deal with  
 14 the exemplary damages first, is it is a punitive award.  
 15 So it is an award in a court system of the court's  
 16 disapproval of the conduct, usually of a state body but  
 17 it may be others, and the misconduct as opposed to  
 18 a value of the injury that's being suffered. So it is  
 19 a bit like a fine but it is one that goes to the  
 20 claimant.  
 21 There are other jurisdictions where exemplary  
 22 damages are awarded by juries in the US in millions of  
 23 dollars a lot of the time. It is a much less common  
 24 feature of claims in this country. The Republic of  
 25 Ireland compensation scheme, from memory, allows for

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1 reason I thought that that was something that could be  
 2 reflected actually in the autonomy award. That's  
 3 really the purpose of having something over and above  
 4 the social impact award which was about the direct  
 5 effect of stigma and other things which exists  
 6 regardless actually of the conduct of this type.  
 7 These are concepts which are quite difficult to be  
 8 expressed but I think much easier to understand when  
 9 looking at the stories that I heard and are available  
 10 to the Inquiry.  
 11 Q. So in relation to exemplary damages, is this right,  
 12 the -- or a key reason why you have not made  
 13 a recommendation is because in your view it would  
 14 essentially turn on findings of misconduct --  
 15 A. Yes.  
 16 Q. -- pejorative critical findings about the role of the  
 17 state, and that's the job of the Inquiry rather than  
 18 you?  
 19 A. It is, and it also fits, in my view, rather uneasily  
 20 into a scheme which is meant to be about compensation  
 21 and a scheme which is meant to take the place of --  
 22 because it is broader than in some ways litigation. So  
 23 in one sense you might say that the need for exemplary  
 24 damages is at least reduced whatever the findings of  
 25 the Inquiry by the fact that there is this scheme in

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

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

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

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

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

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

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

14 A. Yes.

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

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

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

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1 complexity to an already complex system.

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

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

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

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

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

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

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

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1 a relatively small proportion of what would otherwise  
 2 be a significant award, but we would have to see.  
 3 I see the case for it.  
 4 Q. Then we talked about the significance and the problems  
 5 created by missing medical records in the context of  
 6 establishing eligibility. The same kind of issues  
 7 might arise in the context here of establishing  
 8 testing when a patient wasn't informed and so on.  
 9 Would you, again in broad terms, envisage a similar  
 10 kind of approach as previously? So the assessor would  
 11 not be sitting as a tribunal of fact, would not be  
 12 interrogating the medical records, would not be  
 13 calling for evidence from the clinicians, but there  
 14 would be essentially an extent of having regard to the  
 15 findings of this Inquiry on the broader issues and  
 16 then perhaps taking on trust having regard to the  
 17 credibility of what's advanced, the applicant's  
 18 account of having been tested without consent or not  
 19 given information?  
 20 A. Very much that I think. I would expect that the  
 21 evidence that this Inquiry would be such as -- evidence  
 22 before this Inquiry to be such as to establish patterns  
 23 which could be taken into account. I think also it  
 24 might be relevant to note whether or not any individual  
 25 had been tested without their consent. If it was the

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1 up with a standard figure, by which I mean not the same  
 2 amount is given to everyone but there is a standard sum  
 3 which refers in part to a length of time that  
 4 an individual has suffered from the impact. Because it  
 5 is one thing to -- for an individual to have suffered  
 6 one year of stigma and then died, I don't wish to be  
 7 cruel about this but that may be some cases, whereas  
 8 others we are talking about a lifetime, 40, 50 years of  
 9 this. So there would have to be a reflection of time  
 10 and so on.  
 11 But I would think that it is as area where  
 12 perhaps less regard should be paid to individual  
 13 circumstances, and I say that for this reason.  
 14 I believe from what I have seen that the stigma and,  
 15 to some extent, general social consequences of these  
 16 diseases is such that everyone who has contracted them  
 17 will have suffered them. How they suffer them will  
 18 differ from case to case. So on one extreme people  
 19 may have lost friends, lost family, lost jobs and so  
 20 on. At the other end, none of those things have  
 21 happened because they kept everything quiet and to  
 22 themselves. It seems to me to distinguish in money  
 23 terms the value of one various from the other would be  
 24 artificial. It seems to me the way in which these  
 25 things are received, in a sense matters less than how

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1 circumstances are such that everyone might fear that  
 2 without knowing that that in itself might need to be  
 3 reflected in an award. Obviously, if it were possible  
 4 to show these specific insults in a technical sense had  
 5 occurred then that would make for a stronger case.  
 6 Q. Can I turn then to consider, next, recommendation 8.  
 7 So if we go over to the next page, please,  
 8 Lawrence.  
 9 So we are now looking at the heads of damage or  
 10 heads of award, I should say, for those who were  
 11 infected.  
 12 A. Yes.  
 13 Q. We have the five components there set out.  
 14 In relation to the impact injury award, you have  
 15 already explained how you envisage that happening with  
 16 the role of the medical panel and the legal panel and  
 17 the creation of the tariff and the grids.  
 18 Would you envisage the same in relation to the  
 19 social impact award?  
 20 A. I would, but the difference would be -- clearly, social  
 21 impact is not a medical matter, although clearly if  
 22 clinicians, and we can see that from the expert  
 23 reports, are well versed in noting some of these  
 24 impacts, there is also the psychosocial evidence, I see  
 25 this as an area where it would be appropriate to come

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1 long they have been received for.  
 2 But, again, there will be potential grades in  
 3 this because -- or could be, but I think essentially  
 4 we are talking about a standard figure that everyone  
 5 would get and would know what it is they get referable  
 6 to the length of time they have suffered from this  
 7 from.  
 8 Q. Can I just ask you about the table on page 107 of the  
 9 report. Again, so that there's no confusion about  
 10 what the significance of this table is.  
 11 A. Yes.  
 12 Q. So just before we look at the text above it, the table  
 13 itself says:  
 14 "Illustrative periodic figure for the impact of  
 15 stigma and social [exclusion]"  
 16 A. Yes.  
 17 Q. This table envisages that there might be different  
 18 social exclusion stigma awards for different  
 19 infections.  
 20 A. Possibly.  
 21 Q. Certainly for different periods of time. And you have  
 22 explained the rationale for that.  
 23 A. Yes.  
 24 Q. In relation to different infections --  
 25 A. The reason I have not been more specific is that

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1 I, frankly, didn't feel able, from what I saw, to work  
 2 out for myself whether HIV was a "worse" category than  
 3 hepatitis C or much the same, and so I think that would  
 4 be an area perhaps someone would need to look into.  
 5 Q. That is really the purpose of going to this. You are  
 6 not positively advocating that there should be  
 7 distinctions based upon the different disease?  
 8 A. No.  
 9 Q. You say in terms in paragraph 9.48 that would have to  
 10 be something that is decided by the expert panels.  
 11 A. My instinct was there might be a difference. It was  
 12 also my instinct that if you had both, there was  
 13 a co-infection, that might be worse, but I wasn't sure  
 14 about that.  
 15 Q. If we go back to the table, again, this is  
 16 an illustrative table. This suggests that the impact  
 17 of stigma and social isolation could mirror the  
 18 categorisation of mild, moderate and severe. Does  
 19 that necessarily follow? You may have had -- that the  
 20 stigmatising impact of whether it's HIV or hepatitis B  
 21 or hepatitis C may not depend upon the severity of the  
 22 underlying condition and the other experiences that  
 23 the individual might have suffered in terms of side  
 24 effects of treatment and so on?  
 25 A. Well, maybe, but on the other hand, someone who has had

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1 or other advice available to you about the feasibility  
 2 of constructing that kind of tariff system?  
 3 A. No, only what I -- no -- in terms of these particular  
 4 diseases?  
 5 Q. Yes.  
 6 A. No, not. It is not a question which was answered  
 7 obviously by the evidence that I saw, unless I missed  
 8 something. But it does seem to me from what I read  
 9 that there are some cases that are more serious than  
 10 others. Obviously, there are people who happily do not  
 11 develop liver problems, there are many who don't get  
 12 cancer, there are many who had a relatively  
 13 symptom-free time, albeit with worry maybe and  
 14 treatment and so on, whereas others had terrible  
 15 symptoms from a long period of time. So there are  
 16 degrees of severity.  
 17 The extent to which they can be classified and  
 18 described, if you ask me that, no, I have had no  
 19 expert advice on that. But, frankly, we -- certainly  
 20 as lawyers we spend our whole time looking at  
 21 conditions like asbestosis or pneumoconiosis, which  
 22 may be one condition but affects different people in  
 23 different ways and evaluating that in coming to  
 24 different values. All I am seeking to do here is try  
 25 to collect and classify -- or get cases classified

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1 15 years of symptom-free life, for instance, followed  
 2 by a period where these things come to life or a period  
 3 post-infection of an undiagnosed and symptom-free  
 4 period, he's unlikely to have suffered as much stigma,  
 5 in fact none, until later on. So I think there is  
 6 a case for saying there will be different degrees of  
 7 severity.  
 8 Q. But does that suggest that the length of time may be  
 9 more significant than the course that the illness has  
 10 taken?  
 11 A. It's both. If it's a mild case of hepatitis C, if  
 12 there is such a thing, and you may tell me there isn't,  
 13 but if there is such a case then there will be a level  
 14 of stigma, particularly if there are long periods of no  
 15 symptoms where life could be relatively normal, but if  
 16 we are talking about as opposed to someone who is  
 17 visibly very ill from these awful diseases. So I just  
 18 put that forward as a possible way forward.  
 19 It may be there aren't very many cases at the  
 20 mild end. But it does seem to me one needs the option  
 21 there, but I do think the length of time suffered for  
 22 is a significant impact.  
 23 Q. Yes. Just going back then to the injury impact award,  
 24 where you do envisage the categorisation potentially  
 25 into mild, moderate, severe, did you have any expert

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1 into more categories so that it is easier and quicker  
 2 to make awards than it would otherwise be.  
 3 Q. Would it be right to understand, drawing on your  
 4 broader experience of how compensation is assessed  
 5 more widely, it may not be easy to describe those  
 6 categories but it ought to be possible to do so?  
 7 A. Yes. Insofar as this may actually not be exclusively  
 8 a medical matter, and I think say somewhere, probably  
 9 not prominently enough, I don't necessarily see the  
 10 medical and legal panels operating in isolation all the  
 11 time, I can see there being an interchange between  
 12 them. So as would happen in a court case, the lawyers  
 13 and the judge would be consulting the medics about the  
 14 nature of the condition in a way which makes their  
 15 evidence relevant to damages, so I wouldn't necessarily  
 16 expect the medical panel to be able to come up  
 17 with this without dialogue with the legal panel.  
 18 Q. Again, I'm very conscious that you are trying to  
 19 describe a scheme that doesn't take forever to get up  
 20 and running, but would there also be a role on this  
 21 really very important issue of how you categorise  
 22 cases, a role for consultation with those infected --  
 23 A. Definitely, it is absolutely essential, and indeed you  
 24 would probably expect me to say this as Chair of  
 25 Healthwatch and the president of the Patients

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

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

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

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

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

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

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

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

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

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

13 Q. In your report, if we could go back, please, to  
14 page 103, so we have got a table here at the bottom:  
15 "Illustrative grid for an impact award by  
16 categories of severity."

17 So this is the injury impact element of your  
18 recommendations.

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

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

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

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

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

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

19 A. Yes.

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

23 A. Yes.

24 Q. Could we go to page 151, please.

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

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

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

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

21 If we go over the page, we can see there, just  
22 in relation to the top half of the page, there is  
23 a range given there of just under £60,000 to £107,410.  
24 So would it be right to understand that the way in  
25 which these kind of guidelines might be used in the  
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1 benefit of those listening what the Judicial College  
2 Guidelines are.

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

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

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

24 Now, of course, they don't cover every  
25 circumstance, as is illustrated by the sad facts we  
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1 assessment of damages, those representing the parties  
2 would look at them, the court would look at them and  
3 would then do their best to identify where within that  
4 range the individual case fell?

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

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

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

22 A. No.

23 Q. -- but I'm asked to explore with you because of the  
24 use of the figures made in your report and this,  
25 presumably whether it is the government looking at  
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1 your recommendations, the arm's length body setting up  
 2 its scheme if one is commissioned, the panels looking  
 3 at it or individual assessors they should guide  
 4 themselves to the extent that they are going to look  
 5 at the Judicial College Guidelines as a source and  
 6 only one source, they should look at the most recent  
 7 version?  
 8 A. Certainly. I'm not sure if the 2022 edition hasn't  
 9 already come out.  
 10 Q. It has --  
 11 A. I think it came out more or less as I signed off this  
 12 report, must to my --  
 13 Q. It came out in May, in fact, so a few weeks after your  
 14 report.  
 15 A. You've got to stop somewhere. But you are absolutely  
 16 right, we have to use -- or they should use the  
 17 up-to-date editions. And indeed the figures -- where  
 18 occasionally in these Guidelines a significant change  
 19 is made other than the rate of inflation because there  
 20 has been some case that has seen a different perception  
 21 in something, and that would be one reason why any  
 22 figures they come up with probably need to be kept  
 23 under review.  
 24 Q. Would it also be right to understand that again,  
 25 looking at it from the perspective of a court, for

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1 (3.14 pm)

2 (A short break)

3 (3.45 pm)

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

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

9 The footnote at the bottom of the page says  
 10 this:

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

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

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1 present purposes being the principal user of these  
 2 guidelines, that a judge, when deciding on the  
 3 equivalent of the injury impact award, the general  
 4 damages for pain, suffering and loss of immunity, will  
 5 potentially increase further by reference to the  
 6 current RPI?  
 7 A. Yes, I'm sorry. My pause is whether it is still the  
 8 RPI or now something else, the CPI, the Consumer Prices  
 9 Index. I think it depends.  
 10 Q. So the important --  
 11 A. But there is a rate -- clearly the rate of inflation --  
 12 we uprate these figures and we are now, unhappily, back  
 13 in times of inflation being more than minimal, so this  
 14 would be paid attention to in some detail in a court  
 15 case, yes.  
 16 Q. And probably should be something that the scheme or  
 17 the panel would themselves have in mind --  
 18 A. Yes, it probably would be possible to have in the rules  
 19 of the scheme that it would automatically uprate things  
 20 by that, by reference to whatever index they referred  
 21 to.  
 22 MS RICHARDS: Sir, I note the time, perhaps a good moment  
 23 for the afternoon break.  
 24 SIR BRIAN LANGSTAFF: Yes, that is a good point at which  
 25 to break. 3.45 pm.

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1 something called the Simmons v Castle uplift.

2 A. I think you are right about that.

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

7 A. Yes.

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

12 A. Yes.

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

25 A. It includes the figure?

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1 Q. Yes, that's what I'm told. It may be that you --  
 2 A. I'm sorry, I perhaps should declare for the sake of  
 3 transparency that I actually retired from full-time  
 4 practice two years ago, so for that reason rather  
 5 gladly I have not kept as up to date as I might, but --  
 6 and I certainly haven't looked in detail at the 2022  
 7 figures. If, in fact, solicitors no longer take costs  
 8 which were intended to be reflected in the 10% uplift,  
 9 then I would expect that uplift to go rather than be  
 10 included in whatever the figures are left.  
 11 Q. I can perhaps pick it up over night by checking the  
 12 2022 guidelines and see if the position is clear.  
 13 A. Maybe I can do the same.  
 14 **SIR BRIAN LANGSTAFF:** Yes, I mean, there's an option which  
 15 is that I think we have in the room somebody who is  
 16 part of the panel which compiled the damages, and if  
 17 so I would certainly give permission for him to talk  
 18 to Sir Robert and Sir Robert to talk to him if that  
 19 were thought advisable over the break.  
 20 **MS RICHARDS:** It may not surprise you to know, sir, that  
 21 it is Mr Snowden who asked me to raise this point.  
 22 **SIR BRIAN LANGSTAFF:** In which case he might be the  
 23 appropriate person to -- (overspeaking) --  
 24 **MS RICHARDS:** The short point being that effectively, in  
 25 addition to the RPI and taking the figures from the

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1 I think -- and you could put some of these in either  
 2 but maybe more accurately they are social impact, which  
 3 is where they are in this section.  
 4 Q. But either way, again, when -- on your model, when the  
 5 legal panel is identifying the range of tariffs, your  
 6 suggestion is that there should be reflected --  
 7 A. Yes.  
 8 Q. -- these losses.  
 9 A. And again, these are figures which no one would see --  
 10 claim -- reflect the reality of people suffering that  
 11 are nominal, that -- and it would seem to me there is  
 12 no case for them being very different from that which  
 13 you get in a court hearing.  
 14 Q. Can I then, if we go to the bottom of the page, just  
 15 pick it up with the care award. So, again, this is  
 16 an element of the award that could be claimed by  
 17 an infected person.  
 18 If we go over the page top of the next page.  
 19 Page 110, please. You identify in paragraph 9.62 that  
 20 the need an incidence of the care required may be very  
 21 variable. So this isn't a one-size-fits-all type of  
 22 award, some people might have had very extensive  
 23 needs, some might have had comparatively limited needs  
 24 for care.  
 25 Then you have set out below how the court would

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

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

9 Can I just come again briefly to the social  
 10 impact award.

11 A. Yes.

12 Q. If we go to the report, page 108. I asked you some  
 13 questions earlier about the way in which the social  
 14 impact award might be approached. I just wanted to  
 15 flag up, again really just so that those following can  
 16 understand, that your recommendation is that two  
 17 matters to be reflected in the social impact award is  
 18 interference with the ability to form a marriage,  
 19 partnership or equivalent long-term relationship and  
 20 then, over the page, the loss of chance to have  
 21 children?

22 A. Yes. I should say, on re-reading this, the report is  
 23 not as clear as it could be on whether that should be  
 24 part of the social impact or the autonomy award, but  
 25 there is a potential, I think, for overlap there. But

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

6 So you have said here:

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

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

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

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

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1 a broad-brush approach to the thing rather than  
2 a detailed bespoke assessment for each individual.  
3 Q. The advantage of the more broad-brush approach that  
4 you've go on to outline the following two perhaps,  
5 which I will read in a moment, is speed --

6 A. Yes.

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

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

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

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

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

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

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

15 "9.67 Whatever approach is taken, this is  
16 an area where the advantages of avoiding a demanding  
17 process involving detailed evidence and expert support  
18 suggest that a high degree of self assessment should  
19 be encouraged, but limited by reference to expert  
20 based standardised presumptions with regard to care  
21 needs and costs."

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

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

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

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

19 A. Yes.

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

23 A. Yes.

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

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

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

18 A. Yes.

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

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

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1 scheme itself getting just some general advice about  
2 care needs.

3 A. Yes.

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

14 A. Yes.

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

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

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

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

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

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

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

15 How would you propose that working in practice?

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

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

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

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

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

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

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

14 A. Yes, and maybe for other financial losses.

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

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

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

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

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

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

14 A. Sure.

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

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

20 A. Yes.

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

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

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

13 A. No.

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

16 A. Yes.

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

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

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

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

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

19 Obviously in other cases that is less so, so  
20 people will say, "I have been working in a particular  
21 managerial position but I lost a promotion because of  
22 my illness and if I'd got the promotion I would have  
23 earned so much more", so there is that sort of  
24 evidence, and then if there is uncertainty, of course,  
25 according to the case. Again, if we choose to you can

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1 A. I think I dealt with that elsewhere, and certainly in  
2 the case of children who have no career history and so  
3 they have no period of their life with a working  
4 history not affected by their illness, then one almost  
5 certainly has to resort to some sort of overall  
6 average. The reason being that while -- you know, the  
7 children of Goldman Sachs bank don't necessarily end up  
8 as Goldman Sachs bankers, many of them go the very  
9 opposite way and become conscientious social workers.  
10 And rather less, likewise the children of social  
11 workers might become bankers, so you can't speculate  
12 about these things, you just have to take averages, and  
13 as with all such approaches it overcompensates some  
14 people and undercompensates others, but they at least  
15 get recognition for that particular loss, but that's  
16 true of the Common Law system as much as it would be  
17 here.

18 Q. Again, you have made this clear in your report and in  
19 your earlier evidence, but you would not propose past  
20 support payments to be deducted from those sums --

21 A. No. And I have set the reasons out for that.  
22 Principally because of the nature and the way in which  
23 these were described and formulated at the time, and if  
24 they are meant to be charitable payments, well, they  
25 are charitable payments.

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1 get as precise as you like about it or it is possible  
2 on the evidence but, again, my approach here has been  
3 to seek to encourage a scheme to approach things on  
4 a rather broader basis so people can get a swift  
5 solution without the need for hugely complicated  
6 figures and all the rest of it.

7 Q. Would there again be an element of choice that  
8 an individual might, for example, say, "When I was  
9 diagnosed with HIV and became ill or ill from my  
10 condition from the treatments I was receiving for it  
11 I had to give up my work as a teacher" --

12 A. Yes.

13 Q. -- and they can provide an indication of the income  
14 they were on, they can describe what they thought  
15 their career path would have been, probably with  
16 a degree of straightforwardness, and the calculation  
17 of past loss of earnings could be on the basis of what  
18 they have lost in those terms?

19 A. Yes.

20 Q. Alternatively, an individual could either not feel  
21 able to say exactly what would have happened, perhaps  
22 particularly for those infected when younger and  
23 before an employment and they could still bring their  
24 past loss of earnings claim but it would be assessed  
25 most likely in the way you have described here?

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1 Q. I have been asked to ask you about your use of the  
2 word "persuasively" in the second paragraph of 9.95.  
3 Does that suggest some higher burden or more cogent  
4 evidence that's required?

5 A. I think what I mean is that I would go back to the fact  
6 that I wouldn't suggest that there is a formal burden  
7 or standard of proof set out, which leads to legal  
8 complexity. But I would suggest that -- and I'm  
9 deliberately trying not to use legal language -- that  
10 an infected person should be able to show -- be  
11 persuasively assessed that they have been unable to  
12 work or had reduced earning capacity. Which, frankly,  
13 I don't think would be difficult in most cases.

14 But there will be cases of difficulty, where  
15 middle-aged adults have been unemployed for years for  
16 all sorts of different reasons and, you know, what  
17 would -- if they come along and suddenly say that they  
18 were going to be earning hundreds of thousands of year  
19 as an entrepreneur, it might be possible -- it would  
20 only be right for the scheme to question that.

21 What I'm trying to say is of course you should  
22 start off by listening carefully with respect to what  
23 the applicant says, but this is slightly different  
24 from an applicant coming forward with a history of  
25 what has happened as a matter of fact as opposed to

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1 what this is, which would be expressing their opinion  
2 as to how well or otherwise they would have done. And  
3 to be quite honest, most of us probably had a slightly  
4 rosier-coloured view of our prospects in life than  
5 maybe others might think. Not all of us.

6 Q. You have talked here about the important role of the  
7 assessor --

8 A. Yes.

9 Q. -- and the need for a degree of proactivity, sympathy,  
10 understanding and the like, but in terms of what you  
11 are describing for the individual to make out a case  
12 as to why they are in category 1 rather than  
13 category 2 for the injury award or to explain why they  
14 might be entitled to the loss of relationship element  
15 of the social impact award, or to make out a claim for  
16 past gratuitous care provided by family members or  
17 loss of earnings, they're going to -- a lot of  
18 individuals are going to require help to do that,  
19 aren't they?

20 A. Yes. Well, I would hope, firstly, that the assessment  
21 system would be supportive and would be within it doing  
22 its best, as it were, to produce the case for and with  
23 the applicant. You are right, this is not necessarily  
24 easy stuff, you know, any more than filling in your tax  
25 return is easy stuff for all people, but guided through

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1 the morning when everyone is fresh and hopefully the  
2 room might be a bit cooler.

3 **SIR BRIAN LANGSTAFF:** Yes, well, it has been a very warm  
4 day for lots of us. So let's break now and come back  
5 at 10.00 am. So 10.00 am tomorrow for the next set of  
6 questions. 10 o'clock.

7 (4.22 pm)

8 (The Inquiry adjourned until 10.00 am on Tuesday,  
9 12 July 2022)

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1 a process it seems to me that most people should be  
2 able to do that.

3 Now, obviously, there will be cases of  
4 significant complexity where some form of outside  
5 help -- and I have advised or recommended that there  
6 should be a sort of advocacy support system and, of  
7 course, some people will have their own legal  
8 representatives, but I'm deliberately trying to  
9 suggest that this should be as least legalistic as is  
10 possible, but I don't think we can avoid it in all  
11 cases. And some cases people's circumstances vary  
12 significantly, but some people's cases in financial  
13 terms are much simpler than others. So it is not  
14 necessarily everyone who will need outside support but  
15 most people, I would accept, will need internal  
16 support from the scheme about putting their claim  
17 together, and it can't just be a matter of asking  
18 someone to fill in a form online at home and hope for  
19 the best. I just don't think that's going to work.  
20 You need a process of interview, collaboration and  
21 conversation, all taking time but one would hope less  
22 time than having to repeat that umpteen times, which  
23 is what would happen in litigation.

24 **MS RICHARDS:** Sir, I'm going to move to another topic and  
25 I'm going to suggest, therefore, that we do that in

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2 **SIR ROBERT ANTHONY FRANCIS (sworn)**

2 **Examination-in-chief by MS RICHARDS**

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(57) eligibility... - experience

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(58) experience... - formalise

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(60) grandparent - here



<b>H</b>	126/1 131/6 177/20 178/18 178/21 <b>hopefully [2]</b> 166/16 179/1 <b>hoping [1]</b> 40/2 <b>horrific [1]</b> 96/4 <b>hospital [3]</b> 93/8 105/10 160/20 <b>hot [1]</b> 1/18 <b>hour [3]</b> 40/13 105/13 167/5 <b>hours [7]</b> 40/17 105/4 105/13 160/24 161/3 161/14 162/1 <b>house [1]</b> 167/6 <b>how [59]</b> 3/23 6/14 9/21 10/15 13/2 13/16 14/23 22/6 23/4 28/22 31/17 31/18 40/12 40/17 40/20 40/21 41/1 42/20 54/6 58/8 60/17 61/1 79/12 85/12 85/16 87/21 89/8 107/22 117/14 118/17 120/8 123/6 124/4 124/23 125/5 127/2 134/4 134/15 138/15 139/17 139/25 144/4 144/21 145/14 145/24 146/13 147/13 147/18 148/22 151/12 159/25 160/7 162/1 162/6 165/1 165/2 168/15 172/14 177/2 <b>however [3]</b> 73/22 147/12 169/12 <b>HTLV [1]</b> 84/14 <b>HTLV-III [1]</b> 84/14 <b>hugely [2]</b> 161/10 174/5 <b>human [5]</b> 51/22 131/19 134/11 134/12 134/17 <b>hundreds [4]</b> 1/16 135/16 135/20 176/18 <b>hunting [1]</b> 111/2 <b>hurdle [1]</b> 172/11 <b>I</b> <b>I absolutely [1]</b> 41/24 <b>I accept [2]</b> 108/20 110/8	<b>I actually [3]</b> 67/15 103/24 157/3 <b>I admit [1]</b> 125/22 <b>I agree [1]</b> 82/10 <b>I also [2]</b> 21/8 67/2 <b>I am [7]</b> 12/24 65/16 71/15 72/23 118/8 143/24 156/14 <b>I anticipate [1]</b> 119/12 <b>I apologise [2]</b> 14/15 87/15 <b>I appreciate [5]</b> 53/9 61/7 77/16 93/2 165/6 <b>I are [1]</b> 158/7 <b>I ask [4]</b> 22/25 71/22 92/10 123/19 <b>I asked [1]</b> 158/12 <b>I believe [4]</b> 20/4 43/17 98/13 139/14 <b>I call [1]</b> 46/1 <b>I came [1]</b> 37/22 <b>I can [16]</b> 11/14 20/6 56/24 57/7 72/21 94/5 100/8 102/1 117/3 121/2 130/13 144/11 157/11 157/13 158/4 161/19 <b>I can't [1]</b> 103/9 <b>I cannot [1]</b> 10/20 <b>I certainly [2]</b> 5/13 157/6 <b>I come [3]</b> 35/21 101/12 146/1 <b>I confess [1]</b> 40/11 <b>I consider [1]</b> 65/19 <b>I considered [1]</b> 52/2 <b>I could [6]</b> 44/4 67/12 76/5 116/6 136/25 168/22 <b>I couldn't [2]</b> 10/18 133/18 <b>I deal [1]</b> 20/24 <b>I dealt [1]</b> 175/1 <b>I deliberately [1]</b> 9/11 <b>I did [9]</b> 6/20 6/23 8/14 9/15 11/5 55/24 67/16 72/15 102/16 <b>I didn't [2]</b> 68/17 131/3 <b>I do [11]</b> 9/24 49/14 97/9 102/1 116/5 125/16 125/20 133/23	142/21 156/8 168/20 <b>I don't [22]</b> 5/15 17/5 44/21 51/19 56/1 56/11 71/4 85/15 93/14 93/15 100/1 105/13 118/9 118/18 119/23 120/24 121/7 133/16 133/21 144/9 176/13 178/10 <b>I envisage [2]</b> 117/1 117/20 <b>I envisaged [1]</b> 72/14 <b>I expect [1]</b> 1/17 <b>I explore [1]</b> 74/9 <b>I feel [1]</b> 77/12 <b>I felt [3]</b> 22/5 51/14 101/6 <b>I first [1]</b> 42/16 <b>I frankly [1]</b> 5/13 <b>I had [4]</b> 10/14 68/5 88/24 174/11 <b>I handed [1]</b> 16/1 <b>I hark [1]</b> 121/14 <b>I have [48]</b> 10/21 14/11 17/18 18/16 19/12 22/13 34/2 43/16 51/15 55/5 60/10 65/13 67/8 67/10 67/11 67/12 71/20 77/3 80/17 94/4 97/1 97/17 98/17 99/20 101/10 101/25 106/10 108/12 113/10 116/22 120/4 126/18 133/16 134/20 135/11 139/14 140/25 143/18 147/4 157/5 158/5 162/10 162/14 170/6 173/20 175/21 176/1 178/5 <b>I haven't [1]</b> 64/11 <b>I heard [4]</b> 10/11 20/3 100/23 132/9 <b>I hope [6]</b> 10/21 49/25 65/16 96/15 126/1 131/6 <b>I identified [1]</b> 73/5 <b>I identify [1]</b> 87/1 <b>I imagine [2]</b> 93/13 93/14 <b>I intended [1]</b> 97/15 <b>I just [20]</b> 3/23 17/21	18/2 49/18 56/25 65/3 77/4 100/9 106/9 107/17 113/19 117/13 120/9 140/8 142/17 155/23 158/9 158/14 160/1 178/19 <b>I knew [1]</b> 131/3 <b>I know [4]</b> 69/5 86/24 121/14 162/16 <b>I learnt [1]</b> 21/3 <b>I looked [3]</b> 39/2 52/4 67/2 <b>I lost [1]</b> 173/21 <b>I made [1]</b> 6/25 <b>I may [8]</b> 24/23 52/3 61/10 67/4 75/8 118/19 155/23 166/17 <b>I mean [21]</b> 44/5 61/17 72/11 80/2 93/13 94/15 98/14 104/7 108/5 108/13 110/23 113/17 119/24 126/14 136/9 139/1 148/3 149/7 157/14 167/12 176/5 <b>I met [2]</b> 45/19 68/18 <b>I might [2]</b> 69/2 157/5 <b>I missed [1]</b> 143/7 <b>I misunderstood [1]</b> 167/13 <b>I must [1]</b> 72/15 <b>I needed [3]</b> 10/2 10/16 10/17 <b>I note [3]</b> 54/12 105/17 154/22 <b>I obviously [1]</b> 168/23 <b>I occasionally [1]</b> 152/6 <b>I only [1]</b> 15/4 <b>I ought [1]</b> 75/14 <b>I pick [1]</b> 89/23 <b>I picked [1]</b> 64/7 <b>I propose [1]</b> 71/4 <b>I put [5]</b> 21/6 63/17 126/22 127/9 167/1 <b>I read [5]</b> 21/19 73/4 103/8 131/16 143/8 <b>I received [2]</b> 59/16 59/20 <b>I recognise [3]</b> 13/2 13/16 22/17 <b>I recommended [2]</b>
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(61) here... - I recommended

<b>I</b>	81/1 82/1 82/1 82/18 82/21 83/17 85/14 87/5 87/13 87/19 92/11 97/11 97/16 98/10 103/2 103/24 108/16 112/6 112/19 113/10 115/11 116/22 117/20 120/16 120/18 121/12 121/24 128/1 129/3 132/8 133/3 133/19 133/24 134/6 136/6 136/9 136/16 136/21 137/20 137/23 140/3 142/5 144/8 147/16 147/17 147/18 153/11 154/9 156/2 157/15 159/1 162/9 162/15 167/9 169/6 171/5 173/11 175/1 176/5 <b>I thought [9]</b> 9/23 21/15 39/18 48/1 64/8 68/20 132/1 148/6 152/7 <b>I to [1]</b> 84/23 <b>I tried [1]</b> 89/18 <b>I turn [1]</b> 138/6 <b>I understand [10]</b> 8/22 14/5 24/13 37/9 38/18 47/23 72/11 86/16 152/20 155/24 <b>I want [6]</b> 22/19 49/4 62/3 64/18 79/2 117/8 <b>I wanted [3]</b> 46/18 83/10 94/10 <b>I was [29]</b> 9/20 10/12 11/14 20/22 24/21 36/9 37/12 37/13 39/19 39/25 40/1 44/19 59/18 59/25 81/11 89/6 89/7 89/18 91/3 92/22 93/1 96/15 103/8 127/3 131/16 145/10 146/21 174/8 174/10 <b>I wasn't [2]</b> 68/20 141/13 <b>I will [14]</b> 12/7 12/14 24/3 25/17 26/23 39/12 47/5 48/19 49/13 64/21 105/22 106/4 130/13 163/5	<b>I wonder [2]</b> 76/24 80/24 <b>I would [42]</b> 1/24 14/13 16/13 41/17 56/11 57/3 72/12 73/8 75/17 76/4 76/18 85/9 87/3 103/13 103/15 105/10 109/4 111/3 117/23 119/23 122/7 122/13 123/15 125/16 126/18 126/25 131/4 134/23 135/7 137/20 138/20 139/11 145/2 157/9 157/17 162/20 163/19 173/22 176/5 176/8 177/20 178/15 <b>I wouldn't [4]</b> 56/11 144/15 163/10 176/6 <b>I wrote [1]</b> 20/14 <b>I'd [1]</b> 173/22 <b>I'd got [1]</b> 173/22 <b>I'll [4]</b> 30/12 35/5 58/11 160/3 <b>I'm [77]</b> 1/5 2/10 5/23 5/23 7/17 10/17 17/5 22/13 23/7 25/1 38/14 44/4 46/10 46/11 46/12 51/19 53/5 53/18 59/21 64/5 64/19 67/18 69/6 70/8 70/10 72/4 73/10 75/13 79/18 79/20 80/11 85/21 85/21 87/5 90/25 95/15 97/19 98/7 100/2 100/19 103/21 104/1 105/17 109/21 109/24 110/13 111/1 111/9 111/17 116/4 119/2 119/7 124/17 126/1 128/4 129/10 133/16 133/20 144/18 149/5 149/14 152/23 153/8 154/7 156/13 157/1 157/2 162/16 163/17 167/24 168/10 168/16 176/8 176/21 178/8 178/24 178/25 <b>I've [15]</b> 15/25 22/17 23/23 44/24 49/25 51/15 57/14 60/22 82/2 82/3 82/5 82/10	111/14 112/6 115/17 <b>I've had [1]</b> 15/25 <b>I've read [1]</b> 112/6 <b>I've set [1]</b> 82/5 <b>I've suggested [1]</b> 115/17 <b>I've tried [1]</b> 44/24 <b>I, [1]</b> 141/1 <b>I, frankly [1]</b> 141/1 <b>Ian [1]</b> 13/11 <b>Ian Lavery [1]</b> 13/11 <b>idea [8]</b> 6/17 22/20 31/22 36/11 47/9 85/11 128/18 130/13 <b>ideally [3]</b> 43/16 128/19 129/9 <b>ideas [1]</b> 127/22 <b>identification [2]</b> 84/18 86/10 <b>identified [9]</b> 27/21 43/9 43/11 44/15 57/14 59/12 73/5 113/4 127/21 <b>identifies [1]</b> 69/25 <b>identify [14]</b> 5/24 29/23 41/5 41/5 42/14 70/10 84/5 87/1 110/23 111/10 152/3 159/19 160/18 171/10 <b>identifying [5]</b> 21/11 52/12 53/24 110/1 159/5 <b>if [216]</b> <b>Ill [1]</b> 84/14 <b>ill [3]</b> 142/17 174/9 174/9 <b>illness [6]</b> 115/3 131/25 142/9 172/1 173/22 175/4 <b>illusory [1]</b> 72/7 <b>illustrate [1]</b> 43/7 <b>illustrated [1]</b> 150/25 <b>illustrating [1]</b> 37/13 <b>illustration [1]</b> 148/22 <b>illustrations [1]</b> 64/8 <b>illustrative [4]</b> 140/14 141/16 148/15 149/13 <b>imagine [4]</b> 93/13 93/14 109/8 167/1 <b>immediate [5]</b> 15/4 18/17 21/25 48/15 96/2	<b>immediately [1]</b> 34/25 <b>immunity [1]</b> 154/4 <b>impact [46]</b> 20/3 27/22 28/1 28/7 28/14 29/7 29/21 39/16 39/18 39/23 47/18 47/19 65/10 65/25 70/24 76/15 82/22 95/24 101/1 103/17 107/6 108/6 108/15 109/5 109/6 109/6 132/4 138/14 138/19 138/21 139/4 140/14 141/16 141/20 142/22 142/23 148/15 148/17 154/3 158/10 158/14 158/17 158/24 159/2 170/3 177/15 <b>impacts [2]</b> 68/9 138/24 <b>implement [1]</b> 5/4 <b>implicated [1]</b> 118/5 <b>implication [1]</b> 97/14 <b>implies [1]</b> 150/3 <b>importance [2]</b> 113/5 170/13 <b>important [17]</b> 2/2 9/24 13/2 13/16 15/13 59/23 60/7 60/17 60/20 69/13 82/13 110/12 121/24 144/21 148/19 154/10 177/6 <b>importantly [1]</b> 31/20 <b>impossible [4]</b> 36/10 44/22 118/21 125/21 <b>impressed [4]</b> 89/6 89/18 103/8 128/8 <b>Improving [1]</b> 58/22 <b>inability [2]</b> 88/22 171/25 <b>incapacitated [1]</b> 172/9 <b>incarnations [1]</b> 60/14 <b>inchoate [1]</b> 27/16 <b>incidence [1]</b> 159/20 <b>include [10]</b> 4/19 24/11 48/25 59/7 65/14 71/12 84/9 84/14 97/15 102/24 <b>included [10]</b> 23/19 24/4 65/17 68/4 78/16
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(62) I recommended... - included

<b>I</b>	108/23 108/24 113/6 120/5 120/15 120/20 120/22 122/4 122/22 123/12 125/18 128/22 129/7 133/10 137/24 139/4 139/5 139/12 141/23 152/4 153/3 163/2 165/2 166/21 170/24 171/8 171/10 172/9 174/8 174/20 177/11 <b>individual's</b> [3] 38/24 109/17 166/10 <b>individualised</b> [3] 40/8 40/9 58/9 <b>individuality</b> [1] 42/4 <b>individually</b> [2] 38/24 124/17 <b>individuals</b> [14] 27/6 40/4 70/2 76/15 76/16 76/17 95/12 96/7 109/21 123/17 126/4 133/8 147/8 177/18 <b>ineligible</b> [1] 82/9 <b>inevitable</b> [2] 39/8 95/25 <b>inevitably</b> [2] 82/20 99/10 <b>infected</b> [97] 3/18 3/20 4/18 8/5 8/6 10/2 13/13 13/17 13/20 18/18 18/22 19/4 19/11 20/5 21/11 23/1 24/15 24/20 24/25 25/5 25/24 26/1 26/2 26/12 26/19 26/20 26/21 27/20 29/10 29/12 30/2 30/22 37/16 45/22 46/24 47/18 54/8 59/14 64/25 65/12 66/1 67/25 70/2 71/25 72/2 73/20 74/2 74/6 74/11 74/12 74/12 74/19 76/15 76/16 77/19 78/23 79/4 81/2 81/8 81/15 83/24 88/3 90/16 94/11 98/9 98/16 98/21 99/22 100/4 100/18 100/20 100/21 100/22 100/25 103/19 104/16 104/19	105/2 106/13 107/18 107/21 108/7 108/24 119/21 130/1 138/11 144/22 159/17 163/25 164/6 164/14 168/9 170/18 171/21 172/19 174/22 176/10 <b>infection</b> [40] 23/21 24/8 25/20 29/9 65/17 65/24 66/10 66/15 68/10 69/20 70/5 70/16 71/15 74/13 74/23 76/2 77/20 78/14 85/19 86/8 98/25 99/23 100/4 100/13 103/20 104/3 104/20 105/2 106/15 106/20 107/5 109/6 110/7 136/19 141/13 142/3 171/25 172/1 172/10 172/21 <b>infections</b> [10] 23/12 37/2 65/14 66/12 74/2 84/17 94/7 104/6 140/19 140/24 <b>inferences</b> [1] 89/2 <b>inflation</b> [10] 31/12 33/1 33/9 34/6 48/14 150/16 152/15 153/19 154/11 154/13 <b>inflicted</b> [4] 9/14 50/11 50/12 50/25 <b>influenced</b> [1] 20/22 <b>informality</b> [1] 55/18 <b>informally</b> [1] 44/25 <b>information</b> [40] 10/17 36/7 41/25 59/17 60/4 70/1 70/4 75/22 77/3 79/24 82/23 87/3 88/9 88/14 88/15 89/5 90/4 90/6 91/5 95/15 95/20 120/19 121/9 121/20 122/8 122/11 122/23 123/6 123/10 123/17 126/6 126/7 130/5 135/24 137/19 155/24 165/18 166/9 166/19 166/20 <b>information/evidence</b> [1] 123/10 <b>informed</b> [10] 10/22	41/25 73/23 74/14 93/24 130/4 135/24 136/12 137/8 158/7 <b>infrastructure</b> [1] 3/15 <b>inheritance</b> [6] 112/4 112/6 112/14 112/20 112/25 115/22 <b>inhumane</b> [1] 134/13 <b>initial</b> [3] 5/9 7/3 41/3 <b>injured</b> [3] 50/2 160/14 160/21 <b>injuries</b> [10] 9/14 29/2 37/24 43/18 50/11 62/18 149/3 149/5 149/6 151/2 <b>injury</b> [41] 6/3 27/13 27/22 29/7 29/8 29/18 38/1 39/15 42/17 42/24 47/18 75/5 102/17 102/19 102/22 103/15 108/6 112/12 112/23 119/15 130/18 131/13 131/23 134/10 135/3 136/19 138/14 142/23 146/6 148/17 150/12 150/15 150/19 150/22 154/3 156/6 161/7 161/17 170/3 170/18 177/13 <b>injustice</b> [2] 71/24 73/9 <b>input</b> [2] 7/8 47/11 <b>inquiry</b> [64] 2/20 4/15 4/24 5/1 5/5 6/24 8/3 8/19 8/25 9/7 10/5 10/19 10/21 12/10 12/11 13/2 13/5 13/23 13/25 15/15 16/20 16/22 16/24 18/10 19/9 22/14 24/2 37/16 41/11 41/19 46/17 49/9 49/24 50/16 52/17 65/11 66/23 68/23 69/4 75/1 76/13 85/14 87/2 91/10 91/20 93/25 96/4 113/13 113/16 113/16 118/19 119/20 120/2 123/13 123/15 124/18 130/8 132/10 132/17 132/25 137/15 137/21	137/22 179/8 <b>Inquiry's</b> [5] 5/1 5/5 8/25 67/1 67/19 <b>insignificant</b> [1] 111/19 <b>insofar</b> [6] 24/8 24/19 51/9 68/11 93/22 144/7 <b>instance</b> [12] 27/14 33/19 63/12 79/21 89/12 95/17 95/22 98/1 104/3 113/12 142/1 167/5 <b>instances</b> [1] 109/17 <b>instead</b> [2] 30/3 31/5 <b>instinct</b> [3] 51/21 141/11 141/12 <b>instructed</b> [1] 160/13 <b>insults</b> [1] 138/4 <b>insurance</b> [2] 63/20 63/21 <b>insured</b> [1] 161/6 <b>insurers</b> [1] 64/3 <b>intend</b> [1] 65/1 <b>intended</b> [6] 14/20 30/16 64/17 97/15 155/17 157/8 <b>intention</b> [5] 4/11 12/8 12/22 13/5 13/22 <b>interact</b> [1] 121/15 <b>interacted</b> [1] 121/17 <b>interchange</b> [1] 144/11 <b>interdependence</b> [1] 117/5 <b>interest</b> [3] 48/14 118/3 118/7 <b>interested</b> [2] 14/25 63/8 <b>interference</b> [6] 28/7 131/18 131/19 131/20 134/7 158/18 <b>interferences</b> [1] 130/3 <b>interferon</b> [3] 37/6 42/10 96/6 <b>interim</b> [15] 17/22 18/3 18/17 19/3 19/18 19/20 21/9 21/18 21/25 48/16 126/19 126/21 127/5 127/6 127/15
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(67) mild... - needs



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(68) needs... - operated



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(76) shared - something



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