

Thursday, 25th March 2021

(10.00 am)

**SIR BRIAN LANGSTAFF:** Good morning. Can you see me?

**THE WITNESS:** Yes, I can.

**SIR BRIAN LANGSTAFF:** Well, I can see you and you can obviously hear me. I understand since you have retired from being a professor you prefer not to use the title "Professor". That's right, I think, isn't it?

**THE WITNESS:** I don't think I am entitled to call myself and I don't, so no.

**SIR BRIAN LANGSTAFF:** So you don't. So we will call you Mr Mildred if we have to use any name.

**THE WITNESS:** Yes, please do.

**SIR BRIAN LANGSTAFF:** Very well. Can I explain to you, Mr Mildred, where we are and who is listening. First you can tell us you are at home, are you?

**THE WITNESS:** I am, yes.

**SIR BRIAN LANGSTAFF:** I gather there is somebody else there who may come in with a cup of coffee as and when required?

**THE WITNESS:** I don't think so. There is somebody else here but I think doing something different in a different room.

**SIR BRIAN LANGSTAFF:** I have been misinformed but, in any

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talking to. Now, Mary will ask you to take the oath.

**MARK MILDRED (affirmed)**

**Questions by MS SCOTT**

**MS SCOTT:** Mr Mildred, can you see and hear me?

**A.** I can. Thank you.

**Q.** You were the chair of the Skipton Appeal Panel from 2006 until its final meeting in July 2017; is that correct?

**A.** Yes.

**Q.** You have set out your background and experience and qualifications in your witness statement and you tell us you were admitted as a solicitor in 1975, and you worked in private practice, specialising in liability for defective products and in class actions and, during that time, you published a large volume of work on the subject and lectured; is that correct?

**A.** Yes.

**Q.** You also tell us in your statement that, during your career as a solicitor in private practice, you were a leading member of the team advising the Claimants in the HIV haemophilia litigation from 1988 and remained involved in that litigation through to settlement and the establishment of the Macfarlane Trust in 1991; is that also correct?

**A.** Yes.

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event, when we have a break, you can talk to that person about anything you like, but not about the evidence that you have given or may yet give. The familiar --

**THE WITNESS:** Yes, I understand.

**SIR BRIAN LANGSTAFF:** -- thing which judges say and it is the rule.

Now, you are talking, first of all, to this room here, Fleetbank House, where, although we have enough space in non-virus times to have a couple of hundred people, we have eight, all suitably masked up, except for Ms Scott, who will be asking you the questions. Mary will come and ask you to affirm in a moment or two. The other name you may hear is Soumik, whose job it is to show you any particular documents that Ms Scott wants to refer you to.

**THE WITNESS:** Yes.

**SIR BRIAN LANGSTAFF:** But the real audience is that beyond this room, watching remotely, for obvious reasons, there will be -- yesterday there were about 250 watching. It will vary from time to time during the day, but that's roughly the size of the audience who are interested to know what you have to say.

**THE WITNESS:** Yes.

**SIR BRIAN LANGSTAFF:** So those are the people you are

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**Q.** You also tell us that you gave some informal advice to the Claimants' legal teams in the hepatitis C litigation and in the vCJD litigation; is that correct?

**A.** Yes.

**Q.** Just to make it clear to you, Mr Mildred, and to those listening at home that I am not going to ask you any questions today about the work that you did in that litigation but that will be the focus of a further request to you for a further witness statement in due course?

**A.** Yes.

**Q.** You then tell us that you left full-time private practice in 1995 on your appointment as Professor of Litigation at Nottingham Law School, although you continued as a part-time consultant in complex litigation cases throughout your time as a professor; is that right?

**A.** Yes.

**Q.** You have also worked in part-time tribunal judicial roles, including for the Family Health Services Appeal Authority, and you have held non-executive directorships in the NHS, including at the time you were appointed to Skipton being the Department of Health Non-Executive Director of Wandsworth Primary

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1 Care Trust; is that correct?  
 2 **A.** Yes. It is fair to say that, as time went on, the  
 3 academic work and consultancy work diminished and the  
 4 judicial work increased. So by the time I retired  
 5 I was doing almost nothing but First Tier Tribunal  
 6 work.  
 7 **Q.** You came across an advert for the Skipton Appeal  
 8 Panel, you think, in the summer of 2006 in the Law  
 9 Society Gazette. What drew you to apply for the post?  
 10 **A.** Well, it was a subject that I knew a little bit about,  
 11 it was an area of law that I had some experience in  
 12 and I was -- I think the expression is portfolio work,  
 13 at that stage, I was doing different things. I had no  
 14 full-time job, so this was something which I thought  
 15 would be interesting to do and I might be able to do  
 16 to a reasonable standard, so I applied.  
 17 **Q.** You presumably knew a little bit about -- as you say,  
 18 knew a little about -- must have known rather more  
 19 than that about the circumstances in which patients  
 20 had become infected with HIV and hepatitis C as  
 21 a result of your work in the litigation that we  
 22 mentioned earlier?  
 23 **A.** I did, although hepatitis C played only a very small  
 24 part in that. Most of what I knew was about HIV, but  
 25 I did know a little bit about it. I had also acted

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1 that correct?  
 2 **A.** Dracass.  
 3 **Q.** Dracass. Thank you. In 2009, Dr Dracass retired and  
 4 was replaced by Dr Gourlay; is that right?  
 5 **A.** Yes.  
 6 **Q.** In 2012, Professor Mutimer retired and was replaced by  
 7 Professor Peter Mills?  
 8 **A.** Yes.  
 9 **Q.** You tell us that on your appointment you met with  
 10 Mr Fish of the Skipton Fund who provided the  
 11 secretariat to the Appeal Panel; is that right?  
 12 **A.** Yes.  
 13 **Q.** At that initial meeting you were provided with a copy  
 14 of the two different application forms, so that's the  
 15 application form for stage 1 payment and the  
 16 application form for the stage 2 payment, and you were  
 17 also provided a document that you had, in fact,  
 18 already seen, because it had been sent to you in the  
 19 application pack for the appointment as chair, and we  
 20 will look at that in a moment. You think you were  
 21 also provided at that meeting with a copy of the  
 22 Agency Agreement between the Department of Health and  
 23 the Skipton Fund, although that document may have come  
 24 to you later; is that right?  
 25 **A.** I certainly couldn't have been, because it hadn't been

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1 for the Claimants in the Gammagard case, which we  
 2 might even come on to later. It was an immunoglobulin  
 3 that caused hepatitis.  
 4 **Q.** You were interviewed for the post by the NHS  
 5 Appointments Commission and appointed chair of the  
 6 Appeal Panel in September 2006; is that right?  
 7 **A.** Yes.  
 8 **Q.** After the Skipton Appeal Panel came to an end, did you  
 9 have anything to do with the new schemes, the English  
 10 Infected Blood Support Schemes or equivalents in the  
 11 devolved administrations?  
 12 **A.** No, in fact, before I knew that was happening  
 13 I suggested -- by then I had been in post about ten  
 14 years and I thought there was a public interest in  
 15 roles being rotated and committees being renewed. So  
 16 I thought it was time for me to go in any event.  
 17 **Q.** You also tell us in your statement that the other  
 18 members of the Panel who were appointed at the same  
 19 time as you were Annie Hitchman, who was the lay  
 20 member?  
 21 **A.** Yes.  
 22 **Q.** The hepatologist Dr, then Professor, Mutimer?  
 23 **A.** Mutimer.  
 24 **Q.** Mutimer. Dr Patricia Hewitt, who was a consultant in  
 25 transfusion microbiology and the GP, Dr Dracass; is

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1 signed at that stage. I got it some time later,  
 2 because, as has been pointed out, it was not signed  
 3 until a long time after the Fund was set up and a year  
 4 or so, I think, after the Panel was set up.  
 5 **Q.** Can we look, first of all, at the Agency Agreement,  
 6 although you didn't have it initially. Soumik, it is  
 7 SKIP0000033\_058. You see there it is an agreement  
 8 between the Secretary of State for Health and the  
 9 Skipton Fund Limited. This may sound an obvious  
 10 question but it is right, isn't it, that neither you  
 11 nor anyone else from the Appeal Panel were a party to  
 12 this agreement?  
 13 **A.** No, no. So it is right, yes.  
 14 **Q.** Can we go to page 14 of the agreement, please, Soumik?  
 15 We will see at paragraph 6.3, clause 6.3 there:  
 16 "DH [Department of Health] shall as soon as  
 17 possible after the Commencement Date arrange for the  
 18 provision of an independent appeals Panel to  
 19 adjudicate on claims rejected by Skipton."  
 20 Then if we can turn on to page 31, please, part  
 21 4, "Appeals":  
 22 "4.1 An independent appeals panel having been  
 23 provided in accordance with Clause 6.3, Skipton will  
 24 provide the secretariat and organise all necessary  
 25 meetings of the Panel, prepare cases to be considered,

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1 record the Panel's decisions and communicate the  
 2 decision to each appellant.  
 3 "Skipton will pay Panel members' fees and  
 4 expenses."  
 5 Is this how it worked in practice?  
 6 **A.** Well, almost. I am sure you will come on to the  
 7 writing of decisions but it says there that the Fund  
 8 will record the decisions and communicate them. It  
 9 was agreed with the Fund -- well, with Nick Fish --  
 10 that I would write the decision letter, send it to the  
 11 Skipton Fund and he would send it out to each  
 12 appellant, so it is almost right, but not quite right.  
 13 **Q.** Then we looked, when Mr Fish gave evidence, at the  
 14 parts of this agreement that set out the definition of  
 15 qualifying persons. I am not going to take you to  
 16 those but was a copy of this agreement made available  
 17 to other members of the Panel, other than yourself?  
 18 **A.** I don't know.  
 19 **Q.** So you didn't make that -- you didn't make this  
 20 agreement available to them yourself --  
 21 **A.** No. No, I didn't.  
 22 **Q.** -- but the Skipton Fund may have done?  
 23 **A.** *(Inaudible)*  
 24 **SIR BRIAN LANGSTAFF:** Just one question on the process,  
 25 which is set out at 4.1, and it really relates to

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1 changes in eligibility, either because they were  
 2 communicated by Nick Fish or else because they were in  
 3 the public domain, but I didn't see the text of the  
 4 document changing as it was amended.  
 5 **SIR BRIAN LANGSTAFF:** So you were sitting in appeal on  
 6 decisions made under a scheme which, although you  
 7 understood the basic idea, you had not seen the actual  
 8 wording at that later stage?  
 9 **A.** I hadn't seen except -- well, I didn't see future  
 10 copies of the agreement itself, but the things which  
 11 mattered to us were the eligibility criteria, and if  
 12 they were changed, those changes came to our  
 13 attention.  
 14 **SIR BRIAN LANGSTAFF:** Thank you very much.  
 15 **A.** I don't think anything else in the agreement which  
 16 relates to the appeal procedure was changed. I may be  
 17 wrong. I stand to be corrected, but I don't recall  
 18 anything about our process being changed.  
 19 **SIR BRIAN LANGSTAFF:** Thank you.  
 20 **MS SCOTT:** Can we turn, Soumik, then to SKIP0000031\_229.  
 21 Is this the document that you were provided as part of  
 22 the appointment process and then provided with again  
 23 by Mr Fish at that first meeting.  
 24 **A.** I remember having it to make my application, so I knew  
 25 what the constraints on -- or what the scheme was for

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1 what's on the first page of the document. So if we  
 2 can go back to 33\_058, first page, please, Soumik.  
 3 No, before that. It is the bit in brackets at the  
 4 top:  
 5 "Incorporating amendments agreed between the  
 6 parties on 30th April 2012."  
 7 The first question really to you, Ms Scott: is  
 8 there anything on the face of this document which  
 9 shows what those amendments were?  
 10 **MS SCOTT:** From memory, sir, no. I can't recall that.  
 11 I am just having a look through to see if there's any  
 12 text in underlining or brackets and I can't see that  
 13 there is.  
 14 **SIR BRIAN LANGSTAFF:** One of the questions really is, as  
 15 a matter of course, you had adopted the process of  
 16 writing up your own decisions. Going back, if we can,  
 17 please, to where we were at paragraph 4.1.  
 18 **MS SCOTT:** Page 31.  
 19 **SIR BRIAN LANGSTAFF:** Do you know why that itself was not  
 20 amended in 2012?  
 21 **A.** Well, I have no idea. The only copy of this agreement  
 22 that I ever saw was the one which must have been given  
 23 to me shortly after it was first signed, which I think  
 24 is 2007, from memory. I had no idea about the series  
 25 of amendments that happened after that. I knew about

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1 the appeals. If Nick says that he gave me a copy when  
 2 we met, then I am sure he is right. I don't remember  
 3 that.  
 4 **Q.** In fact, that information came from your witness  
 5 statement, so -- but you --  
 6 **A.** I know I met him after I was appointed. I must have  
 7 had this document to make my application in the first  
 8 place. If I said in my witness statement that he gave  
 9 me another copy, that seems to me curious, but if  
 10 I said it, I must have believed it when I wrote that.  
 11 **Q.** If we go to page 3 of this document, we can see it  
 12 sets out the role, the Terms of Reference and the  
 13 constitution of the Appeals Panel.  
 14 **A.** I am sorry, Ms Scott. I don't know if anything turns  
 15 on this, but I am just having a very quick look at  
 16 paragraph 9 of my witness statement and I can't see  
 17 where I said I got another copy of the application  
 18 form. I may be wrong, but ...  
 19 **Q.** Perhaps it is my misreading of your witness statement.  
 20 **A.** I saw that application form when I made my  
 21 application.  
 22 **Q.** I understand, yes. I misread your witness statement.  
 23 I don't think anything turns on it.  
 24 If we turn to page 3, we can see there it sets  
 25 out what -- the role of the Skipton Appeals Panel, and

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1 that's really set out at the end of the third  
2 paragraph. The role is, because there is a right to  
3 appeal to the independent appeal panel against the  
4 decision of the Skipton Fund, and then sets out the  
5 Terms of Reference:

6 "The role of the Appeals Panel is to reconsider  
7 the cases of any claimants who appeal against  
8 individual decisions made by the Skipton Fund. The  
9 Panel will look at how the decision was reached and  
10 examine all available evidence, or seek further  
11 written evidence where necessary ..."

12 Then it says:

13 "In considering the evidence the Appeal Panel  
14 will look solely at the written evidence and will not  
15 seek personal attendance."

16 Is this how you understood, that there was no  
17 power to hold oral hearings?

18 **A.** Yes. It suggests to me, and nobody on the Panel I  
19 think had any other view, in setting out: if you want  
20 to be on this Panel, you will deal with it by means of  
21 open hearings.

22 **Q.** Then it goes on to say:

23 "The Panel will not be able to consider appeals  
24 against the ex gratia payment scheme itself, but only  
25 to examine the process to determine the claims within

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1 **SIR BRIAN LANGSTAFF:** May I just ask a question here in  
2 respect of the first paragraph? The first sentence  
3 makes it clear that the job of the Appeals Panel is to  
4 reconsider cases, so that's reconsideration, but the  
5 second sentence begins:

6 "The Panel will look at how the decision was  
7 reached and examine all available evidence ... to  
8 either confirm or change the Skipton Fund's decision."

9 That sounds suspiciously like a review  
10 jurisdiction rather than a reconsideration, doesn't  
11 it?

12 **A.** Yes, it does. I noticed that.

13 **SIR BRIAN LANGSTAFF:** But you read it as  
14 a reconsideration?

15 **A.** Well, I think that may be a distinction without  
16 a difference, because the cases we were involved in,  
17 and I am sure we will come on to this, were nearly  
18 always -- well, two thirds at least, I think, were  
19 cases where the Skipton Fund appeared to have turned  
20 round the application for the payment simply, if not  
21 solely, very, very mainly, on the basis there was no  
22 documentation of transfusion. So one could say,  
23 really: We looked at it, we said yet again, "They have  
24 refused this applicant because there is no record of  
25 his or her transfusion". So I don't think --

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1 the terms of the scheme."

2 Again, is that where your understanding of, if  
3 I can put it this way, the jurisdiction of the Appeal  
4 Panel ended, ie if it was an appeal against the terms  
5 of the scheme, it had to be by way of judicial review  
6 rather than by way of appeal to the Panel?

7 **A.** Yes. I mean, it seemed to me plain that what this  
8 meant was there are qualifying criteria for payments  
9 and the Panel can't vary those. The Department has  
10 set out where it wants to make ex gratia payments and  
11 where it doesn't, and I didn't think we could just say  
12 "Well, we don't like that. We won't have a natural  
13 clearer rule", or "We won't have a" -- well, that's  
14 one example.

15 **Q.** Then it goes on to set out what the test is that the  
16 Appeal Panel will be applying:

17 "Appeals may be made against decisions  
18 concerning both stage 1 and stage 2 payments. For  
19 stage one appeals, the Panel will need to determine  
20 whether, on the balance of probabilities, chronic  
21 hepatitis C infection resulted from receipt of NHS  
22 blood or blood products, and for stage two appeals,  
23 the likelihood, on the information provided, that the  
24 claimant has developed cirrhosis or primary liver  
25 cancer."

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1 I certainly agree, Sir Brian, that there are different  
2 appeal criteria, if you like, but in practice I don't  
3 think the second sentence really added very much to  
4 the first.

5 **SIR BRIAN LANGSTAFF:** It is certainly not the way you went  
6 about it, is it, from your witness statement? As you  
7 say, it probably doesn't matter, but it is a curious  
8 bit of drafting possibly.

9 **A.** Certainly, I think. I mean, we looked at the Skipton  
10 file, which was generally -- this is not meant at all  
11 critically -- a pretty modest file, wasn't very much  
12 in it, and we would see a letter which said, "Very  
13 sorry but there is no evidence you have had a  
14 transfusion. Rejected."

15 **SIR BRIAN LANGSTAFF:** Yes.

16 **A.** No doubt we will come on to our approach. We thought  
17 we had to do a bit more than that.

18 **SIR BRIAN LANGSTAFF:** Yes. Yes, thank you very much.

19 **MS SCOTT:** Turning to the second paragraph under "Terms of  
20 Reference", which sets out the test under stage 1 and  
21 stage 2, it is pretty clear the test for stage 1 is on  
22 the balance of probabilities, because it says so. How  
23 did you understand the test for stage 2, because it  
24 says that you must determine the "likelihood".

25 How did you understand and interpret that?

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- 1 **A.** Stage 2 cases were many fewer than the stage 1 cases,  
2 and very sadly the preponderance of the stage 2 cases  
3 were sadly how far the disease had developed. So in  
4 many cases -- in the standard case, has somebody got  
5 cirrhosis or not, for example, with help from the  
6 hepatologist member of the Panel we can say, "Well,  
7 this person clearly has liver disease. In our view it  
8 hasn't yet got to the stage of cirrhosis but I am  
9 afraid to say it is likely that it will turn into  
10 cirrhosis". So what we did in those cases was to say,  
11 in effect: not yet, but please apply again when --  
12 when -- the formulae which were -- I think were  
13 accepted by the hepatitis community -- showed that we  
14 had got to the stage where clinically a diagnosis of  
15 cirrhosis was appropriate. With the some sort of  
16 difficulties attached to that. They were much more  
17 diagnostic questions.
- 18 **Q.** I will come on to ask you some questions about what  
19 the criteria were in due course, but am I to  
20 understand that the balance of probabilities was the  
21 test applied to likelihood for stage 2 applications as  
22 well, so, on the balance of probabilities, whether or  
23 not the claimant has developed cirrhosis or primary  
24 liver cancer?
- 25 **A.** Sorry if I repeat myself but I don't think it worked

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- 1 advice to review the evidence in favour of cirrhosis  
2 where claims for the second payment have been turned  
3 down should this prove necessary."  
4 Do you understand what that was referring to?  
5 Is that something that ever happened, that you got  
6 additional expert advice?
- 7 **A.** No, I have never seen before, but in the papers I was  
8 sent to prepare for this hearing, there was an earlier  
9 draft of arrangements for appeals, and that had a pool  
10 of five hepatologists who would do the research and  
11 then presumably serve up an opinion or a consensus to  
12 us. That never happened. There was never a pool of  
13 anybody else to help. There were simply the members  
14 of the Panel.
- 15 **Q.** Can we go then, Soumik, on to page 7 of this document?  
16 It sets out what the role of the Panel chairs and  
17 members are:  
18 "... have a collective responsibility for the  
19 operation of the Appeals Panel. They will be required  
20 to:  
21 "engage fully in collective consideration of  
22 each case, taking account of the information",  
23 et cetera, "including the substance and principles of  
24 the Scheme."  
25 Were you given any information other than

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- 1 in quite the same way. On the stage 2 appeal there  
2 would be formulae on the application form, and I am  
3 afraid I can't remember the details but it would be  
4 measurement, and I know one of the enzymes was ALT and  
5 I can't remember the abbreviation of the other, but  
6 there was a set formula, which was, I think, accepted  
7 by all concerned, that once one passes a certain level  
8 there is cirrhosis and before that there may be  
9 fibrosis, but it hasn't yet got to the stage where  
10 clinicians would say this is cirrhosis, but in most  
11 cases, sadly, those who got that sort of liver disease  
12 progressed to cirrhosis, and at that stage the papers  
13 came back to us and we said "Yes, there is a diagnosis  
14 which we are happy to accept", and there will be a --  
15 we allow the appeal. So it was a completely different  
16 process from stage 1.
- 17 **Q.** So it was effectively a "yes" or "no" to the  
18 diagnosis?
- 19 **A.** On the basis of, if you like, laboratory measurements,  
20 yes.
- 21 **Q.** Then the document goes on to the constitution of the  
22 Appeals Panel and sets out who would be on it. Are  
23 you able to assist us with the last paragraph there:  
24 "Arrangements will be put in place for the  
25 Appeals Panel to take additional expert hepatological

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- 1 what's in this document as to what the substance and  
2 the principles of the scheme were that you were  
3 supposed to be taking into account?
- 4 **A.** I can't remember when we got this document, but the  
5 only thing that could possibly have qualified I think  
6 would be the formality of the Agency Agreement, which,  
7 as I think we have agreed, we got in about -- well,  
8 some time after it was finally signed, which was the  
9 middle of 2007.
- 10 **Q.** And then to:  
11 "reach" --
- 12 **A.** There was nothing else.
- 13 **Q.** And then:  
14 "... reach fair and considered decisions in  
15 what can be difficult situations; engage fully in  
16 collective consideration of each case, taking account  
17 of the information available ..." et cetera. And:  
18 "... act within the Appeal Panel's remit."  
19 Then "Communications":  
20 "Panel members will not communicate directly  
21 with claimants, their caring physicians or any  
22 physicians involved with their applications.  
23 Administrative tasks will be carried out by the  
24 Skipton Fund who will present appeals for  
25 consideration by the Appeals Panel. The Appeals Panel

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1 will submit its decisions directly to the Skipton  
2 Fund, who will be obliged to accept those decisions.  
3 Should Panel members require any further information  
4 about the case when considering an appeal, it should  
5 be requested on behalf of the Panel by the Skipton  
6 Fund."

7 Was that procedure, that no direct  
8 communication between the Appeal Panel and the  
9 appellant, physicians, et cetera, was that something  
10 that happened in practice?

- 11 **A.** Strictly, yes. And I think, while we are at it, the  
12 sentence about the communication of decisions may be  
13 an answer to Sir Brian's question earlier. That's why  
14 we sent the decision which I wrote to the Fund for  
15 Nick Fish or one of his colleagues to send out to the  
16 appellant.

17 I suppose I should add one small qualification.  
18 There were several cases where Dr Mutimer was the  
19 clinician, but we dealt with that, of course, by  
20 excluding him from the discussions. We didn't ask him  
21 to make any comments about the case in advance of the  
22 meeting that members did circulate and he played no  
23 part in the decision-making.

24 In case I forget later, there is one case which  
25 we turned down where one of the reasons was that there

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1 was non-existent, except for the one meeting in 2011,  
2 I think, about the co-infected, changing the criteria  
3 for them. And I suppose that was because the  
4 Skipton Fund were their agents, I don't know, but we  
5 had no relationship at all with the Department of  
6 Health. So we were left to get on with it. That was  
7 the truth of it. There was a big backlog built up and  
8 we were expected to try to get on and decide the  
9 cases, the appeals.

- 10 **Q.** That was my next series of questions. What, if any,  
11 contact was there between the Appeal Panel and the  
12 Department of Health and you said there was none at  
13 all, apart from the one meeting you have mentioned in  
14 your witness statement, which I think you say in your  
15 witness statement took place in January 2013, which  
16 I will come on to ask you about --

- 17 **A.** Yes.

- 18 **Q.** -- but that was the only direct contact that the  
19 Appeal Panel had with the Department of Health?

- 20 **A.** That's right. The members were appointed for three  
21 years. I think, on occasions, I had to sort of send  
22 an e-mail to Nick Fish and say "Our terms are coming  
23 up, what are you going to do about it?" I think the  
24 truth was that the Department of Health was very busy.  
25 After a while, the Lansley reforms were going on and

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1 was a discrepancy between two places where the  
2 appellant said she had had the transfusion, and one of  
3 them was Roehampton. Well, that must have meant Queen  
4 Mary's, Roehampton, and by a historical quirk, that  
5 was owned by and under the jurisdiction of Wandsworth  
6 Primary Care Trust, of which I was the vice chair, so  
7 I absented myself.

8 This is all historic, a long, long time before  
9 I was involved with the Primary Care Trust, but from  
10 an abundance of caution I didn't play any part in that  
11 decision.

- 12 **Q.** Would it have been helpful to have had more  
13 information from the Department of Health about the  
14 terms of the scheme, the Appeal Panel and how they  
15 were expecting you to run it or was there -- did you  
16 have sufficient for your purposes?

- 17 **A.** In a sense we did. What was surprising to me was so  
18 little information, but by a year in we had the Agency  
19 Agreement, which formalised what we had been told  
20 fairly informally in the application form and the note  
21 on the Panel that we are looking at.

22 And what we took from it was that we didn't  
23 have paper hearings and we used the balance of  
24 probability test. It's fair to say that the  
25 involvement of the Department of Health with the Panel

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1 huge amounts of their resources, as I understand it,  
2 were being transferred to NHS England. I think the  
3 last thing on their minds was our Appeal Panel. If  
4 I'm wrong, there was no evidence to show they were  
5 very interested in what we were doing. I think they  
6 thought "It is a problem we have, in some sense,  
7 resolved by appointing the Appeal Panel and they are  
8 getting on with it and nobody has raised any major  
9 objections".

10 You sent me sheaves of Skipton Fund directors'  
11 meetings and AGMs that, of course, had had nothing to  
12 do with us but, occasionally, I would see they would  
13 say "The fund is quite happy with the way the Panel is  
14 going on". Maybe that was the way the Department used  
15 its agents to satisfy itself what was going on, but  
16 all this is outside my direct knowledge.

- 17 **Q.** Was any information from the Department of Health ever  
18 fed back to you through the Skipton Fund?

- 19 **A.** Well, only, I suppose, when they changed the  
20 qualifying criteria. I can't think of anything else.

- 21 **Q.** So all the changes to the qualifying criteria came  
22 through the Skipton Fund?

- 23 **A.** I think so. I honestly can't remember -- I mean,  
24 there might have been Department of Health press  
25 releases or communications to the hepatology

24

1 community. I think the case is that we were informed  
 2 by the fund that the agreement had been varied.  
 3 I think that's right but I honestly can't remember the  
 4 detail of it, I am afraid.

5 **Q.** Before I come on and ask you some questions about the  
 6 relationship between the Appeal Panel and the Fund,  
 7 I just turn to the meeting in January 2013. Your  
 8 witness statement tells us that this arose as a result  
 9 of changes made to the scheme criteria in 2011,  
 10 allowing the estates of those who had died before  
 11 29th August 2003 to apply to the scheme, and the Panel  
 12 was, therefore, being asked to consider some cases of  
 13 people with haemophilia who were co-infected and had  
 14 died prior to 29th August 2003 where the record of the  
 15 main cause of death was HIV and there had been no  
 16 biopsy or post mortem examination to establish  
 17 cirrhosis; is that right?

18 **A.** It is right. The way I remember it is that David  
 19 Mutimer -- and this is shortly before retired from the  
 20 Panel -- he was very concerned indeed about this  
 21 because he thought it almost certain, very highly  
 22 probable, way more than one would need to convince  
 23 a Panel to allow an appeal, that anybody who had HIV  
 24 and who had a clotting disorder would almost certainly  
 25 have had hepatitis C and cirrhosis, by reason of their

25

1 retired and Professor Peter Mills had taken his place  
 2 on the Appeals Panel. I think it is -- it is certain  
 3 that Howard Thomas's view of the speed of co-infection  
 4 causing cirrhosis was less -- I wouldn't say extreme,  
 5 what is the right word -- was less dynamic than David  
 6 Mutimer's; in other words, that Howard Thomas, and  
 7 I think Peter Mills probably agreed with him, thought  
 8 that the speed of development wasn't as fast as David  
 9 Mutimer's formula suggested.

10 Anyway, that was the one contact we had with  
 11 the Department of Health. I think the civil servant  
 12 was Ben Cole. I know that the senior person was  
 13 Ailsa Wight, who used to occasionally write and say  
 14 "You have been reappointed, thank you for what you are  
 15 doing". But that is the only contact I had with her.

16 We went to this meeting at the Department of  
 17 Health. Dr Hewitt was with us and I can't remember  
 18 who else -- oh, and Nick Fish was and maybe the chair  
 19 of the Skipton Fund.

20 **Q.** Why, if Professor Mutimer had a view that this cohort  
 21 would, in fact, have had cirrhosis, did the Appeal  
 22 Panel feel it necessary to refer the question for  
 23 agreement with the Department of Health?

24 **A.** Because this was all completely hypothetical and we  
 25 were told -- I can't remember the detail of the change

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1 co-infection, and the question was how fast the  
 2 co-infection increased the chances of cirrhosis. That  
 3 was the basis of it.

4 So he thought that a logical application of the  
 5 new rules was that almost everybody who was in the  
 6 category you have just read out would, in fact --  
 7 although there was no evidence of it -- have had  
 8 chronic hepatitis C and almost certainly cirrhosis.  
 9 So David developed a model, and I can't remember the  
 10 detail -- it was very highly technical and, although  
 11 I understood in lay terms of what it was all about,  
 12 I didn't understand the equations. He had an expert  
 13 view about how quickly the fact of co-infection worked  
 14 on chances of cirrhosis being -- it wasn't identified  
 15 until the person was dead but the fact that they  
 16 would, by the time of their death, have had cirrhosis.

17 The meeting with the Department of Health was  
 18 simply to try to agree the formula of how fast the  
 19 co-infection brought about the cirrhosis. It  
 20 happens -- the only time I have met Howard Thomas, who  
 21 the Inquiry heard from yesterday -- he appeared -- I  
 22 think, but I'm not sure, it was before he was a  
 23 director of the Skipton Fund but he was a world expert  
 24 on hepatitis C and he was at that meeting.

25 By the time of the meeting David Mutimer had

26

1 of qualifying criteria, but David Mutimer said, in  
 2 a sense, "Here's one way of looking at it". That's  
 3 a very good question, come to think about it. I think  
 4 we thought that, given this was an entirely  
 5 controversial subject and that there were no  
 6 measurements -- these people had died without any  
 7 biopsies and without any test results, and David  
 8 simply suggested a model.

9 One could say, I suppose, that we should have  
 10 just said "All right, that's David Mutimer's model, we  
 11 will use it". I am not sure I can do better than  
 12 that. I think we thought the appropriate thing to do  
 13 was to say "Was this the department's intention?"  
 14 Yes, that's how we approached it. I think when David  
 15 Mutimer first introduced the subject at one of our  
 16 meetings or by an email beforehand, he said "I wonder  
 17 if this is what they meant to happen because, on  
 18 a literal application of this wording, those without  
 19 measurements, without biopsies would appear, in some  
 20 cases at least, to be entitled to a further payment;  
 21 is that what they meant to happen?"

22 So I think we took the view that we ought to  
 23 check that and once we had done that, of course, then  
 24 there were questions of: what is the correct speed of  
 25 infection? It was an exponential, I remember that.

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1 There was no doubt there was an exponential increase  
2 in the likelihood of cirrhosis. We wanted to know,  
3 given we had no witnesses but only hypotheses, we  
4 wanted to know what was the right approach, if you  
5 like, in terms of a scientific enquiry.

6 **Q.** Do you recall what the outcome of that meeting was?

7 **A.** The outcome was that there was a reply, as  
8 I understand it, from the Department, again highly  
9 technical requirements. No doubt will have had --  
10 I don't know whether it was Professor Thomas who was  
11 behind it or anybody else at all employed by the  
12 Department, but there was a formula that they  
13 suggested.

14 Now, I do remember, because I know that when we  
15 come on to the Ramsay report, there is a suggestion  
16 that I made a suggestion -- it isn't a suggestion, it  
17 is a fact that I made a suggestion to Nick Fish that  
18 they use, they rely upon the report. I can see the  
19 force of suggesting I shouldn't have done that, which  
20 I accept. But, on the other hand, I found in the  
21 documents that when the Department of Health gave  
22 their view on the matter, Skipton Fund, no doubt  
23 through Professor Thomas, developed its own formula  
24 for the speed of development of cirrhosis, and Nick  
25 sent me an e-mail saying "This is what we are going to

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1 the criteria by which we say somebody should be  
2 awarded a stage 2 payment", the Appeal Panel  
3 effectively said "Well, we need to be independent, so  
4 you go your own way, we will do our own thing and we  
5 will see where we go"?

6 **A.** I think there was another stage. I think the outcome  
7 was the Department said "Yes, we can see that must be  
8 the logical consequence of the way we have shown the  
9 criteria", and then the Fund, no doubt highly  
10 influenced by Professor Thomas, used a formula, we  
11 used a formula, but we hardly ever used the formula  
12 because there were almost no appeals made -- zero  
13 appeals, because the applicants were satisfied by the  
14 Fund's decision, which must have been to accept the  
15 application.

16 **Q.** I am going to ask you now some questions about the  
17 relationship between the Skipton Fund and the Appeal  
18 Panel. We have touched on some of these issues  
19 already.

20 **SIR BRIAN LANGSTAFF:** Just before you do that, as  
21 I listened to you talking, the Appeals Panel was set  
22 up to look at the evidence, all the materials. It is  
23 entirely practical and sensible for one member of the  
24 Appeals Panel to say "This is my experience, this is  
25 my view", in essence, I suppose, providing evidence to

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1 use; do you agree?" On this occasion I wrote back to  
2 him and said "It is not a question for me to agree,  
3 you develop your criteria, we will apply our criteria,  
4 otherwise the appeal would have very little effect".

5 **Q.** In effect, otherwise the Appeal wouldn't be  
6 independent from the Skipton Fund and Department of  
7 Health decision making?

8 **A.** If we had said "Yes, we will all sign up to the same  
9 agreement". What happened in practice, just to be  
10 clear about it, was that this whole thing arose as  
11 a big controversy, if you like, a big scientific  
12 controversy, but we had almost no appeals because, I  
13 think, nearly all the people who applied were  
14 satisfied with the Fund's decision. So the cases just  
15 didn't come to us. So, in one sense, it was academic  
16 because we had -- I am sorry to keep interrupting.

17 I think in the end we had slightly more  
18 generous, if you like, criteria in our formula than  
19 the Skipton Fund, but nobody appealed and therefore it  
20 must have been that the Fund's criterion was adequate  
21 for the appeals -- for the applications to be granted.  
22 This is all surmise.

23 **Q.** So is this right, that having gone to the Department  
24 of Health saying "Is this what you meant?" when they  
25 then in response after the meeting said "Well, this is

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1 the Panel. Nobody ever thought of that as a conflict,  
2 I take it?

3 **A.** Do you mean because David Mutimer gave a view about  
4 it?

5 **SIR BRIAN LANGSTAFF:** Well, he would have a view but he  
6 was providing essentially evidence that "This is what  
7 happens, this is what my experience is, this is, if  
8 you like, the expert evidence I am giving to the  
9 Panel". That's one way of looking at it. This is  
10 a tribunal, of sorts.

11 **A.** Yes, I know, a very unusual one, in my experience,  
12 because it was picked, I imagine, because there were  
13 technical questions about these applications and these  
14 appeals which required expertise from a hepatologist  
15 and a haematologist. Now, we have seen that, or  
16 I have said, that in the documents is a draft for the  
17 working of the Appeals Panel, which suggests there  
18 should be a pool of consultant haematologists to give  
19 evidence, yet there wasn't.

20 **SIR BRIAN LANGSTAFF:** Yes. So, in essence, the scheme was  
21 set up to rely upon the evidence, if you like, of the  
22 expert view, the expert evidence, the opinion of the  
23 hepatologist on the Panel.

24 **A.** Yes, in a sense. The view, the technical view was  
25 clearly highly influential because, by definition,

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1 that particular member had a greater knowledge of the  
2 subject than the rest of it and it could sometimes be  
3 the GP, I sometimes might have to give a legal  
4 opinion. But I think what we tried to do was,  
5 treating each other as much as we could as equals, we  
6 would ask "David, what does this mean, what are the  
7 likely consequences of this measurement?" and he would  
8 give his opinion, or Ms Hewitt would give her opinion  
9 about something to do with blood, and we would take  
10 that into account and then we would discuss it.

11 So there is no doubt that on matters of  
12 hepatology David Mutimer, followed by Peter Mills, had  
13 more than 20% of the input into the question, but we  
14 didn't automatically say "David says therefore we  
15 agree".

16 **SIR BRIAN LANGSTAFF:** Yes, I understand.

17 **A.** It is not perfect. I am certainly not suggesting for  
18 a second that this was an ideal way of going about  
19 things it but it seemed to be the set of rules that  
20 the Department had put in place.

21 **SIR BRIAN LANGSTAFF:** Yes, yes. Thank you very much.

22 **MS SCOTT:** So moving onto relationships with the Skipton  
23 Fund, you obviously had a relationship with Mr Fish,  
24 who was providing the secretariat to the Appeal Panel.  
25 Did you have any contact with anyone else from the

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1 was when I got the massive bundle of them for this  
2 exercise.  
3 **Q.** Do you know whether any of the medical members of the  
4 Panel had discussions with medical directors of  
5 Skipton Fund?  
6 **A.** Well, we know just from the papers I have been sent  
7 that Patricia Hewitt offered her opinion about the  
8 possible infectivity of UK anti-D product. I have  
9 seen somewhere in the bundle towards the end an e-mail  
10 exchange between David Mutimer and I think Nick Fish,  
11 certainly with somebody at the Fund. We didn't have  
12 joint meetings every year or anything like that.  
13 There was no institutional contact.  
14 **Q.** You say in your statement that you attended meetings  
15 at the Skipton Fund when occasion demanded, certainly  
16 no more than once a year. Can you --  
17 **A.** That's a quite sober estimate.  
18 **Q.** Can you give us an idea what kind of meetings those  
19 would have been?  
20 **A.** Looking back on it, I don't actually think I had any,  
21 except to the extent when I went there to read files,  
22 if Peter Stevens was there, he might say "Let's have  
23 a chat", and he used to say "How's it going," and  
24 I would say "We are doing our best", sort of thing.  
25 I know on one occasion he said "Nick, why don't we

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1 Skipton Fund, any of the other directors or members of  
2 staff?

3 **A.** Face-to-face, only in the early years when I used to  
4 go -- when it was time for a meeting, or a month or so  
5 before it was time I used to go to the Fund to read  
6 the files which were coming up for appeal, to identify  
7 to the extent I could what further material we would  
8 like to see to make our decision easier and, on  
9 occasion, I would meet Peter Stevens and we would have  
10 a sort of polite chat.

11 I had completely forgotten that he wrote to me  
12 asking me to intervene with the Department on the  
13 question of natural clearers until I was sent the  
14 papers for this exercise, and I didn't rebut that.  
15 I remember, to be honest, being slightly embarrassed  
16 because I could never remember which was Peter Stevens  
17 and which was Martin somebody else, who was the chief  
18 executive.

19 **Q.** Martin Harvey.

20 **A.** So I used to hope they would say "Hello, it is Martin,  
21 nice to meet you again". There was absolutely minimal  
22 contact. At Board level, no, we didn't get their  
23 minutes. The first time I have seen their minutes --  
24 and I didn't read all of them because most of it had  
25 nothing to do with the evidence I could give to you --

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1 invite Mark to the Christmas lunch". They never did  
2 and I wouldn't have gone but I didn't want to be rude.  
3 **Q.** So you don't think, in fact, that there were any kind  
4 of formal meetings where the Skipton Appeals Panel and  
5 the Skipton Fund got together and discussed matters?  
6 **A.** I'm certain there weren't.  
7 **Q.** What information -- we know from your previous  
8 evidence, and indeed from looking at the files, that  
9 the Skipton Fund or Nick Fish, Mr Fish anyway, as the  
10 administrator, received the Skipton Appeal Panel  
11 decision letters. Was any other material or  
12 information provided by the Skipton Appeal Panel to  
13 the Skipton Fund about the decisions that it had  
14 reached?  
15 **A.** I can't think of anything. Do you have something  
16 particular in mind?  
17 **Q.** No. It is an open question.  
18 **A.** No. As far as I remember, I would write, if  
19 necessary, to him saying -- well, at the end of each  
20 meeting, almost without exception, there would be  
21 cases where we felt we just didn't have enough  
22 evidence to make a decision. So I would ask him,  
23 aside from the decision letters, to look at these  
24 cases. "We need the following information", but apart  
25 from that I can't think of anything.

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- 1 **Q.** The Inquiry has seen minutes -- indeed they were sent  
2 to you and I don't know whether you read them, it  
3 doesn't matter for the purposes of this question --  
4 seen minutes of the Skipton Fund meeting minutes, in  
5 which Peter Stevens has asked Mr Fish to seek further  
6 clarification from the Skipton Appeal Panel as to how  
7 they reached a certain decision. Do you recall such  
8 requests being made of you for further clarification  
9 from the Skipton Fund?
- 10 **A.** Now you say it, Nick Fish was very scrupulous and I am  
11 sure if he was asked to do that, he would have  
12 written. I don't remember the occasion or the  
13 occasions. I don't remember what sort of questions  
14 they were. General speaking, we didn't feel we ought  
15 to account to the Fund. That is also to say that it  
16 went the other way round, that, if we had accepted or  
17 refused all the appeals, we would not have thought  
18 that they had any business or jurisdiction to say  
19 "Well, that's not right". Equally, we had no targets,  
20 we had no budgets. We dealt with every case as it  
21 were.
- 22 If I had been asked -- suppose I was asked "Why  
23 did you decide that", I don't think I would have  
24 chosen to add to the decision on the basis we were  
25 told in the initial paperwork that you looked at this

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- 1 So that's the beginning of the e-mail trail.  
2 We will look at where it goes in a moment, but why was  
3 it that you were asking the Skipton Fund, or inviting  
4 the Skipton Fund, to collaborate on the approach to  
5 the scheme?
- 6 **A.** I had forgotten all about this and I can't, I am  
7 afraid, give you a very good answer. I think what  
8 prompted it was when we came on to -- it was a very  
9 long time, as I remember it, before we got any cases  
10 where the appellant had a clotting disorder, and maybe  
11 this is me with a throw-back to the HIV/haemophilia  
12 litigation and I suddenly think "Am I being silly  
13 here, does NHS blood or blood product mean  
14 manufactured by or provided by?" That's where it all  
15 started.
- 16 In other words, is the criterion that you are  
17 paid if anything you get is provided through the NHS  
18 or, in the case of haemophilia, do you only get paid  
19 if Factor VIII is NHS Factor VIII and not commercial  
20 concentrate? That's where it all started.
- 21 The, I suppose, more direct answer to your  
22 question is that, as they were the agents of the  
23 Department of Health, my wording is sloppy and what  
24 I am doing is asking the Fund, as agents, to provide  
25 a view from the Department. I accept that that e-mail

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- 1 morning that the decision of the Appeals Panel was  
2 final.
- 3 **Q.** Can we look at an e-mail thread? It is at  
4 NHBT0091224\_007? This is an e-mail thread between --  
5 it starts off with an e-mail from yourself to Mr Fish  
6 and then -- so this is the end of the e-mail thread on  
7 18th August 2011. So if we can start on the last  
8 page, page 4, please. So about halfway down the page  
9 is the first e-mail on 9th August. It says:
- 10 "Nick  
11 "The haemophilia cases have made us think again  
12 about the Scheme. Is the proper criterion simply  
13 treatment with blood or blood products in NHS clinics  
14 or must that treatment also be with NHS blood or blood  
15 products?"
- 16 Then it says:  
17 "In cases involving haemophilia it would be  
18 very useful to know whether the haemophilia was ...  
19 mild or severe and ... whether the treatment was  
20 restricted to cryoprecipitate. If it was not, as much  
21 evidence as possible should be provided to show  
22 whether the clotting factors included commercial  
23 concentrate or were restricted to NHS product.  
24 "I look forward to hearing from you in due  
25 course."

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- 1 says -- that would have been why we sent it to them.
- 2 **Q.** Why then would it be appropriate for the Appeal Panel  
3 to seek clarification or guidance from the Department  
4 of Health on an issue of the interpretation of the  
5 scheme?
- 6 **A.** Because their intention would have at least have been  
7 informative, if not binding on us. I can't remember  
8 now, and I am sure we are not going to look at the  
9 Agency Agreement, but I can't remember whether NHS  
10 blood or blood products was defined in the Agency  
11 Agreement as anything that was given to a patient in  
12 an NHS setting or anything that was made by the NHS.  
13 The whole thing in retrospect -- and, as I say, I have  
14 no recollection of this at all until I saw it in the  
15 bundle -- was a complete red herring.
- 16 **Q.** Do you think taking this kind of approach asking for  
17 clarification, going to the Department of Health,  
18 asking for their view or their guidance on how matters  
19 should be interpreted, do you think that that impugned  
20 the independence of the Appeal Panel?
- 21 **A.** Well, if so, to an extremely small extent. The Agency  
22 Agreement is the only formal document that we have  
23 that governs our business and I think it would have  
24 been important, that it turned out to be a complete  
25 red herring, to check that people were entitled if

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1 their infection came from treatment in an NHS facility  
2 rather than treatment from a product the NHS had made.  
3 I don't think I can say any different to that.

4 I perfectly accept that we could have taken  
5 an independent view without asking the Fund on behalf  
6 of the Department or the Department direct, but that's  
7 what we did. I can't change that.

8 **Q.** Having said I am going to look at other -- the rest of  
9 those e-mails, in fact, I don't think it is necessary  
10 for the purpose of that question. So, Soumik, you can  
11 take that document down.

12 You have already mentioned the e-mail that you  
13 sent to Mr Fish, suggesting that the Skipton Fund  
14 should use a particular report when dealing with  
15 applications about intravenous drug use and you said  
16 in your witness statement that you think, with the  
17 benefit of hindsight, that that was an error. Can you  
18 just explain to us why you think that that was  
19 an error to have made that request of the  
20 Skipton Fund?

21 **A.** It was a suggestion, not a request. Because, as with  
22 the criteria for co-infection, it was for them to  
23 develop their formula and for us to develop our  
24 formula. We had got something -- I think I said in my  
25 witness statement that it seemed to us that where

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1 **A.** I understood we were provided with complete files.  
2 What else was in Skipton's office, I wouldn't know.  
3 I can't see any reason why we wouldn't have done. I  
4 assumed that we did have complete files.

5 **Q.** You have explained how in the early days you would  
6 attend the office to decide whether any further  
7 information was required prior to the hearing of the  
8 appeal. What happened latterly? There's an inference  
9 that you stopped attending the office to stop carrying  
10 out that task, so how was that task performed  
11 latterly?

12 **A.** We would get the papers in advance of the meeting. Of  
13 course, when I went to look at the files, I could  
14 only -- if there was something which would have been  
15 very helpful, some laboratory test results that I just  
16 wouldn't, as a lawyer, have known existed or should  
17 exist or what they might mean or whether they were  
18 complete, et cetera. So I was really saying, in cases  
19 where there was minimal information, "Could you please  
20 at least ask them to provide such and such?"

21 But there would also be cases where one of the  
22 technical members of the Appeal Panel would say,  
23 either before or at the meeting, "The records end here  
24 but they should go on to there, we can't really make  
25 a fair decision without seeing the rest of it", in

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1 there was a paper by, we were told, the leading  
2 authority in the UK about infection from intravenous  
3 drug use and infection from blood transfusions, we  
4 thought they were objective, quantitative, peer  
5 reviewed -- well, derived from peer review journal  
6 evidence that was, in one sense, objective and we  
7 thought it would be a shame if somebody had been  
8 turned down on non-quantitative grounds, if you like,  
9 and appealed to us and we would say "Well, there is  
10 a piece of paper that proves that it is wrong".

11 I accept I shouldn't have done it and I learned  
12 the folly of my ways by the time I told Nick Fish that  
13 they should use their formula for co-infection and we  
14 would use ours.

15 **Q.** I am going to ask you some questions now about the  
16 procedure and we have touched on some of this already  
17 and you have explained to us that you -- well, is this  
18 right: you were provided with the appeal papers by  
19 Mr Fish?

20 **A.** Yes.

21 **Q.** Were those all the papers that the Skipton Fund had;  
22 in other words, there wasn't a cohort of papers that  
23 the Skipton Fund saw that the Appeal Panel never saw?

24 **A.** Well, I couldn't possibly answer that, could I?

25 **Q.** But as far as you were aware?

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1 which case the case would be adjourned or deferred and  
2 we would ask for more.

3 **Q.** We know from what you have already told us that all  
4 requests for information would have gone via Mr Fish.  
5 Would he make requests for further information off his  
6 own back or would they always have to be directed by  
7 the Appeal Panel?

8 **A.** Again, I mean, I can't really answer that question.  
9 I heard at the end of Professor Thomas's evidence  
10 yesterday, the very end of it, he talked about seeking  
11 out information, but I think -- again, I don't want to  
12 trespass on the Skipton Fund's territory -- but it  
13 looked as if they started off with Nick Fish, and Mrs  
14 Boyd -- or Dr Boyd, I can't remember her status --  
15 making a decision, and then toward the end, because we  
16 were making different decisions so often on the basis  
17 of getting more information and making inferences,  
18 I think they enlisted -- I know they enlisted  
19 Professor Thomas and Professor Dusheiko to make  
20 similar sorts of inferential decisions that the Appeal  
21 Panel made.

22 That's a long way off saying -- Professor  
23 Thomas himself said yesterday "We would ask for  
24 information, like photographs of a scar". So  
25 I suspect the Skipton Fund's process and procedures

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- 1 changed when they got medically qualified directors  
2 employed to look at files on board, but that really is  
3 a question for the fund.
- 4 **Q.** I don't think I made my question specific enough:  
5 I meant in relation to the appeal process. So would  
6 Mr Fish, in performing the role as secretariat to the  
7 Appeal Panel, make requests for further information  
8 himself or would those requests always have to come  
9 through somebody on the Appeal Panel?
- 10 **A.** Well, in the papers these are guidance notes -- are  
11 our guidance notes for appellants and that would set  
12 out what would help us make a more informed decision,  
13 and it seems from the files that we have seen that  
14 this was routinely sent out by the Fund to people when  
15 they say they wanted to appeal.
- 16 **Q.** I will look at that in a moment. Just sticking with  
17 the procedure, is this right from your witness  
18 statement: you tell us there were no time limits for  
19 appeals --
- 20 **A.** Yes.
- 21 **Q.** -- there were no fees payable for appeals --
- 22 **A.** No.
- 23 **Q.** -- and there was no application form that had to be  
24 completed for an appeal?
- 25 **A.** No, that's right, and also -- I am sorry to interrupt

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- 1 certain, but helping to allow us to make better  
2 decisions would be a list of things that would help us  
3 in our decisions and as some sort of explanation of  
4 the way we went about it.
- 5 **Q.** So you have there, under "Missing Records", set out  
6 some steps that appellants can take in order to find  
7 their records --
- 8 **A.** Yes.
- 9 **Q.** -- including going to the GP and obtaining -- if  
10 records aren't available, obtaining a letter to that  
11 effect from the relevant NHS body?
- 12 Did the Skipton Appeal Panel provide any direct  
13 assistance to appellants in tracking medical records  
14 down; in other words, would they --
- 15 **A.** No.
- 16 **Q.** No. Did you ever come across an appellant who could  
17 not afford the cost of copying or producing medical  
18 records?
- 19 **A.** We were never told that was the case and I suppose,  
20 perhaps naively, I assumed that wouldn't be a cost to  
21 the appellant. I vaguely remember from my days of  
22 practice, and perhaps one of the tribunals that I sat  
23 on, that there was a small fixed fee, which I think to  
24 be in the order of £10, but the honest answer is we  
25 never had that experience of somebody saying "I can't

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- 1 you -- it was also the case that we didn't say "Right,  
2 you have appealed, that's it". You could come -- "If  
3 there is more information, come back to us and we will  
4 look again".
- 5 **Q.** Shall we look then at the guidance provided to  
6 appellants? It is NHBT0090738. Was this a document  
7 that you wrote, can you recall?
- 8 **A.** There are different versions of this document in the  
9 papers and I know it was expanded and I got this  
10 wrong. I think I misremembered in my witness  
11 statement. After or around the time of the judicial  
12 review, and I think, if I remember rightly, and in my  
13 bundles, if we need it, we have got the different  
14 versions. I don't know yet, because I can't see the  
15 end of it, whether this is the final version, but as  
16 I describe in the witness statement, because all of  
17 the difficult cases in our initial few meetings were  
18 cases where there wasn't any documentation of  
19 a transfusion, it wasn't an argument about whether or  
20 not the case was outside the parameters of the scheme,  
21 if you like.
- 22 There were cases where the appellant said  
23 "I had one", and there was no indication in the notes,  
24 medical records or in the file that they did. So we  
25 thought we are never going to resolve this for

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- 1 do this because I can't afford it". To be honest, we  
2 didn't think about it.
- 3 **Q.** Then you set out at paragraphs 5 to 7 the direct  
4 first-hand evidence that the appellant can provide:  
5 a personal statement, paragraph 5; paragraph 6, any  
6 statements from witnesses; and then paragraph 7,  
7 written evidence about treatment that they believe led  
8 to the infection.
- 9 Were you aware that the Skipton Fund had not  
10 been able to consider any of this kind of evidence?  
11 All they had considered, at the first stage, was the  
12 form as it had been filled out by the clinician?
- 13 **A.** I don't think -- I wasn't specifically aware of that.  
14 What I was aware from looking at the files was that  
15 most of the cases we got to deal with were cases where  
16 no documentation of transfusion equals no ex gratia  
17 payment, which may be an answer to your question  
18 meaning, yes, that's what happened. But, I mean, we  
19 didn't intervene in the Skipton Fund's  
20 decision-making.
- 21 **Q.** Then paragraph 8:  
22 "In the absence of complete records the Panel  
23 will make a judgment on the likelihood of your  
24 exposure to hepatitis C given the type of treatment,  
25 the circumstances and the outcome that you describe."

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1 Is that what you refer to in your witness  
2 statement as "clinical plausibility"?

3 **A.** Yes, in effect.

4 **Q.** I will come back and ask some questions about that.

5 Then, over the page, there are some  
6 paragraphs on IVDU:

7 "Applicants who have had a history of exposure  
8 to recreational intravenous drug use (such as heroin)  
9 are unlikely to succeed in their appeal."

10 Then there is a reference to the expert report,  
11 or the expert advice:

12 "However, because the Panel considers each case  
13 individually, you should document all your intravenous  
14 drug use in as much detail as you can.

15 "2. The Panel will make a judgment on the  
16 relative likelihood of your having obtained  
17 hepatitis C from [IVDU] or from NHS treatment."

18 Again, I will come back to ask you some  
19 questions in relation to that, but certainly this  
20 suggests that IVDU isn't the end of the application;  
21 there is an assessment that is carried out. Is that  
22 right?

23 **A.** Yes, yes. We have to be the right approach.

24 **Q.** Then, at the bottom of the page -- it then sets out  
25 what other risk factors are, other reasons for

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1 **Q.** We are not entirely sure which iteration this was,  
2 but -- sorry.

3 **A.** Well, if that's (inaudible), it is an early one.

4 **Q.** Well, there's another page. If we go over to the next  
5 page, it says:

6 "Obtain a copy of your original application  
7 form ... make sure you agree with your consultant."

8 And then the last paragraph is on natural  
9 clearers and explaining the position in relation to  
10 them.

11 **A.** I think that is a later version, that long  
12 paragraph on natural clearers. The last one was  
13 longer than the first one, I know that, so you could  
14 compare possibly the two documents in the bundle.

15 **Q.** Whichever iteration was in place at the time, this was  
16 the information and guidance and assistance that the  
17 appellant would have received from the Appeal Panel?

18 **A.** Yes.

19 **Q.** One of the features of the scheme was that there was  
20 no -- the clinicians filling out the application form  
21 couldn't charge a fee, or at least if they did charge  
22 a fee, Skipton Fund or the Appeal Panel wouldn't pay  
23 for it.

24 Given that the clinicians were required to  
25 search -- or could be required, in some cases, to

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1 refusal. And then at paragraph 3, at the bottom, it  
2 says:

3 "Fluid replacement ... artificial plasma  
4 expanders and intramuscular anti-D immunisation, (in  
5 pregnancy and miscarriage/abortion) are not associated  
6 with hepatitis C infection and will not be considered  
7 by the Panel as probable causes of your infection."

8 So is it right to understand that if the  
9 history was infection via anti-D, that was a "no",  
10 that was a strike, there was no balancing and  
11 consideration of the evidence?

12 **A.** Well, that's slightly too simple, if I may say so,  
13 because if somebody had had anti-D, which was  
14 manufactured in Germany or the Republic of Ireland,  
15 then there was a distinct probability that product  
16 would be infected. But that being said, NHS produced  
17 anti-D immunisation. And I know there's a -- I have  
18 heard questions to Mr Fish and I've heard counsel's  
19 presentation about anti-D, and no doubt you will ask  
20 me about it and no doubt you will ask Dr Hewitt about  
21 it.

22 **Q.** I will come back to that.

23 You have said that there were different  
24 iterations of this guidance?

25 **A.** Yes.

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1 search back through many years of old records to find  
2 relevant entries, do you think that the quality of the  
3 evidence provided by clinicians may have been improved  
4 if payment had been made?

5 **A.** Well, with respect, I don't think that's a question  
6 for the Panel. That's surely a question for the Fund,  
7 isn't it? We had no relation with the doctors. We  
8 simply had a file of papers delivered, read them  
9 carefully and discussed them and made a decision.

10 The problem -- I think the problem, as  
11 I understand it, was the long lapse of time leading to  
12 the destruction of records under NHS policies. So  
13 I don't know -- I mean, I know from other tribunals  
14 that there's an evidence gathering stage, normally  
15 done by the office, where the relevant NHS body is  
16 asked or ordered to produce somebody's records. So  
17 I don't think it is a question of the consultant  
18 trawling through records to try and find a clue.

19 I think that's something that the Fund would have done  
20 or we would have done. I think, as I understand it,  
21 the clinician had to give an opinion about whether or  
22 not somebody had been given a blood transfusion which  
23 had infected the appellant with HCV, not that the  
24 consultant was being asked to do a very onerous search  
25 of large files. The problem was the lack of

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1 documents, not the burden of going through them.  
 2 **Q.** The same, as I understand it from your witness  
 3 statement, was to have all five members of the Panel  
 4 present at every meeting. Is that right?  
 5 **A.** Yes.  
 6 **Q.** And we know from your previous evidence that all  
 7 hearings were conducted on the papers. There were no  
 8 oral hearings at all?  
 9 **A.** Yes.  
 10 **Q.** Is that something that you ever considered to be an  
 11 impediment in your decision-making?  
 12 **A.** Well, I deal with this in my witness statement. If  
 13 there are questions of credibility or memory or  
 14 quality of evidence or even looking for scars that  
 15 weren't -- operation scars in photographs, I have no  
 16 doubt that with -- and with representations,  
 17 submissions, cross-examination, I have no doubt we  
 18 could have given more informed decisions, but the  
 19 Department of Health set up a system we applied to be  
 20 appointed -- we were appointed. We worked by the  
 21 system. Like rules of court, in effect.  
 22 Of course, I am not saying that this was the  
 23 best system of justice available. I am saying that  
 24 this was -- within the rules set by the Department we  
 25 did the best we could.

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1 perhaps.  
 2 **SIR BRIAN LANGSTAFF:** Okay. Well, let's proceed.  
 3 **MS SCOTT:** You describe in your witness statement that you  
 4 would discuss each case on the agenda in turn and come  
 5 to a determination with your fellow Panel members and  
 6 you would seek for unanimity, and if you couldn't get  
 7 that, there would be a majority vote. Is that right?  
 8 **A.** It's right. It was extremely rare that it came to  
 9 that. Very rare indeed.  
 10 **Q.** Your options were, effectively: uphold the Skipton  
 11 Fund's decision, overturn the Skipton Fund's decision  
 12 or send the matter back because you needed more  
 13 information and you weren't in a position to make  
 14 a determination?  
 15 **A.** Well, yes. I would express the third as "ask for more  
 16 information".  
 17 **Q.** Then you have explained to us that you drafted the  
 18 reasons following the decisions made by the Panel.  
 19 Was it necessary for the Panel to agree on the reasons  
 20 or was that left to you, your discretion?  
 21 **A.** I don't know how far you want to get into the decision  
 22 writing process now, because the answer varies on what  
 23 the decision was.  
 24 **Q.** It is the process rather than -- that I am interested  
 25 in.

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1 **Q.** You have explained in your witness statement the Panel  
 2 would meet approximately quarterly?  
 3 **A.** Yes.  
 4 **Q.** Is that right? Did the Panel keep any records of  
 5 their decisions or any minutes of meetings or anything  
 6 of that sort?  
 7 **A.** I kept notes of the discussion, and at the end of  
 8 2017 -- because, remember, this was all being done  
 9 from my home, I have hidden in my home some  
 10 extraordinarily sensitive documents about  
 11 443 individuals. I said to Nick Fish "I really don't  
 12 want to keep these. I shouldn't keep these", and they  
 13 were sent back to the Fund.  
 14 We didn't publish notes of our discussions. We  
 15 didn't publish minutes of the decision-making process.  
 16 I fully accept, as I am sure you will come on  
 17 to, that there was a question about the form of the  
 18 decision letters. But I mean, no, we didn't keep  
 19 full minutes.  
 20 **Q.** Sir, I note the time. I still have a few more  
 21 questions on the procedure itself. I don't know  
 22 whether it would be sensible to finish those before we  
 23 break or whether we should break now?  
 24 **SIR BRIAN LANGSTAFF:** How long will they take?  
 25 **MS SCOTT:** They shouldn't take very long. Ten minutes

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1 **A.** As I said in my witness statement, if it were clear  
 2 what the decision was and the reasons for it, then  
 3 I would write -- at the end of the discussion I would  
 4 say, "Right. This is what I am going to say. Is that  
 5 right?" and people would say "yes" or "no", and then  
 6 I would send it.  
 7 In some cases where there were technical  
 8 matters I would -- this is probably one in 30  
 9 decisions -- I would send the -- if it were  
 10 a hepatology query, to the hepatologist, if blood, to  
 11 Dr Hewitt. I would say, "Here's a draft of my letter.  
 12 Have I got this bit right?"  
 13 **Q.** Where there was a split in the vote, if I can put it  
 14 that way, was that something that was ever relayed to  
 15 the appellant?  
 16 **A.** No, because it was very rare indeed. Whether it was  
 17 because, in a sense, I think we trusted each other and  
 18 we deferred to each other on matters technical,  
 19 I think if there were a real weight of opinion one  
 20 way, it would be very, very unusual for one person, as  
 21 it were, to register a minority opinion requiring  
 22 a vote.  
 23 **Q.** The Inquiry has seen a range of decision letters. Is  
 24 this fair, that when the decision was to overturn the  
 25 appeal, that the reasons were generally rather

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1 shorter; when the decision was to effectively reject  
 2 the appeal, they went into somewhat more detail?  
 3 Would that be fair?  
 4 **A.** Well, it was more than that. I don't know whether you  
 5 want me to get into the whole subject of  
 6 decision-writing now, but in effect when I first met  
 7 Nick Fish at the Fund, I said to the effect of, "What  
 8 is the Fund looking for in terms of the decision? Do  
 9 you want a judgment? Do you want a letter?" And he  
 10 said -- and you may say I shouldn't have accepted this  
 11 -- "A letter, keeping it as brief and simple as you  
 12 can". I don't know whether at that stage or  
 13 subsequently I said, "What if we are allowing the  
 14 appeal? Do you want us to go into reasons? Does the  
 15 Fund want reasons or shall we just say, "We are  
 16 satisfied that you qualify'?" And to the best of my  
 17 recollection, and you might want to ask Nick Fish  
 18 whether he remembers the same, I think it was the  
 19 agreed that a simple decision saying "You have been  
 20 successful" would be enough. There is, of course,  
 21 a question about whether we should have produced more  
 22 formal judgments, and no doubt we will come on to  
 23 that, but that was what happened. So, yes, if you  
 24 succeeded, you were just told in effect, "Good news.  
 25 You have succeeded."

1 said he was 62 in 2006. He was an immensely  
 2 experienced GP and I thought had an extremely wide  
 3 medical knowledge. If he was 62 in 2006, by 1965 --  
 4 which was, I think, the -- generally -- well,  
 5 certainly for the purposes of co-infection, it was the  
 6 date that hepatitis C was thought to be circulating in  
 7 the UK, he would at least have been a medical student,  
 8 if not a doctor.

9 That's a roundabout answer. I can't be  
 10 certain, but -- put it this way, we never based our  
 11 decision -- or what swung us to "yes" rather than "no"  
 12 or "no" rather than "yes" was never a relayed  
 13 secondhand decision by a different clinician.

14 **MS SCOTT:** Sir, those are the questions I wanted to ask you  
 15 process. So perhaps now would be a good time to  
 16 break?

17 **SIR BRIAN LANGSTAFF:** Yes. We will take a break. We  
 18 normally take half an hour. So if you can be back  
 19 here, please, at 11.55. So 11.55.

20 (11.27 am)

(Short break)

22 (11.55 am)

23 **MS SCOTT:** I am going to ask you some general questions  
 24 now about how the Panel approached appeals and then  
 25 I am going to come on to ask you questions about

1 **Q.** Just finally then on the procedure, you have told us  
 2 a little bit about the role that the medical members  
 3 of the Panel took in advising been the Panel as to  
 4 medical matters within their own expertise. What was  
 5 the position, or did this ever arise, where you were  
 6 faced with a medical question that was outwith the  
 7 expertise of all those on the Panel? Were you able to  
 8 or did you ever seek further input from clinicians?  
 9 **A.** I didn't and, as I said a moment ago, I'm sure that  
 10 most of the members would have looked at old medical  
 11 textbooks if they needed to, might have consulted  
 12 older colleagues if it was a question of what happened  
 13 in the 1950s, that sort of thing, but people came  
 14 armed with whatever corpus of expertise they had or  
 15 information they had to contribute to the decision.  
 16 **Q.** Do you recall instances where secondhand information,  
 17 if I can put it like that, secondhand advice was being  
 18 relayed to the Panel from another clinician who was  
 19 perhaps practising in the '50s or perhaps practised in  
 20 a different discipline, to tell you about the  
 21 likelihood of blood transfusion being used for  
 22 different procedures?  
 23 **A.** Not specifically. The other thing is -- I was  
 24 thinking about this before we started -- Dr Dracass,  
 25 I think the appointment letter or the press release

1 particular cohorts of appeals.

2 Firstly, what was your understanding of the  
 3 risk of being infected with hepatitis C via a factor  
 4 blood product?

5 **A.** I know that Dr Ramsay in her report -- I think it is  
 6 on page 3 -- said that in -- I think it was 1980 to  
 7 1990, one unit in 200 of blood was infected with HCV.

8 Sorry, 1 in 200. I said 1 in 100, I think but  
 9 it was 1 in 200.

10 **Q.** So your understanding of the risk of being infected  
 11 with hepatitis C from blood transfusion came from  
 12 Dr Ramsay's report, did it?

13 **A.** Dr Hewitt would have talked in general terms about the  
 14 history of infectivity of blood with hepatitis C but,  
 15 as I said, before when we tried to get some cogitative  
 16 data from Dr Ramsay she quoted 1 in 200 units of blood  
 17 being infected with hepatitis C in quite a late decade  
 18 for the lifetime of this Panel -- sorry, not the  
 19 Panel. But the cut-off date was 1991. So for the ten  
 20 years before that, when presumably hepatitis C was no  
 21 lower than it was in earlier years, it was said to be  
 22 1 in 200.

23 **Q.** We have heard evidence from various witnesses in  
 24 relation to the risk of being infected with  
 25 hepatitis C via a blood product such as Factor VIII or

1 Factor IX being 100%; is that the view that the Panel  
2 took?

3 **A.** I am sure it was but, in a sense, it didn't matter  
4 what view we took because there were no cases coming  
5 to us, because all of the people infected -- sorry,  
6 all the people who had had clotting factors were  
7 automatically allowed -- their applications were  
8 granted. So we didn't have any "I had Factor VIII but  
9 I have been refused" appeals because there weren't  
10 any.

11 **Q.** Did you have any appeals were people had said that  
12 they had had cryoprecipitate?

13 **A.** Not that I can remember. Again, this wasn't something  
14 I looked into closely because it didn't affect us but  
15 I have a recollection, which may or may not be right,  
16 that cryo was counted as a clotting factor and,  
17 therefore, the stage 1 applications were being  
18 granted. I may be wrong about that, I don't know.

19 **Q.** How did you assess the balance of probabilities as  
20 a matter of generality when you were determining  
21 appeals?

22 **A.** It is an extremely difficult issue, isn't it, because  
23 it is clear that that's the standard the Department  
24 set: it must be probable that the infection came from  
25 blood or blood products, but for our purposes really

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1 evidence, we think in some cases that one can say,  
2 hand on heart, it is probable that there was  
3 a transfusion". Then at that stage our presumption in  
4 favour of the appellant kicks in and we would not say  
5 "But we still have to find out whether that was  
6 an infected unit or not; we will assume it was and we  
7 will allow the appeal".

8 I don't know what the right time to -- just  
9 a matter of context because of the very helpful note  
10 that counsel produced on the Skipton Fund on this  
11 area. I think, from memory, there were 6,700-odd  
12 applications to the fund and there were 433 appeals,  
13 which is, I think, about 6.5%. 300 of those were  
14 cases variously described as "medical records" or  
15 "lack of information" and, of those, by common consent  
16 they are the most difficult cases. We allowed 60% of  
17 those, round numbers. There were 300, we approved 180  
18 and refused 120.

19 I noted at the end of -- in his witness  
20 statement and at the end of his evidence Professor  
21 Thomas, who Professor Mills said was the foremost  
22 authority on hepatitis C, certainly in the UK,  
23 possibly in the world, he describes them as "difficult  
24 decisions" and if we can later, because I looked up  
25 the transcript last night, there are two passages

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1 blood. Was it more likely than not? Now, what we did  
2 do, we made a major presumption in favour of  
3 appellants, which was that if they had a transfusion,  
4 we made the assumption against the arithmetic that it  
5 was infected. If Dr Ramsay is right, and I have no  
6 way of knowing whether she is or not, only 1 in 200  
7 units of blood transfused to appellants would have  
8 been infected with hepatitis C.

9 We ignored that. We thought we don't want to  
10 make it too difficult, we will assume that anybody who  
11 has had a blood transfusion, unless there is  
12 a countervailing factor, such as intravenous drug use,  
13 we would assume that that blood unit was infected.

14 We could see when we started work that the  
15 Skipton Fund took a rather literal approach: if there  
16 was no record of a transfusion, then that was it,  
17 application refused. We thought it couldn't be right  
18 for us to do that, because it would make the whole  
19 appeal process pointless if we simply followed the  
20 Skipton approach, and I thought it was legitimate, and  
21 we discussed this and we agreed, that one could look  
22 at inferences. One could say "There is no proof as  
23 such that appellant X had a transfusion but looking at  
24 the overall context of medical history, availability  
25 of records, outcomes, strength of recollected

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1 where he deals with the inferential process and  
2 I think what he says is very interesting indeed. But  
3 I will leave it to you when you want to do that.

4 So what we got was as much information as we  
5 could and then we said "Now, on the basis of all this  
6 taken together, do we think it is probable, not  
7 possible, but probable", which is our criterion, "that  
8 there was a transfusion, in which case we will assume  
9 it was the cause of the infection".

10 **Q.** The application form already included a statement from  
11 the clinician to say that they thought the blood  
12 transfusion or a blood transfusion was the probably  
13 cause and that there were no other risk factors. Why  
14 was that not enough, given the fact that they had  
15 assessed the patient and the Appeal Panel was not in  
16 a position to do that?

17 **A.** We thought our obligation was to take a fresh view  
18 because, in the same way as we didn't want to just say  
19 "Skipton Fund said no evidence, therefore we refuse  
20 the appeal", if the Department of Health had wanted  
21 a scheme where the certification of the clinicians was  
22 conclusive, it would have said so.

23 May I add, as well, that of the 300 cases that  
24 came to us, and particularly of the 120 that we  
25 refused on those grounds, the information of the

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1 clinician was often much more equivocal than "Yes,  
2 I confirm it is the only cause". I can't give you  
3 examples off the top of my head, but if one trawled  
4 through those 120 cases, I would be very surprised  
5 indeed if all 120 had certificates from the clinician  
6 "Yes, there was a transfusion". Quite often we would  
7 see things like "Patient says transfusion such and  
8 such".

9 **Q.** So clearly if the certificate is equivocal, then  
10 that's something that the Panel would have taken into  
11 account; is that correct?

12 **A.** Yes.

13 **Q.** If the certificate is "Yes, it is my view that the  
14 probable cause of the hepatitis C was the identified  
15 blood transfusion", what weight did the Panel give to  
16 that?

17 **A.** It gave it considerable weight, but it didn't, of  
18 itself, push us over the balance of probabilities,  
19 really for the reasons I have just said, that if  
20 that's what the Department had wanted, a certificate  
21 from a clinician equals a payment, that's what it  
22 could have had but it didn't choose that.

23 **Q.** Did the qualifications and experience of the clinician  
24 filling out the form make any difference to the amount  
25 of weight given to it by the Panel?

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1 other words, if there is evidence that there is  
2 a positive PCR test after six months, we would just  
3 allow it, straight up.

4 **Q.** What did the Panel do where there was evidence that  
5 the person had cleared hepatitis C but no evidence as  
6 to when this had been cleared; in other words, the PRC  
7 test was after -- was not taken until several years  
8 after the infection was identified?

9 **A.** You mean a positive test or a negative test?  
10 Negative?

11 **Q.** Negative test, yes.

12 **A.** I think, at that stage, we fell back on the general  
13 epidemiological data, which suggested -- I can't  
14 remember the proportion -- but a very, very high  
15 proportion of people who cleared it, cleared it in the  
16 first six months, which was presumably why the  
17 Department put that criterion in the scheme.  
18 Therefore, if the burden is to show it is more likely  
19 than not and, say, 95% -- I am picking a number out of  
20 the air, but of that order -- if they clear it, clear  
21 it within six months, there is a 1 in 20 chance that  
22 is this person didn't.

23 **Q.** Did the Panel ever consider an alternative approach,  
24 namely that on the evidence before it, it was only  
25 possible to conclude that the applicant had cleared

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1 **A.** I honestly can't remember. It certainly wasn't  
2 a system where "He is a professor or she is  
3 a professor, we will accept that" or "He or she is  
4 a junior doctor in the back of beyond, we won't accept  
5 that". There was nothing like that.

6 **Q.** Would not a straightforward application of the burden  
7 of proof on the balance of probabilities mean that,  
8 unless you had a reason to think that the clinician  
9 was wrong, you could approve the application?

10 **A.** I don't think so.

11 **Q.** I am going to ask you some questions then about  
12 natural clearers.

13 **A.** Before you go onto that, I was sent a decision from  
14 an HIV Panel by Benet Hytner QC, and I was told that  
15 was because the approach there was the least unlikely  
16 and did we think about using that. Do you want to  
17 deal with that?

18 **Q.** I will come on to deal with that a little bit later on  
19 this morning.

20 I am going to ask you some questions about  
21 natural clearers. Was the test for determining  
22 whether someone had cleared hepatitis C within six  
23 months determined on the balance of probabilities?

24 **A.** Yes, it was, but it was really determined on PCR  
25 tests, the results of PCR tests, as I remember it. In

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1 the virus at the point the PCR test was negative, why  
2 it was only safe to conclude that the person had  
3 cleared the virus on that date?

4 **A.** I don't think so, for the reason I have just  
5 articulated. These were relatively unusual cases for  
6 us. They weren't the sort of main diet of the Panel  
7 and, in general, we reserved ambiguities like that on  
8 terms of -- according to the advice -- or on the  
9 accepted view was 95% likely that it had cleared, if  
10 at all, within six months.

11 **Q.** I am going to ask some questions now about anti-D  
12 immunoglobulin. You say in your witness statement  
13 that the Panel had a settled view on the chances of  
14 being infected with anti-D, as a result of the advice  
15 from Dr Hewitt. Can we look at SKIP0000031\_071? This  
16 is a letter dated 24th February 2005 to Mr Keith  
17 Foster, the scheme administrator. Can we go over to  
18 the second page, please? We see there it is signed by  
19 Dr Patricia Hewitt. Can we go back to the first page?

20 Is this a document that the Appeal Panel had,  
21 do you recall?

22 **A.** I honestly don't remember. I know there were two  
23 letters. I know that Patricia Hewitt wrote another  
24 one with a co-signatory and I think, but I will be  
25 corrected, that was in response to a request for

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1 a sort of template from Nick Fish, but the views were  
 2 pretty much the same, as I recall it. I mean, I have  
 3 read both of these letters recently preparing for  
 4 today. I can't remember whether I saw this letter.  
 5 Of course, it was written long before the Panel was  
 6 convened.

7 **Q.** So when you say in your witness statement that the  
 8 Panel had a settled view on advice from Dr Hewitt, was  
 9 that advice given during Appeal Panel meetings rather  
 10 than written advice that the Panel were aware of and  
 11 understood to be her view?

12 **A.** In essence, yes. There was no doubt I think, from her  
 13 experience, her position and, indeed, her reputation,  
 14 she was the person who knew most about this in the UK.  
 15 She made it perfectly clear there were no recorded  
 16 cases of hepatitis C infection caused by UK anti-D.  
 17 And if that's the case, given the yellow card systems  
 18 and the close community of haematology, and  
 19 particularly -- I can't think of the right word -- the  
 20 transmission of blood products and blood to patients,  
 21 I think she was best placed to know. And Dr Mutimer  
 22 and all the other medical members never raised any  
 23 possible objection to her view.  
 24 Now, having seen somebody with -- sometimes  
 25 there were batch numbers which were confirmably UK

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1 treatment was with anything but UK product and there  
 2 was no evidence that UK product had ever infected  
 3 a patient with hepatitis.

4 I am sorry, there are lots of negatives in  
 5 there, but the short answer is we did not believe  
 6 anti-D carried a risk, let alone a balance of  
 7 probability risk.

8 **Q.** Soumik, you can take that document down.  
 9 Was it possible to know, when you saw  
 10 an appellant's records, what kind of anti-D had been  
 11 given?

12 **A.** I think you would be far safer asking Dr Hewitt that  
 13 question. I never remembered seeing something saying  
 14 "Irish product. Named patient basis", anything like  
 15 that.

16 **Q.** Do you --

17 **A.** Sorry, just to finish the answer. In some, but not  
 18 all, of the cases, the batch number of the anti-D was  
 19 written in the notes and Dr Hewitt said, and I was no  
 20 position to contradict her, "That is UK product."

21 **Q.** So, is this fair: in some of the appeals it was  
 22 possible to identify conclusively from the records  
 23 that the anti-D was a British product?

24 **A.** Yes.

25 **Q.** But for some of the appeals that information wasn't

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1 product, sometimes not, but she says in either this  
 2 letter of the other one that anybody who got Irish or  
 3 German anti-D was only given on a named product basis.  
 4 Which would mean that the records would be very likely  
 5 to reflect the fact this was a specially authorised  
 6 treatment. We never saw one.

7 **Q.** Was this the Panel's understanding from Dr Hewitt,  
 8 that intramuscular anti-D that had been manufactured  
 9 in the UK had an unparalleled safety record?

10 **A.** Well, that's a normative judgment, isn't it? What we  
 11 accepted was there were no records of intramuscular  
 12 NHS or UK-derived anti-D had ever been recorded to  
 13 cause hepatitis in a patient.

14 **Q.** Did the Panel also accept that there were cases of  
 15 infections from anti-D where they were manufactured  
 16 outside the UK and imported and provided on an IV  
 17 basis?

18 **A.** Well, I'm not sure what you mean. We knew that  
 19 certainly the Irish product was imported. I see now,  
 20 at the bottom of this page, Dr Hewitt says:  
 21 "I am not aware that the product used in  
 22 Germany was ever imported into the UK."  
 23 I am in no position to agree or disagree with  
 24 that, I simply don't know, but the position on the  
 25 ground was there was never any evidence that anti-D

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1 available?

2 **A.** In some of the appeals it was not -- well, I was not  
 3 in a position to identify the batch number or the  
 4 source of the product, and at that point Dr Hewitt,  
 5 uncontroverted by other medical members of the Panel,  
 6 asserted that this was anti-D and there was no risk of  
 7 hepatitis. That's the best I can do, I am afraid.

8 **Q.** I have shown you the 24th February 2005 letter from  
 9 Dr Hewitt, and you mention that there's another later  
 10 letter, from July 2010. Were those letters ever  
 11 provided to applicants as part of the decision process  
 12 to help them understand the basis for the decision?

13 **A.** No, we didn't send out "Attached to this decision is  
 14 a copy of Dr Hewitt's letter".

15 **Q.** Do you think it would have been a good idea to do so,  
 16 in the interests of transparency and fairness to the  
 17 applicant, so they could understand the basis on which  
 18 their application had not succeeded?

19 **A.** Potentially, but we were this a position where, as  
 20 I mentioned before the break, we had agreed, rightly  
 21 or wrongly, with the Fund that we would send out  
 22 short, concise letters, and we were -- I mean, I could  
 23 have written judgments, but I wasn't encouraged to or  
 24 asked to, in which case one would set out, as in  
 25 a normal court or tribunal judgment, evidence relied

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1 upon.

2 **Q.** Did you have any concerns that --

3 **A.** May I add to that?

4 **Q.** Yes.

5 **A.** We also put the basis of the decision in the guidance

6 notes for the applicant.

7 **Q.** Did you have any concerns that, as Dr Hewitt was the

8 only member of the Appeal Panel who had expertise in

9 this area, she was effectively assessing the value of

10 her own expert opinion?

11 **A.** Well, theoretically yes, but we have heard that the

12 Department was very hard pushed to get a haematologist

13 onto the Panel. I am not suggesting this makes this

14 all perfectly okay, but Dr Hewitt was, and is,

15 a well-recognised expert on the subject. She was, in

16 my view, entirely neutral, and very fact rather than

17 value-based in her judgments and appeals, and I didn't

18 think we had a better source of opinion. I can see in

19 one sense it is not transparent, but it seemed to me

20 that it was -- what we had was most likely to lead to

21 both a truthful and a fair outcome.

22 **Q.** Do you recall having any appeals about gamma globulin?

23 **A.** No. I mean, I knew all about that because in 1995,

24 just as I was leaving private practice, there was

25 a gamma globulin -- I think two batches were imported,

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1 hepatitis C was higher for an intravenous drug user

2 than it was for somebody who had received a blood

3 transfusion?

4 **A.** May I interrupt you? I use the word "hunch" but it

5 was more than that. The received wisdom, if you like,

6 not by me, because I wasn't a doctor, but the Fund,

7 whoever trained Nick Fish, trained him that IVDU was,

8 in principle, far more likely than a blood transfusion

9 to affect someone with hepatitis C.

10 The three doctors on our Panel were clearly of

11 the same view. So it wasn't a hunch in the sense of

12 a guess, it was a received wisdom. But I thought,

13 rather than say it is a received wisdom, it would be

14 fairer to appellants if we tried to quantify their

15 relative risks.

16 **Q.** The purpose of this report was to do precisely that?

17 **A.** Yes.

18 **Q.** Can we go over to page 2 of the report? Third

19 paragraph down she set out what their model is. She

20 says:

21 "Using this model, it was not possible to

22 estimate the risk of infecting" -- I think she must

23 mean infection -- "for periods less than one year but

24 this does suggest that, over recent years, about 16%

25 of injectors in England and Wales acquire HCV

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1 it was made by Baxter Healthcare in the United States,

2 and two of the batches had hepatitis C in them. And

3 I negotiated settlements on behalf of those who were

4 infected with Baxter, and their lawyers. So I knew

5 about it. It was intravenous, as far as I remember,

6 and there was no doubt whatsoever that these batches

7 were infected with hepatitis.

8 I even, oddly, remember why. It was infected

9 through the manufacturing process and that they had no

10 defence under the Consumer Protection Act, because the

11 FDA in America had used them to use a particular

12 manufacturing process as the price of getting

13 a product licence and it was -- so the company wasn't

14 protected by a national or EU requirement, which would

15 have been a defence under the Act, but they couldn't

16 avail themselves of that. I remember the case very

17 well. But there weren't any -- we didn't have any

18 gamma globulin cases.

19 **Q.** I am going to move on now to intravenous drug use.

20 Can we look at the Dr Ramsay report. It is

21 SKIP0000031\_217.

22 So you have explained in your witness state how

23 this came about, that the members of the Appeal Panel

24 had a hunch -- I think you put it slightly stronger

25 than that -- that the risk of being infected by

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1 infection in the first year of injecting."

2 Then she goes on to say:

3 "Data suggests that most injectors are

4 initiated or assisted by friends, and that amongst

5 those who initiate others into injecting, sharing of

6 needles and syringes and of paraphernalia is more

7 common than amongst those that have not initiated

8 others."

9 Did you take from this that the history of how

10 the person started to take intravenous drugs was

11 important?

12 **A.** I thought it was a factor to be considered, yes.

13 **Q.** Then in the next paragraph, about halfway down that

14 paragraph, she says:

15 "The risk of transmission from a single episode

16 of syringe-sharing with an individual with chronic HCV

17 infection was estimated to be between 1 .6 and 4.3%."

18 Then skipping the next sentence:

19 "Assuming that susceptible individuals share

20 randomly with [injecting drug users] in this

21 population, this would generate a risk of transmission

22 of between 0.4% and 1.5% per single sharing episode

23 for intravenous drug users in London in 2002-3."

24 Then she goes on at the bottom of that page to

25 say, in that last paragraph there, talking about

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1 additional factors that may influence the risk, she  
2 says the prevalence in London and north West of  
3 England are particularly high and associated with high  
4 risks of transmission.

5 Then over the page at the bottom of the first  
6 paragraph, she talks about the temporal connection:

7 "... injecting drug use prior to 1990 is likely  
8 to be associated with even higher levels of risk of  
9 HCV acquisition."

10 At the bottom of that page, in the last  
11 paragraph in the middle of that paragraph, is the part  
12 that you have already referred to:

13 "Assuming that infection would follow receipt  
14 of all donations from HCV RNA positive donors, this  
15 would equate" -- she is talking about risk of  
16 transmission by blood transfusion -- "this would  
17 equate to an approximate risk per transfused donation  
18 of around 0.0 5% in that period."

19 Soumik, you can take that down now.

20 Did understand this report to exclude  
21 transfusion as a cause of hepatitis C where there was  
22 a history of intravenous drug use?

- 23 **A.** We can't exclude it absolutely, but we looked -- I  
24 mean, on page 2, about one in six injectors acquire  
25 HCV infection in the first year of injecting. Now,

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1 have adjusted the percentages accordingly?

- 2 **A.** There was no such case. There was one case,  
3 certainly, where -- in fact, I think probably the only  
4 appeal we had where there was a confirmed transfusion  
5 but there was also IVDU, and we thought in that case,  
6 taking into account the account from the person  
7 herself and, if I remember rightly, members of the  
8 family, we thought if we applied the Ramsay figures to  
9 that, the analysis to that, it was still comfortably  
10 more likely that the hepatitis C infection was from  
11 drug use.

12 Now we may have been right; we may have been  
13 wrong. What it appeared to us, if we had to say was  
14 it probable that the infection came from hepatitis C  
15 (sic), we had to say no, it wasn't. It was possible,  
16 but it certainly wasn't probable. That was our view  
17 of it.

- 18 **Q.** In some -- I wouldn't say many -- of the cases --  
19 I wouldn't say many because I don't know if that is  
20 right -- but some of the cases that the Inquiry has  
21 looked at, there is a history given by the appellant  
22 that there was no sharing of equipment.

- 23 **A.** Yes.

- 24 **Q.** Is it right to understand that in those cases where  
25 they were rejected by the Panel, it was because the

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1 amongst syringe-sharing deniers you halve that risk.  
2 So one in 12 people who deny sharing needles are  
3 infected. So about 8% in round numbers, whereas about  
4 half a per cent-- have I got that right -- yes, about  
5 half a per cent-- no, 0.05, so 1 in 2,000 get  
6 hepatitis from transfusions. It seemed, not just to  
7 me, because I wouldn't have thought I had the best  
8 view on this, but the medical members on the Panel  
9 said "This is clear confirmation that if there are two  
10 competing causes, the probably cause is injecting even  
11 once, even denying sharing, with an intravenous drug".  
12 But the plain numbers -- I must admit that was  
13 immediately my -- I don't claim expertise on the  
14 subject but I have dealt with a fair amount of  
15 epidemiological studies over my career in litigation,  
16 and it said the same to me. You are far more likely  
17 to get it from even one sharing-denying use of  
18 intravenous drugs than you are from a unit of blood.

19 Of course, that doesn't mean the risk is nil,  
20 but it means it is not over 50%.

- 21 **Q.** Did the Panel consider the history of drug use versus  
22 the history of blood transfusion and amend the  
23 percentages accordingly? In other words, if there is  
24 one account of one intravenous drug event and there is  
25 an account of multiple transfusions, would the Panel

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1 Panel did not accept that account given by the  
2 appellant?

- 3 **A.** The last thing we wanted to do with any appellant who  
4 had the misfortune to be infected with hepatitis C was  
5 to make judgements about truth. We weren't equipped  
6 to make judgements about truth. We weighed in the  
7 balance somebody saying "I used drugs but I never  
8 shared needles" against the figures in the Ramsay  
9 report.

10 The Ramsay report says half the people who --  
11 sorry, half as many people are infected with  
12 hepatitis C from drug use who deny sharing needles as  
13 those who admit sharing needles, and the overall  
14 incidence is more than ten times higher than the risk  
15 attached to hepatitis C.

16 I think I go back to an earlier point. If we  
17 had had a system where there were complete records,  
18 there was first-hand evidence, the Skipton Fund, if it  
19 wanted to, was able to cross-examine the appellants  
20 and we could make a decision based on what we heard,  
21 that would have been one thing, but we didn't. We had  
22 a paper-based appeal. We had, if you like, the  
23 population statistics. We took into account what the  
24 appellant said. We didn't -- as far as I remember in  
25 433 appeals, we didn't suspect anyone was lying to us.

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- 1 **Q.** Where there is no opportunity to test the evidence,  
2 for precisely the reasons you give, wouldn't the  
3 fairest approach have been to have accepted that  
4 evidence about the sharing of needles, and so on, at  
5 face value, unless of course there was objective  
6 evidence in the material before the Panel to suggest  
7 that that wasn't the case? Wouldn't that have been  
8 the fairest approach?
- 9 **A.** You have to go back to the way the scheme was set up.  
10 There was a burden of probability. So I can't see, in  
11 the face of those figures, how one can -- the  
12 Department of Health could have said "And on appeal  
13 any appellant who asserts that she didn't share  
14 needles shall have the benefit of the doubt". It  
15 could have said any of those things. It could have  
16 said "Where there's a possibility that infection came  
17 from blood, the appellant is entitled to an award" but  
18 it didn't. I know that this is caused a great deal of  
19 unhappiness but we perceived that we were applying the  
20 burden that the scheme was set up to administer.
- 21 **Q.** Did the Panel look at other evidence to try to work  
22 out whether the dates of the transfusion were  
23 consistent with the infection, compared with the dates  
24 of the intravenous drug use, so, for example,  
25 progression to liver disease or matters of that

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- 1 together thought it should have and we then contrasted  
2 it with the risks set out in the Ramsay report. It is  
3 the classic case where, in our view, it failed on the  
4 balance of probabilities. I am entirely open to the  
5 fact that in some cases we got it wrong. It would be  
6 a miracle if we had 433 cases and they were all  
7 decided correctly, but we did our best in what were  
8 very limited circumstances and with limited resources.  
9 I don't think I can say more than that, I am afraid.
- 10 **Q.** You have seen the report that the Inquiry has provided  
11 about its analysis of the Skipton Fund and the Appeal  
12 Panel's decision-making?
- 13 **A.** Yes.
- 14 **Q.** Is this right, that there were 48 appeals before  
15 the -- I can take you to the pages if that would  
16 help -- 48 appeals where intravenous drug use was  
17 a factor. 44 of those were refused and the four that  
18 were allowed were allowed on the basis that the  
19 appellant had been wrongly accused of being  
20 an intravenous drug user, ie they succeeded because  
21 the appellant was not an intravenous drug user?
- 22 **A.** Well, I have not reviewed these files. I am very  
23 happy to accept that that note is completely correct.
- 24 **Q.** Does that not suggest that, in fact, the Panel were  
25 treating the Ramsay report as meaning that it excluded

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- 1 nature, evidence of that kind?
- 2 **A.** I can't remember in particular. The truth was that  
3 after the Ramsay report was used and appeals were  
4 unsuccessful, the appeals -- they didn't completely  
5 dry up but they were very, very rare after, say,  
6 2007/2008. You might say that's unfair too but, based  
7 on the evidence we had -- and the case you put in the  
8 bundle is one of the most marginal cases because we  
9 know for sure there is a transfusion and we know for  
10 sure that there was a small amount of drug use. If  
11 I remember -- and I may well be wrong, in which case  
12 I'll be corrected -- that particular appellant said  
13 she bought the drugs from a friend. Well, Dr Ramsay  
14 says buying it from friends -- doesn't say those exact  
15 words -- increases the risk of infection with  
16 hepatitis.
- 17 **Q.** Isn't the risk of relying on the conclusions in  
18 Dr Ramsay's report, which are of necessity at the  
19 general level, isn't the risk of that that one ignores  
20 or overlooks or doesn't give appropriate weight to the  
21 actual evidence from the appellant that's in front of  
22 the Panel?
- 23 **A.** Well, I think I am going to repeat myself. We looked  
24 at the evidence from the appellant and any other  
25 witnesses. We gave it what weight the five of us

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- 1 transfusion as a risk -- as the probable cause of  
2 hepatitis C when an appellant has a history of  
3 intravenous drug use?
- 4 **A.** In most cases we thought the risks documented in  
5 Dr Ramsay's report far outweighed the risk of  
6 a hepatitis C transfusion. I think I said before, but  
7 I will repeat, there is only one case that I can  
8 remember, and I have not reviewed these cases for  
9 today, where there was actual evidence of  
10 a transfusion, let alone was it a 1 in 200 or 1 in  
11 2000 risk, if there was a transfusion of the unit  
12 being infected, there wasn't even a record of  
13 a transfusion.
- 14 One can envisage a case where somebody, for  
15 medical reasons or for experiment or academic study or  
16 something, somebody is given a single injection with  
17 intravenous drugs in a clinic or experimental  
18 surrounding and it is clear that all the kit is  
19 completely virus free, sterilised, and the drug is  
20 pure and has been obtained from a government  
21 laboratory or something, where one can see that there  
22 is no risk of transmission of hepatitis. Those were  
23 not the cases we were dealing with.
- 24 **Q.** What was the approach in relation to intranasal drug  
25 use? Did you have any appeals in relation to that?

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- 1 A. No. I think Ms Richards in her presentation said  
2 "What's that got to do with it", in effect. I think  
3 the answer -- I wondered myself -- I think the answer  
4 is that it was to do with sharing straws for snorting  
5 cocaine but we never had any of those cases.
- 6 Q. Was a copy of Dr Ramsay's report provided to  
7 appellants --
- 8 A. No, for the same reason.
- 9 Q. Do you think it would have been a good idea to do in  
10 the interests of transparency and fairness, so they  
11 could understand why their appeal had been turned  
12 down?
- 13 A. In a different regime, yes. If I had been writing  
14 a judgment, such as I wrote for different tribunals,  
15 I would refer to the passages from Dr Ramsay's report  
16 relied upon or accepted by the Panel, but that wasn't  
17 the situation. It is a highly technical report. This  
18 is going to sound really weak, there was nothing to  
19 stop an appellant or an applicant turned down by the  
20 Fund asking for it. I would have had absolutely no  
21 objection to anybody seeing it but we didn't routinely  
22 send it out. Maybe we should have done, but we  
23 didn't.
- 24 Q. Do you also think it would have been fairer to the  
25 appellant if the decision letters in these cohorts of

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- 1 or were they only used -- was clinical plausibility  
2 a fallback position used where there was no evidence  
3 either way to suggest a transfusion, ie if there was  
4 a first-hand account from the appellant that there had  
5 been a transfusion, and supporting evidence from  
6 family members that there had been a transfusion,  
7 would the Panel still rely on clinical plausibility?
- 8 A. Yes, because, for example, somebody might say "I was  
9 in a road traffic accident and I broke my ankle and  
10 I got hepatitis some time afterwards and I have been  
11 told there are no records". Yes, we would have said  
12 "Is it probable somebody on this limited information  
13 with a broken ankle would have had a transfusion?"
- 14 You see, from our point of view, the  
15 alternative really, if you are applying a balance of  
16 probabilities test, is just to say "Well, hard luck,  
17 there is no evidence". We were trying to be helpful  
18 when we did this. We were trying to say "The Fund has  
19 turned you down on the basis there is no proof,  
20 literal proof, no record of transfusion, we must be  
21 here to do something a bit more than that, and that's  
22 how we will approach it".
- 23 Obviously, the more records that existed, the  
24 more confident we could be that our leaning towards  
25 transfusion or not was in the right direction.

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- 1 cases had explained what conclusions the Panel had  
2 come to about the appellant's own account of their  
3 drug use?
- 4 A. I mean, yes, in the sense that had we not assumed,  
5 rightly or wrongly, what was intended and what  
6 I provided was a short form summary decision, yes, one  
7 could go into it. I was used to writing 20 pages of  
8 A4 judgments about medical cases in a different  
9 tribunal. It could have been done. Our belief --  
10 I should take responsibility myself. My belief was  
11 that wasn't what was required or intended. Again,  
12 I may be wrong but that's the view we took.
- 13 Q. I am going to ask you some questions now about the  
14 largest cohort of appeals that you have identified,  
15 the lack of medical records cohort.
- 16 A. Yes.
- 17 Q. We have touched on the clinical plausibility and you  
18 have explained to us how that works. Was that  
19 something that the Panel considered, both in cases  
20 where medical records were missing entirely and cases  
21 where there were medical records but they didn't show  
22 a record of a transfusion?
- 23 A. Yes.
- 24 Q. Were they used in most cases where there was a lack of  
25 medical records or a lack of a record of transfusion,

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- 1 Q. How confident could the Panel be about its conclusions  
2 on clinical plausibility where, for example, the  
3 history is of a procedure that's outwith anyone on the  
4 Panel's expertise, so for example, an orthopaedic  
5 procedure or a gynaecological procedure or something  
6 of that nature. How confident could the Panel be  
7 about the likelihood of requiring blood transfusion  
8 for that procedure.
- 9 A. Well, there were three doctors who had had medical  
10 training. I think you can ask Dr Hewitt to confirm  
11 she has had some experience of gynaecological work.  
12 I'm not sure, but I seem to remember so, but I may be  
13 wrong. Doctors would no doubt look at the standard,  
14 the leading textbooks, Panel member doctors would,  
15 I am sure, as I've said in my statement inform  
16 themselves. I wouldn't and Annie Hitchman wouldn't.  
17 We wouldn't go on the Internet and say "such and such  
18 gynaecological procedure, what's the chance of a blood  
19 transfusion", that would not be within our competence,  
20 but the doctors would express an opinion.
- 21 Q. We heard --
- 22 A. May I just add that I think all these questions are  
23 going to end up in the same place. If you had been  
24 able to award a payment to somebody who had possibly  
25 had a transfusion, of the 120 refusals we actually

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1 made, certainly not all of them would have been  
2 awarded because somewhere there were good records and  
3 there was clearly no transfusion, but I would have  
4 thought a majority of the 120, if the criteria -- I am  
5 sure the majority of the 120, if the criterion was  
6 a possibility, or a reasonable possibility, or you get  
7 an award unless the Fund can prove that you didn't  
8 have one, all these different counterfactual  
9 standards, many more of those 120 -- those 300  
10 overall -- it wouldn't be 120 winning the appeal. It  
11 would be -- I don't know -- maybe 250. We considered  
12 that the phrase "balance of probabilities" was there  
13 for a purpose.

- 14 **Q.** We heard evidence yesterday from Professor Thomas that  
15 the approach that they took at the Skipton Fund to  
16 this was to look for evidence as to the likelihood of  
17 the blood transfusion being carried out for that  
18 particular procedure in the same way we have heard the  
19 Appeal Panel did, and that if there was a less than  
20 50% likelihood of the procedure requiring a blood  
21 transfusion, then the fund would consider it unlikely  
22 to have occurred. Is that the same approach that was  
23 taken by the Appeal Panel?  
24 **A.** If we thought it was less than 50% likely that there  
25 had been a transfusion, we felt constrained by the

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1 have required a blood transfusion, ie there was a 49%  
2 chance of having a blood transfusion, then you don't  
3 make the burden of proof on clinical plausibility. Is  
4 that -- you are looking like you don't agree with  
5 that?

- 6 **A.** Well, not that I don't agree with it, but we didn't --  
7 I can see why you are putting it that way. We didn't  
8 say, "Let's have 100 cases like this", because there  
9 would have been no factual basis for that. We said,  
10 "Now, here we have somebody who says, no doubt  
11 honestly, that he/she recalls a blood transfusion in  
12 certain circumstances, we can't find any evidence of  
13 it in the papers, we can find peripheral evidence that  
14 suggests that he/she did/didn't have a transfusion,  
15 given that we have to think it is more likely that  
16 he/she did than didn't, we allow or reject the  
17 appeal".  
18 We didn't do it on a sample of 100 basis.  
19 I accept that that's what 51% means, but we didn't do  
20 it on a cohort basis. We did because otherwise partly  
21 we're -- not under attack but it has been put to us we  
22 didn't take enough account of the individual  
23 circumstances. If we had said of 100 people, what  
24 would have happened? That would be diminishing the  
25 importance of the individual's testimony even further,

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1 obligation to deal with the case on the balance of  
2 probabilities, we would have felt constrained to turn  
3 down the appeal. What Professor Thomas said --  
4 I looked up the transcript last night -- is in fact  
5 very interesting. Perhaps you will take us to the  
6 passages, which are on page 161 and 170 of the  
7 transcript respectively.

8 But effectively he says "If it was 20% likely,  
9 we would have refused it and sent it to the Panel".  
10 He then justifies this on the basis that the Fund uses  
11 an objective standard and we use a subjective  
12 standard. With the greatest respect to  
13 Professor Thomas, I don't find that anywhere in the  
14 Agency Agreement. We are surely operating on the same  
15 standard, which is the balance of probabilities.

- 16 **Q.** So on --  
17 **A.** While we are on the subject, I can't remember which  
18 page -- that's 161. At 170, he says "These were  
19 terribly difficult cases". Well, I completely agree.  
20 **Q.** So would you accept that, on the basis of the approach  
21 that Professor Thomas outlined and which I think you  
22 have said was also the approach of the Appeal Panel on  
23 clinical plausibility, ie there had to be more than  
24 51% -- out of every 100 people that had a procedure,  
25 that particular procedure, if only 49 of them would

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1 which would have been highly undesirable and highly  
2 unfair on the appellant.

- 3 **Q.** So is this right: clinical plausibility was not  
4 assessed on a percentage basis, ie the discussions the  
5 Panel were having were not "Well, this particular  
6 procedure has about a 20% or a 25% or a 40% chance of  
7 requiring a blood transfusion"?  
8 **A.** What we did was we looked at all the evidence supplied  
9 by the appellant. We looked at all the medical  
10 records. We looked at anything like the Ramsay report  
11 or Dr Hewitt's report and we said "Well, here we have  
12 two conflicting versions, for this appellant to be  
13 given an award we have to show that the positive to  
14 her version is more likely than the negative to her  
15 version". I don't think I can put it any other way  
16 than that.  
17 **Q.** How did the Panel factor in accounts from the  
18 appellant about, for example, a history of significant  
19 blood loss or having to stay in hospital for a long  
20 period of time after what should have been a routine  
21 operation or the operation going on for longer than it  
22 should have been, matters of that nature? How were  
23 those factual matters weighed in the balance as  
24 against a conclusion that the Panel had reached that  
25 it was clinically implausible that the particular

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1 procedure required a blood transfusion?  
 2 **A.** I will have to resort to anecdotes here. I remember  
 3 vividly one case where somebody said, "I was gushing  
 4 with blood, I bled for a long time, severe loss of  
 5 blood". Then there is a record of blood loss in the  
 6 notes and it is less than one unit of transfused  
 7 blood.  
 8 Now, Dr Hewitt again, she may be right, she may  
 9 be wrong but, in my view, she was likely to be right,  
 10 she said you would never, ever give a transfusion to  
 11 someone who had lost less than a unit of blood. You  
 12 know, every time one has a nosebleed or cuts yourself  
 13 in the garden or something you think "Oh, my God!  
 14 Look at all that blood", but that is a perception  
 15 which is real to the perceiver but it is certainly not  
 16 determinative of the need for a transfusion.  
 17 Again, when somebody stays in hospital, we just  
 18 didn't have that much information in most cases. So  
 19 what was very helpful was a discharge note to the GP  
 20 from the hospital, where you say, "Arrived on such and  
 21 such a day; prepared for surgery; routine procedure;  
 22 no complications; discharged on the Nth day, which was  
 23 expected", there is no basis in that to suppose that  
 24 things went in such a way that they required  
 25 a confusion -- I keep saying that -- a transfusion.

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1 account by somebody we presumed to be honest, telling  
 2 his or her recollection to the best of their ability,  
 3 but it seems to us unlikely, going to pretty much  
 4 impossible, that this could have happened in the way  
 5 described". I'm sorry. You asked me about cases  
 6 where there is no countervailing evidence. Right.  
 7 I don't think I can do any better than that. Don't  
 8 forget, we approved 60% of these cases. We were not  
 9 turning them down left, right and centre.  
 10 **Q.** Can I put this example to you? If the Appeal Panel  
 11 knew the particular person a particular operation in  
 12 respect of which 10 or 20% of patients would have  
 13 required a transfusion and the appellant said that he  
 14 or she had had a blood transfusion, and there was no  
 15 evidence of other causes of contracting hepatitis C,  
 16 but equally there was no record of the blood  
 17 transfusion, what would the Panel's view of that have  
 18 been?  
 19 **A.** Probably the same as Professor Thomas's: if it's a 20%  
 20 chance, it is not probable.  
 21 **Q.** But on what basis --  
 22 **A.** Don't forget -- (overspeaking) -- evidence.  
 23 **Q.** On what basis, though, could it be said that the blood  
 24 transfusion was not the most likely cause, because  
 25 there was no other cause, no other probable cause had

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1 We may be right, we may be wrong, but we were trying  
 2 to use the evidence as it existed.  
 3 **Q.** In the example you gave, that's an example, isn't it,  
 4 where there is objective evidence within the material  
 5 before the Panel that suggests that the first-hand  
 6 account being given by the appellant is not all that  
 7 it seems?  
 8 **A.** No, no, sorry, I am not saying that at all. I am  
 9 saying that the appellant's perception that she lost  
 10 loads and loads of blood is not borne out by the  
 11 measurement taken by the hospital.  
 12 **Q.** Yes.  
 13 **A.** Now, you know, maybe the hospital measured it wrong,  
 14 I don't know, but we are doing the best we can with  
 15 what we've got. On the evidence as we have it, it  
 16 seems very unlikely, in this example, that somebody  
 17 who had lost less than a unit of blood would have been  
 18 given a blood transfusion. Maybe, actually it did,  
 19 but we are dealing with the balance of probabilities.  
 20 **Q.** How could the Panel consider and come to conclusions  
 21 on the credibility of first-hand evidence where there  
 22 is no objective evidence to tell the Panel one way or  
 23 another, as there was in the example you gave, without  
 24 having heard from an applicant or the witnesses?  
 25 **A.** We had to do the best we could. We'd say "Here is an

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1 been identified?  
 2 **A.** There was no evidence that a transfusion had taken  
 3 place, let alone, if there was, there was a 1 in 200  
 4 chance it was infected.  
 5 **SIR BRIAN LANGSTAFF:** I thought you were actually being  
 6 asked to look at the situation where the evidence is  
 7 not just a 20% chance of this particular procedure  
 8 having a transfusion, but where the applicant him or  
 9 herself says that they had a transfusion.  
 10 That was the scenario you were putting, wasn't  
 11 it, Ms Scott?  
 12 **MS SCOTT:** Yes.  
 13 **SIR BRIAN LANGSTAFF:** So it is not just a question of the  
 14 10 or 20%, he or she could very well be one of the 1  
 15 in 10 or 1 in 5, and what might make the difference,  
 16 it is being put to you, is that he or she says "I did"  
 17 and there is no evidence that there is any other  
 18 source of hepatitis C, because that, of course, is the  
 19 starting point. Someone has hepatitis. Question:  
 20 have they satisfied you on the balance of  
 21 probabilities that they got it from a qualifying  
 22 cause?  
 23 **A.** It is not a direct answer to the question, but  
 24 Dr Hewitt, I remember -- I am sure you will ask her  
 25 about this -- to the best of my recollection she said

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1 that lots of people who haven't had blood transfusions  
2 have hepatitis C and nobody ever really knows where it  
3 comes from. Now, that's obviously a paraphrase of  
4 what she said. I can only repeat -- well, I suppose  
5 it also depends on the reasoning process, because  
6 I think it's -- maybe it's going to be put to me that  
7 we should look for the least unlikely, well -- and  
8 I will have something to say about that in due course.  
9 If the -- we didn't go out of our way to say "She is  
10 not telling the truth", because generally speaking we  
11 didn't think it, but I mean, may I say, *post hoc ergo*  
12 *propter hoc*, unless there is some reasonably  
13 convincing evidence that a transfusion took place in  
14 the first place, the fact that somebody remembers it  
15 we put in the balance, but in our view it couldn't be  
16 conclusive. I mean, it couldn't be determinative even  
17 on a balance of probabilities basis.

18 And I can see that that -- I can see a view  
19 which says if somebody said they have had  
20 a transfusion and they have got hepatitis, then it's  
21 for us, the Fund and everybody else, to disprove it,  
22 but I don't think that's what the scheme asked us to  
23 do.

24 **MS SCOTT:** You asked me if I was going to ask you a  
25 question about an approach in the document from the

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1 use of fresh/frozen plasma. It was a Dr Rejman from  
2 the Department of Health who went down to Swansea to  
3 look at all the data. There was quite intimate  
4 history about the quality of the marriage concerned  
5 and there was enough for Mr Hytner to make a deduction  
6 about the prospects of the wife of the marriage being  
7 unfaithful, having sex with other people who might  
8 have infected her. That is just miles away from the  
9 paradigm case that we dealt with, where there was --  
10 the only thing that was certain was hepatitis C  
11 infection.

12 More than that, because I was curious, and  
13 I hadn't looked at this area of the law for ages, but  
14 preparing for today, I looked up to the extent I could  
15 without a law library the proper approach in cases of  
16 competing causes. The most alternative decision I  
17 could find was *Nulty v Milton Keynes Borough Council*,  
18 a decision of the Court of Appeal in 2013, which said  
19 precisely that one should not do what Mr Hytner did.

20 I could read -- it is only two little  
21 paragraphs. It says:

22 "The Court of Appeal reiterated the principle  
23 in cases where there are competing explanations for  
24 a loss" -- in this case hepatitis C -- "that causation  
25 cannot be established only by a process of elimination

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1 HIV blood and tissue transfer scheme case.

2 **A.** Yes.

3 **Q.** I can take you to the document if that assists, but  
4 this is the moment when I am going to ask you that  
5 question.

6 Where there are a range of possible causes of  
7 hepatitis C infection, none of which are likely,  
8 either because they haven't been identified as risk  
9 factors for the particular appellant, or because of  
10 clinical plausibility, or for any of the reasons that  
11 we have been discussing this morning, did the Panel  
12 ever consider taking a different approach and  
13 considering, "Which one of these four possibilities is  
14 the least -- which one of these is the least  
15 unlikely"?

16 **A.** We never articulated in that way, and I have obviously  
17 thought quite a lot about this since seeing that  
18 decision by Benet Hytner, an immensely distinguished  
19 lawyer, and obviously one takes those reports very  
20 seriously.

21 First of all, there are a number of very  
22 significant differences between that case and one of  
23 the cases we would have had. There was a massive  
24 amount of information. There were purported  
25 recollections by the consultant in charge about the

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1 such that the least unlikely cause of a loss is  
2 identified.

3 "The claimant" -- in this case an appellant --  
4 "must demonstrate that the particular version of  
5 events that they rely upon is more likely to have  
6 happened than not in order for the civil standard or  
7 burden of proof to be satisfied."

8 I am not pretending for a second that I took  
9 the Law Reports into every Panel meeting and referred  
10 to this or any similar iteration of the principle that  
11 Nulty says is being reiterated, but that's in a sense  
12 a sophistic answer. The fact was we didn't have such  
13 rich pickings of evidence as there was in the HIV  
14 case. I don't know anything about the way that that  
15 Panel was set up. I don't know if there was oral  
16 evidence. I don't know if there was advocacy. I just  
17 don't know anything about it, but the level of detail  
18 of evidence in that case was light years away from  
19 what we had in the cases that we turned down.

20 **Q.** Sir, I am going to move on to another topic. I note  
21 it is almost 1 o'clock. I think I have got about  
22 another fifteen minutes or so of questions. So  
23 I don't know whether now is an appropriate time for  
24 a lunch break?

25 **SIR BRIAN LANGSTAFF:** Yes. In that case we will have to

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1 have you back after 2.00, if that's all right.  
2 2 o'clock. So time for lunch now and we will start  
3 again at 2 o'clock.

4 **MS SCOTT:** Thank you.

5 (12.58 pm)

6 (Lunch break)

7 (2.00 pm)

8 **SIR BRIAN LANGSTAFF:** Before we continue with this  
9 afternoon's evidence, I would like to say something to  
10 those watching online. I expect that many of you will  
11 have heard about this morning's statement by the  
12 Paymaster General, the Right Honourable Penny  
13 Mordaunt, MP. You will recall that I first called for  
14 action to rectify the lack of parity and financial  
15 support for people infected and affected after the  
16 Inquiry's preliminary hearings. When we started the  
17 hearing of oral evidence I felt it was essential to  
18 hear from people infected and affected in each nation  
19 of the UK, because the impact of treatment with  
20 infected blood and blood products was felt in all  
21 corners of the UK.

22 Today, I really welcome the commitment to bring  
23 the four national schemes into broader parity, to help  
24 to alleviate what I have described as the grinding  
25 hardship to which far too many people have been

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1 What role, if any, did the genotype of the  
2 person's hepatitis C infection have in the Appeal  
3 Panel's assessment of applications at stage 1?

4 **A.** Very little that I can remember. I know there were  
5 questions of whether there had been infection within  
6 the family. I think it was a relevant consideration  
7 whether the partners had the same genotype to exclude  
8 or make more likely infection through sexual  
9 intercourse. I'm afraid I really can't remember much  
10 more than that but I am sure hepatologists will be  
11 able to -- I'm sorry, in the Panel, maybe Professor  
12 Mills or Professor Mutimer could add more to that, but  
13 it wasn't a major consideration.

14 **Q.** Can you recall what score the appeal Panel required on  
15 a Fibroscan result in order to be satisfied that  
16 somebody had a diagnosis of cirrhosis?

17 **A.** I am afraid I can't.

18 **Q.** Can you recall if it was the same score as that used  
19 by the Skipton Fund?

20 **A.** No.

21 **Q.** You can't recall?

22 **A.** I can't recall.

23 **Q.** Do you know whether or not the score that this Appeal  
24 Panel required was ever published or notified to  
25 appellants?

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1 condemned through no fault of their own.

2 The statement also sets out the Government's  
3 intention to appoint an independent reviewer to carry  
4 out a study looking at options for a framework for  
5 compensation to inform the Government's preparations  
6 for what the Inquiry may recommend.

7 I want to reassure you that this is completely  
8 separate from the Inquiry, that it does not affect the  
9 Inquiry's Terms of Reference and that we will continue  
10 in our investigative work to get to the truth of what  
11 happened and, where recommendations are appropriate,  
12 to make them.

13 I look forward to the announcement of who the  
14 independent reviewer is to be and expect that many of  
15 you will take great interest in their work.

16 I anticipate that the Inquiry will want to hear from  
17 the reviewer once the proposals are published and that  
18 all Core Participants will have the opportunity to  
19 express their views to me on those proposals.

20 In the meantime, as I have said, our work  
21 continues.

22 So, that said, we turn back to hear this  
23 afternoon's evidence.

24 Ms Scott?

25 **MS SCOTT:** Thank you.

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1 **A.** I can't. As I say, I can't remember. I don't know.

2 **Q.** Do you recall whether or not the Appeal Panel ever  
3 required appellants making applications for stage 2  
4 payments to undertake further tests?

5 **A.** Well, I know that it was -- on an ethical basis  
6 a biopsy was never required, no invasive test was  
7 required. I think the way we went about it was to  
8 say, "On the present readings of the various  
9 laboratory tests, our view is that you have not yet  
10 reached the stage of cirrhosis, please -- when you  
11 have more information, please come back to us". As  
12 I said, I think earlier this morning, in effect,  
13 claims for cirrhosis were never rejected because,  
14 regrettably -- I don't know whether it was in all  
15 cases or in a preponderance of cases -- the disease  
16 was progressive and if you didn't have a diagnosis of  
17 cirrhosis today, you might very well have one by later  
18 this year or next year. I am afraid, I am just not  
19 expert in these matters.

20 **Q.** How much weight did the Panel give to the treating  
21 clinician's diagnosis for stage 2 applications? Was  
22 that determinative?

23 **A.** No, it wasn't determinative because, as I say, we  
24 relied on objective markers, but in a sense these  
25 weren't very concerning matters, because we thought it

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1 was, I am afraid, inevitable that progressive liver  
2 disease would end up with cirrhosis. So we were never  
3 saying "No". We were saying "Come back when the  
4 disease seems to have progressed in order to surpass  
5 the scores that were accepted -- conventionally  
6 accepted as evidence of fibrosis".

7 I seem to remember there were four or five  
8 stages. I am afraid my recollection of these things  
9 is very dim. It was scarcely an issue for the Panel,  
10 for the reason I said. We were never rejecting people  
11 at stage 2, unless there were some very odd cases  
12 where somebody said it was liver cancer and the  
13 preponderance of opinion was that it wasn't. In terms  
14 of cirrhosis, it was a question of "not yet" rather  
15 than "no".

16 **Q.** Going back to stage 1 applications, did the Panel ever  
17 consider whether and, if so, how transfusion practices  
18 might vary locally?

19 **A.** Well, yes, to the extent that we realised there was no  
20 uniform criterion for transfusion and, of course,  
21 practice changed over the years. So there were two  
22 variables but, unquantifiably, we didn't ask for  
23 evidence of the rate of transfusion incidents in North  
24 Shields. I mean, I don't think we could possibly have  
25 gone to that level of detail.

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1 a general consideration -- well, certainly there is  
2 a principle, I would say, that the fact it wouldn't be  
3 given today was nowhere near proof that it wasn't  
4 given in 1970. Absolutely not.

5 **Q.** Was the problem of over-transfusion, in particular  
6 historically, discussed at Panel meetings?

7 **A.** I think that's the other side of the same coin, isn't  
8 it, that people -- I can't tell you which medical  
9 members and on which meetings, but the consensus was  
10 that practice was more -- less cautious, if you like,  
11 and no doubt within that there might have been some  
12 people who thought in almost any surgical procedure  
13 "We had better give him some blood to be sure", versus  
14 there must presumably have been some outliers on the  
15 other side who with principle and foresight said "Be  
16 very careful indeed putting other people's blood into  
17 a patient". It was a sort of sense of the passing of  
18 time and the development of good practice. It wasn't  
19 more than that.

20 **Q.** Were you aware during your time on the Panel how much  
21 money had been paid out by the Skipton Fund --

22 **A.** No.

23 **Q.** -- during its existence? Did the money of amount  
24 which had been paid out by the Skipton Fund have  
25 an impact on the Panel's decision-making?

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1 **Q.** Would you accept that evidence of local transfusion  
2 practice is likely to be a more accurate way of  
3 determining whether someone had had a blood  
4 transfusion rather than the clinical plausibility test  
5 that the Panel applied?

6 **A.** In theory, clearly, yes, but you would need somebody  
7 who had surveyed all the data and, of course, there is  
8 the problem of definition of a locality or a region.  
9 You would need a comprehensive survey in exactly what  
10 cases transfusions were probably given and probably  
11 not given. But, even that, one fractured ankle or --  
12 I can't think of another example -- one category of  
13 disease, the severity depends on the individual. So  
14 it isn't that you can say East Anglia broken leg  
15 equals transfusion.

16 **Q.** How did the Panel get evidence of historic blood  
17 transfusion practice?

18 **A.** Well, all I can remember is it being the consensus  
19 once the medical members of the Panel, all five of  
20 them over the lifetime of the Panel, that people had  
21 been much more liberal with transfusions and that,  
22 whether it was caused by recognition that viruses  
23 travel in the blood or what, I honestly don't know,  
24 but that practice became more restrictive as time went  
25 on. I can't give you proportions or dates, but it was

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1 **A.** I said before, no. We didn't have any targets. We  
2 didn't have any budgets. We didn't have any quotas.  
3 We looked at each case on its merits and did our best.  
4 I have never seen the Skipton minutes before I was  
5 sent them for this hearing. I can see there that  
6 every -- I can't remember if it was quarter or what --  
7 the Fund told the department how much had been paid  
8 out and how much they expected to pay out in the next  
9 quarter. We knew absolutely nothing of that; it was  
10 none of our business.

11 **Q.** I am going to ask you some questions about the  
12 procedure now. Did the Skipton Appeal Panel try to  
13 reduce the amount of decisions coming through from the  
14 Skipton fund by talking to the Skipton Fund about what  
15 they could learn from the Appeal Panel's  
16 decision-making?

17 **A.** There's no meeting between the Fund and the Panel  
18 saying "Let's look at some cases. This is why we said  
19 yes or no", nothing of that sort. Presumably the  
20 Appeal Panel -- sorry -- the Fund -- and I don't know  
21 at what level -- would have read the letters and said  
22 "Oh, that's the way they are looking at it". It's  
23 clear from what -- as I say, I've never seen them  
24 before, but from the Board minutes that they were  
25 saying "Well, the Appeal Panel can take into account

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1 things we can't, that's why they are allowing lots of  
2 appeals and that's okay". I paraphrase.

3 **Q.** You have given evidence about -- well, let me put it  
4 this way. Did you ever make representations to the  
5 Department of Health to make the procedure of the  
6 Skipton Fund more flexible?

7 **A.** The Fund?

8 **Q.** Sorry. The Appeal Panel, sorry. Let me ask you that  
9 question again.

10 Did you ever make recommendations to the  
11 Department of Health to make the Appeal Panel  
12 procedure more flexible?

13 **A.** No.

14 **Q.** Why not?

15 **A.** I think we all thought that the Government, as  
16 a matter of Government policy, decided that it was  
17 prepared to give ex gratia payments to people who had  
18 been probably infected by NHS blood or blood products  
19 according to certain criteria, and I don't think we  
20 thought it was our place to say "Change the criteria".  
21 After all, apart from cases where there was a --  
22 I won't use the word "fixed" but a pretty clear view,  
23 such as anti-D, IVDU to a lesser extent, people who  
24 were outside the dates of the scheme, people who got  
25 treatment abroad, and -- the minor categories in your

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1 about finding their medical records.

2 **A.** Yes.

3 **Q.** One of the suggestions was that they get a letter  
4 confirming that there were no medical records. How  
5 did the production or the non-production of such  
6 a letter influence the decision-making process in  
7 cases where there was no supportive medical record?

8 **A.** There were a lot of -- I mean, the bundles we got --  
9 the appeal files we got from the Skipton Fund  
10 contained generally very little information. Quite  
11 a frequent member of those notes or of that appeal  
12 file was a statement from one or more NHS body saying,  
13 "I am very sorry. In accordance with our policies we  
14 destroyed your notes in 19 X."

15 **Q.** So in terms of how the production of such a letter  
16 influenced the decision-making process, are you able  
17 to assist us with that?

18 **A.** Well, I said in my witness statement, one reason we  
19 went about applying a more liberal standard than the  
20 Fund was we realised the unfairness on the appellant  
21 if the fact of a transfusion which had, in fact, taken  
22 place wasn't there for us to see because the notes had  
23 been destroyed. That would have been very unfair,  
24 wouldn't it? But we couldn't change the fact of  
25 destruction. We proceeded on the basis there was no

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1 note about the Skipton Fund, the problem cases, as  
2 I keep saying, are the 300 cases where there wasn't  
3 evidence of a transfusion. Not that it was too late  
4 or it wasn't -- it was abroad or anything like that.  
5 We dealt with those as best we could and, as I keep  
6 saying, we approved 60% of them.

7 I suppose one could say we didn't think it was  
8 our place. I don't know that we thought "This is  
9 a discussion we should be having". We were asked to  
10 adjudicate on the basis of what's in the agreement.  
11 We adjudicate. If the Department or the Fund, as the  
12 agent for the Department, think too many are  
13 succeeding or too few are succeeding or the burden of  
14 proving a transfusion without notes is too heavy, they  
15 could certainly have said so. I didn't think it was  
16 our place.

17 I keep repeating, the burden of proof could  
18 have been unless the Skipton Fund can disprove  
19 a transfusion, there will be money. There will be  
20 an award if there is a reasonable possibility that the  
21 claimant was exposed to infected blood or blood  
22 products. Any of those are possible, but it wasn't  
23 what was set out.

24 **Q.** We looked at the guidance this morning that was sent  
25 out to the applicants, suggesting how they might go

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1 records. That doesn't mean there was or wasn't  
2 a transfusion but there was nothing for us to work  
3 with there.

4 **Q.** Why were your decision letters not more informative?  
5 In your answers this morning you were suggesting that  
6 there was a choice between the decision letters as you  
7 drafted them and a full judgment. Was there not room  
8 for something in between, a more informative decision  
9 letter?

10 **A.** Yes, there was and, looking back on it, I think that's  
11 potentially a major criticism. We could and possibly  
12 should have written fuller letters. We didn't, for  
13 reasons I've -- sorry, I shall accept personal  
14 responsibility for this. I didn't, for the reason  
15 I have described this morning.

16 **Q.** When decisions were made on the basis of clinical  
17 plausibility, ie advice from medical members, either  
18 from their own experience or from investigations that  
19 they had undertaken, was the nature of that advice or  
20 those investigations ever spelt out in a decision  
21 letter?

22 **A.** Sometimes, but shortly. There's also -- there's one  
23 which you sent me in the papers. There is a case,  
24 I can't remember the document number, where the  
25 reporting doctor said that the haemoglobin was 6 or

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1 something and therefore it was highly likely that  
2 a transfusion was needed, it was perfectly clear  
3 looking at the records that the doctor had misread the  
4 column in the records, everybody could see it was, in  
5 fact, 12.4. At that point the consensus of the Panel,  
6 guided of course by the medical members, was that  
7 a person with 12.4% haemoglobin-- I don't know I am  
8 expressing this right, it is technical medical term --  
9 wouldn't in the majority of cases, or commonly, need  
10 a transfusion. You can see that's mentioned in the  
11 decision letter.

12 **Q.** In those --

13 **A.** -- (overspeaking) -- sorry. Carry on.

14 **Q.** No, sorry, I interrupted you.

15 **A.** Well, there were other cases where it was plain from  
16 the records that units of blood had been prepared for  
17 the operating theatre but equally plain that they  
18 weren't used and were put back into the blood bank or  
19 whatever it was called.

20 **Q.** In those cases where reasons were not spelt out in the  
21 decision letter would you accept the reasons that were  
22 given were incomplete and therefore inadequate?

23 **A.** I would accept they were incomplete in that they  
24 didn't detail the whole of the reasoning in most  
25 cases, and I suppose that that was a catch-all,

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1 I don't know from memory what exactly a needle  
2 exchange provided, because a point that was frequently  
3 made in the Panel was needles are one thing but what  
4 has been described by others as paraphernalia is  
5 another. The condition of the drug itself, the bowl  
6 in which it was heated or whatever. So the answer is  
7 it would have helped the appellant towards satisfying  
8 the burden, but it wouldn't have been conclusive.

9 Something I have remembered I meant to say in  
10 relation to the letters, this is not a beginning of an  
11 excuse but never once, to my recollection, did anybody  
12 come back and say "We don't understand the basis for  
13 the decision" or "Please tell us some more". Of  
14 course, I would have answered not only out of courtesy  
15 but out of fairness, if somebody had said "What is  
16 such and such". There were one or two communications  
17 I had via Nick Fish which either expressed  
18 disappointment or said "Why, again", or something. We  
19 obviously couldn't get into long and certainly not  
20 direct discussions but had there been -- the Fund  
21 never said that these letters -- they wouldn't have  
22 had to say they are too short. If the Fund had said  
23 "Look, 23 people have come back to us and said they  
24 don't really understand the basis of the decision", we  
25 would clearly, or I would have clearly have been

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1 explaining that the criterion of clinical  
2 plausibility -- I am not saying I used those words --  
3 was borne out. So I accept they were short letters  
4 and could have been fuller. Of course I do.

5 **Q.** I am going to ask you a couple of questions now about  
6 natural clearers.

7 What sort of evidence could an appellant who  
8 was antibody positive but PCR negative provide to  
9 persuade the Panel that they were in the rare category  
10 of those who cleared at the chronic phase?

11 **A.** I am afraid I am not qualified to answer that  
12 question. I haven't looked at any of these cases  
13 since 2017 and I wouldn't have been able to answer  
14 that question probably without prompting in 2017.  
15 I certainly can't now. Dr Hewitt, if you are calling  
16 her, might be absolutely the authority on what the  
17 answer to that question is, but I am not.

18 **Q.** The last question so far that I have from both myself  
19 and from Core Participants is: would the appellant --  
20 this is in relation to an intravenous drug user case.

21 Would an appellant reporting that they had used  
22 a needle exchange be sufficient to satisfy the Appeal  
23 Panel that intravenous drug use was unlikely to be the  
24 route of transmission?

25 **A.** I think you would have to answer the question --

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1 a bit -- I would have reviewed my practice and, again  
2 for the record, I accept that these letters were very  
3 far from ideal, but I thought they were what was  
4 needed -- no, that's the wrong word -- I thought they  
5 were what was expected and were satisfactory on a very  
6 limited basis. They could have been expanded greatly.

7 **MS SCOTT:** Sir, I am going to suggest, if I may, that we  
8 take a very short break, a five-minute break, to see  
9 whether there are any further questions.

10 **SIR BRIAN LANGSTAFF:** Yes. We will do that and see if  
11 there are any more questions the Core Participants  
12 want to ask. So five minutes. Let's say 2.30. 2.30.

13 (2.23 pm)

(Short break)

15 (2.30 pm)

16 **MS SCOTT:** Sir, thank you. I have no more questions that  
17 I am going to ask from Core Participants.

**Questions by SIR BRIAN LANGSTAFF**

18 **SIR BRIAN LANGSTAFF:** I have just one question, really.  
19 It is about where this particular tribunal, because  
20 that's what it was in essence, fitted into the whole  
21 general scheme of things. It wasn't, I think until  
22 2007 that the tribunal system, as it now is, came into  
23 force. You have been a fee-paid tribunal judge in  
24 a number of tribunals since.  
25

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1 A. And before, if I may say so. Under, I think, the  
2 Health and Social Care Act 2001 a tribunal, which was  
3 called the Family Health Services Appeal Authority,  
4 was set up and I was member of -- one of the original  
5 judges of that before, as you say, the Courts and  
6 Tribunal -- before the Tribunal Service, as such, was  
7 established, and certainly before the amalgamation of  
8 the Court Service and Tribunal Service.

9 **SIR BRIAN LANGSTAFF:** Tribunals obviously vary  
10 tremendously in what they can do and how they should  
11 do it, although the tribunal procedure rules bring  
12 a measure of uniformity to a number of different  
13 chambers these days.

14 A. Yes.

15 **SIR BRIAN LANGSTAFF:** How did you see this tribunal  
16 operating, compared with those others that you had  
17 been concerned with?

18 A. Well, in practice, we had very, very much less  
19 information and rule structure. When I was asked what  
20 I was doing, I would say -- this may be an unfortunate  
21 word in the context -- I said "It is an internal  
22 tribunal of the Department of Health", ie it was  
23 completely outside the Ministry of Justice System and  
24 remained so until 2017, as far as I know, and then the  
25 functions were transferred to -- I can't remember what

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1 everybody -- much less open-to-everybody procedures.  
2 One could look at the tribunal rules on the Internet  
3 but if you had looked for Skipton Fund Appeals Panel  
4 rules, you would have found a sentence, wouldn't you?  
5 I certainly -- I make absolutely no secret of the fact  
6 I wouldn't have written the decision letters the way  
7 I did if I had been sitting in a Courts and Tribunal  
8 Service tribunal.

9 **SIR BRIAN LANGSTAFF:** That would have been much more of  
10 a judgment, would it?

11 A. Yes, and the answer to the question from Ms Scott, if  
12 we were turning down somebody on the basis of  
13 Dr Ramsay's epidemiology, we would have set out the  
14 relevant bits to justify our 1 in 200 versus 1 in 6 or  
15 12, depending on whether you denied sharing needles or  
16 not comparison.

17 **SIR BRIAN LANGSTAFF:** Thank you very much. That's all  
18 I have to ask. Ms Scott?

19 **MS SCOTT:** Mr Mildred, is there anything you would like to  
20 add to your evidence?

21 A. Not really more than that. The sort of potential  
22 criticism or dissatisfaction, I suspect, is the people  
23 who had only clinical plausibility to rely upon, and  
24 the 40% of those who we found, as we saw it, on  
25 a proper interpretation of the test, had fallen the

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1 it was called. The Infected -- whatever it was. So,  
2 as far as I was aware, we were wholly outside the  
3 tribunal -- the general tribunal rules and structures  
4 and, in some ways, one might say that we suffered by  
5 that.

6 **SIR BRIAN LANGSTAFF:** How would you say you suffered by  
7 that?

8 A. Because we didn't have a fixed set of rules. We  
9 didn't have the resources that we would have done in  
10 a tribunal, the secretarial resources, we didn't have  
11 the same discovery compulsory powers that tribunals  
12 have.

13 **SIR BRIAN LANGSTAFF:** Although you would have described  
14 yourself as an internal tribunal of the Department of  
15 Health, you were, I think -- and you made the point  
16 yourself, earlier -- independent of it and of Skipton?

17 A. Yes. I should perhaps use the word "sponsored" rather  
18 than "internal".

19 **SIR BRIAN LANGSTAFF:** The whole sponsoring Department,  
20 I think, probably is the best description?

21 A. Yes.

22 **SIR BRIAN LANGSTAFF:** In terms of the way it worked, how  
23 did that, in your experience, compare to the other  
24 tribunals you have been concerned with?

25 A. Much less guidance, much less fair -- not fair to

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1 wrong side of it. We were all aware what a terrible  
2 affliction hepatitis C is. We took no pleasure in  
3 saying "We can't satisfy the standard the Department  
4 has set us". As you mentioned, I came from  
5 a background of doing exactly this sort of work on  
6 behalf of claimants. There was no appetite on our  
7 part for turning people away, but we felt we couldn't  
8 just do what we felt like.

9 **SIR BRIAN LANGSTAFF:** Can I then just thank you for giving  
10 us a very clear picture of how, because of the way  
11 that the tribunal was set up, and because of the way  
12 that you were told you were expected to operate it,  
13 that really limited a number of the options you might  
14 otherwise have had. You have been very frank about  
15 that and about the way in which you operated the  
16 discretions as you saw them and applied the standards  
17 and made the decisions that you did.

18 So can I thank you for that and for giving us  
19 your time. I think this may have gone a little bit  
20 longer than you had anticipated, but thank you anyway  
21 for being here and for helping this Inquiry.

22 A. Thank you.

23 **SIR BRIAN LANGSTAFF:** Now we will take a break, Ms Scott,  
24 before our next witness, who is Mr Lister?

25 **MS SCOTT:** Yes. We will need to establish the link with

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1 him.

2 **SIR BRIAN LANGSTAFF:** Do we need ten minutes just to make

3 sure he is ...

4 **MS SCOTT:** Yes, that's probably safest.

5 **SIR BRIAN LANGSTAFF:** So let us say 2.45.

6 (2.36 pm)

7 (Short break)

8 (2.45 pm)

9 **SIR BRIAN LANGSTAFF:** Right. You can see me, Mr Lister?

10 **THE WITNESS:** Yes, I can. Hurray. I was wondering what

11 was happening so I am glad to see we are connected.

12 **SIR BRIAN LANGSTAFF:** I am sorry we have left you on your

13 own until now during the day. You might have expected

14 to be heard a little bit earlier. I am glad to say we

15 are now in a position to start.

16 Let me first set the scene for you after you

17 have set the scene for us. You are at home --

18 **THE WITNESS:** Yes, indeed.

19 **SIR BRIAN LANGSTAFF:** -- and are there other people there

20 with you somewhere?

21 **THE WITNESS:** Yes. My partner and two dogs.

22 **SIR BRIAN LANGSTAFF:** Right.

23 **THE WITNESS:** I mention the dogs just in case of barking.

24 **SIR BRIAN LANGSTAFF:** Whenever there's a break, as there

25 will be, because we will probably have to continue

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1 Mr Lister to affirm.

2 **CHARLES EDWARD LISTER (affirmed)**

3 **Questions BY MS SCOTT**

4 **MS SCOTT:** Mr Lister, can you see and hear me?

5 **A.** I can. Thank you.

6 **Q.** You were a trustee and then, later, a director and

7 vice chair of the Caxton Foundation between

8 August 2011 and April 2015. Is that right?

9 **A.** That's correct.

10 **Q.** And you, during that time, served on the NWC, first of

11 all as a member and then as a chair, between

12 September 2011 and March 2014?

13 **A.** That's correct. I took over as chair I think in

14 March 2012.

15 **Q.** You also served throughout your time at the Caxton

16 Foundation on the Audit Committee?

17 **A.** Yes.

18 **Q.** And on the Caxton Foundation and Macfarlane Trust

19 Liaison Committee?

20 **A.** That's correct.

21 **Q.** And you also regularly attended the Partnership Group

22 meetings?

23 **A.** I attended all the Partnership Group meetings and

24 chaired one of them.

25 **Q.** Now, you were employed by the Department of Health

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1 this tomorrow morning, what you must not do is discuss

2 the evidence you have given or may yet be asked to

3 give with anyone, whoever they are, whether it is

4 canine or partner, but you can talk about anybody else

5 you like?

6 **THE WITNESS:** Thank you, understood.

7 **SIR BRIAN LANGSTAFF:** Let me tell you who you are talking

8 to. You may have heard me say this before, I don't

9 know. It is very similar to what I have said to

10 others, because it is indeed very similar. There are

11 eight people here in the room, one of whom is Mary,

12 who will ask you to affirm in a moment or two.

13 Another name you will recognise but you will probably

14 not see him, is Soumik, whose job it is to make sure

15 that you get the right document on your screen when it

16 is referred to by counsel. Then there's Ms Scott, who

17 is the only person, apart from myself at the moment,

18 who is not wearing a mask, and she will be asking you

19 the questions.

20 But the real audience is beyond this room.

21 There will be about 200, 250 of them, thereabouts, who

22 want to hear what you have to say. It is to them that

23 you are talking. This is a public Inquiry. They are

24 our public.

25 So without more ado, Mary, would you ask

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1 between 1971 and 2011, save for a period between 2003

2 and 2009. Is that correct?

3 **A.** That's correct.

4 **Q.** I am just going to put up the part of your witness

5 statement where you set out your roles in the

6 Department of Health.

7 It is WITN4505001.

8 We can see that's your witness statement, and

9 it is page 2 of your witness statement, paragraph 3.

10 You tell us there that from 1991-1995 you were

11 responsible for various aspects of microbiological

12 food safety policy.

13 '95 to '98, you were a team leader on HIV/AIDS

14 and sexual health promotion.

15 1998-2003, Head of Blood Policy.

16 2003-2008, you were at the Human Fertilisation

17 and Embryology Authority.

18 Then various senior roles: project management

19 for HFEA and then senior business manager for the

20 Director General NHS Workforce and head of NHS

21 Leadership 2009-2011.

22 Soumik, you can take that down.

23 Just so it is clear to those who are listening,

24 and indeed to you, Mr Lister, your role at the

25 Department of Health, and in particular as Head of

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1 Blood Policy, is not going to be the focus of my  
2 questions for you today, but you will be receiving  
3 a further request for a statement to cover that area  
4 of your employment in due course, and, if necessary,  
5 further oral evidence in that regard as well.

6 How did you become to be appointed a trustee at  
7 Caxton?

- 8 **A.** Well, as you have mentioned, I went back to the  
9 Department of Health in 2009 after a period of  
10 absence. I think at that point I wasn't sure where my  
11 career was going to go and, fortunately, it was one of  
12 those periods when the Department decided to downsize  
13 and I had the opportunity to leave on an early  
14 retirement package, which I applied for and was  
15 successful. So by the middle of 2011 I knew that  
16 I would be leaving the Department in six months' time,  
17 and I was looking around for other things to do.

18 And one of the things I had thought about quite  
19 early on was trying to find a suitable role as  
20 a charity trustee, because I felt that would suit  
21 a number of skills. I can say more about that if  
22 that's helpful.

23 It just so happened that around that time the  
24 advert appeared in The Guardian for trustees for the  
25 Caxton Foundation, and given the fact that I had

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1 chair of the Caxton Foundation, she had no such  
2 induction and, in fact, had not even seen a copy of  
3 the Trust deed. Can you assist us with how the  
4 induction process seemed so different for her?

- 5 **A.** I can't, to be honest. I mean, the only thing I can  
6 add is that I was responsible for, you know, drawing  
7 up the job description both for trustee roles that we  
8 interviewed for in 2012, and indeed for the role of  
9 chair, and one of the criteria for the role was  
10 familiarity with the legal requirements, including the  
11 Government's document for the charity, the Trust Deed.  
12 So I was surprised that Ann had said she hadn't seen  
13 it.
- 14 **Q.** Did you anticipate that there would be concerns about  
15 your appointment from the beneficiary community, given  
16 your previous role at the Department of Health and  
17 Blood Policy Unit?
- 18 **A.** Perhaps naively, I didn't. It didn't occur to me,  
19 initially, that there would be a conflict of interest,  
20 in that the Department of Health had set up the Caxton  
21 Foundation to meet the charitable objects of providing  
22 discretionary financial support and what would I be  
23 doing as a trustee was furthering those charitable  
24 objects.

25 So it didn't honestly seem to me there was,

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1 a good deal of understanding, certainly around HIV and  
2 hepatitis C, through previous roles in the  
3 Department -- I had been the departmental sponsor for  
4 the Macfarlane and Eileen Trusts, and I had met  
5 a number of the campaigners at that time -- this was  
6 a role I was drawn to. I felt that, given those  
7 skills and experiences, it would be something that  
8 I could make a positive contribution to.

- 9 **Q.** Did you have any experience at that stage of serving  
10 as a trustee on a charity board?
- 11 **A.** I did not.
- 12 **Q.** You have described in your witness statement how the  
13 first few meetings at Caxton Foundation were concerned  
14 with obtaining a clear understanding of the duties of  
15 the charity and the experience of living with  
16 hepatitis C, and you received an induction pack from  
17 the legal adviser which included a copy of the Trust  
18 Deed and you heard a presentation from a member of the  
19 Tainted Blood campaign and also from Professor Thomas  
20 on hepatitis C. Is that correct?
- 21 **A.** That's correct. From memory, all that took place in  
22 the first two meetings of the board, in August and  
23 September 2011.
- 24 **Q.** We heard evidence from Mrs Ann Lloyd on Monday and she  
25 told us that two years later, when she became the

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1 therefore, a conflict with having previously worked  
2 for the Department of Health, but I do understand that  
3 because I had also worked as, sort of, Head of Blood  
4 Policy, that might be perceived as such, and  
5 certainly, as I have said in my witness statement,  
6 when I was asked if I wanted to be on the liaison  
7 committee with the Department of Health, I recused  
8 myself from that, because I felt it would be, sort of,  
9 inappropriate for me to be in a negotiating position  
10 with the Department, given my past history, and given,  
11 as well, that I would know some of the people involved  
12 at the Department of Health end.

- 13 **Q.** When did you become aware that there were concerns  
14 about your appointment as a trustee?
- 15 **A.** I can't remember exactly when. I mean, it was  
16 certainly made very explicit at the Partnership Group  
17 meetings and I know one campaigner described my role  
18 as Chair of the National Welfare Committee as "The fox  
19 in charge of the chicken coop". So yes, I was aware  
20 of that and I understood why people might think that  
21 but, in all honesty, my motivations throughout were  
22 always to achieve the best for our beneficiaries.
- 23 **Q.** So if you were appointed in August 2011 and the first  
24 Partnership Group, as I understand it, was in  
25 June 2013, do you think you had become aware of

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- 1 concerns before then?
- 2 **A.** I can't recall. It is quite possible because,
- 3 although there wasn't routine contact unfortunately
- 4 with the beneficiary communities until then, it may
- 5 well be that I had been aware through other contact.
- 6 I just don't know exactly when I became aware of that.
- 7 **Q.** What do you think the advantages to Caxton were of you
- 8 being a trustee, given your previous role?
- 9 **A.** Well, the advantages, as I saw them, were, firstly,
- 10 that I had got a long career in developing policy, so
- 11 looking at, you know, legal requirements and thinking
- 12 about how those could be implemented effectively.
- 13 I had a lot of experience around good governance,
- 14 setting up organisations to meet legal requirements.
- 15 So that felt relevant. I obviously knew how the
- 16 Department worked, I knew how ministers operated and
- 17 how government in general operated, and I came with
- 18 a sort of understanding of the whole infected blood
- 19 tragedy.
- 20 **Q.** What do you think were the disadvantages?
- 21 **A.** To be honest, apart from the perception of a conflict,
- 22 I still, to this day, can't think that there were
- 23 particular disadvantages.
- 24 **Q.** Did you consider that that there may be a suspicion
- 25 that your appointment may mean that the Caxton

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- 1 **Q.** At the time, was there any consideration given to
- 2 whether or not there may be a conflict of interest in
- 3 one Chief Executive having two charities to manage?
- 4 **A.** Well, we had -- for that reason, we had the service
- 5 level agreement between Caxton and the Macfarlane
- 6 Trust and the liaison committee to address issues. So
- 7 if there were concerns that one organisation was
- 8 getting more of the Chief Executive's time than
- 9 another, then those could be dealt with there.
- 10 I think the alternative of having two Chief
- 11 Executives -- presumably, they would have to have been
- 12 two part-time Chief Executives, who would have had to
- 13 have liaised sufficiently with each other to ensure
- 14 read across -- they would be managing the same group
- 15 of staff together and, again, without thinking about
- 16 that in detail, I can imagine two Chief Executive
- 17 might cause more problems than a single one.
- 18 At least with a single one it would be possible
- 19 to talk through any issues of concern around conflict.
- 20 With two Chief Executives, I think the scope for
- 21 miscommunication and issues around staff leadership
- 22 might have been much greater.
- 23 **Q.** Were you involved at all in any discussions about the
- 24 terms of the Trust Deed?
- 25 **A.** No, not the initial Trust Deed. There were clearly

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- 1 Foundation was not independent of the Department of
- 2 Health or the Government?
- 3 **A.** I think, firstly, I was one member of a Board, drawn
- 4 from a huge range of backgrounds. So, you know, it is
- 5 not as if all decisions were down to me, not at all.
- 6 I had also been aware, of course, that the Macfarlane
- 7 Trust had a history of appointing people with
- 8 a Department of Health and an NHS background and,
- 9 indeed, without stepping into my time at the
- 10 Department of Health, certainly at that point were
- 11 actively looking for people from the Department to
- 12 provide the kind of experience that I have just talked
- 13 about.
- 14 **Q.** So when you arrived at the Caxton Foundation, were you
- 15 involved at all in the decision made that the Caxton
- 16 Foundation should share a Chief Executive with the
- 17 Macfarlane Trust?
- 18 **A.** No. That had been decided already.
- 19 **Q.** Can you recall being told anything about why that
- 20 decision was made?
- 21 **A.** I don't recall. I assume it was in order to have some
- 22 read across between the two charities. I think in
- 23 practice -- well, this is perhaps going on to
- 24 a further question, so I will stop there, but, no,
- 25 I don't think -- it seemed sensible to me at the time.

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- 1 later amendments to the Trust Deed after Caxton was
- 2 established, but I had no involvement with anything to
- 3 do with the first Trust Deed.
- 4 **Q.** Excluding issues around the user trustee, which I am
- 5 going to come on to ask you about in a moment, did you
- 6 have any concerns about the balance of skills and
- 7 experience on the Caxton Board during your time there?
- 8 **A.** That was something that we reviewed. We had -- during
- 9 2012, we had some of the initial trustees leave the
- 10 Board, either as planned or, in one case, because of
- 11 other commitments, and that certainly gave us the
- 12 opportunity to take a look then at the skills we
- 13 needed on the Board. So we looked, for example, at
- 14 the need for somebody with communication skills. So
- 15 we certainly took the time to think "Okay, what skills
- 16 do we have on the Board? What skills are needed?"
- 17 When we advertised for trustees we were specifically
- 18 looking for those additional skills.
- 19 **Q.** Were you concerned that it had too strong
- 20 a representation of people with NHS and Department of
- 21 Health background on the board? A point picked up by
- 22 the APPG in their report. They reported in
- 23 January 2015 that there were four out of the nine
- 24 directors at that time who had that kind of
- 25 a background. Was that something that concerned you

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1 or was it a focus of discussion on the board?  
 2 **A.** No, it wasn't. I was the only one, I think, who had  
 3 a direct Department of Health background. Ann  
 4 obviously had an NHS background as chair at that  
 5 stage. Margaret Kennedy had worked for the NHS but as  
 6 a podiatrist, from recollection. So I didn't see that  
 7 as an issue. I think it was really about the balance  
 8 of skills and experience on the board, which I think  
 9 was quite right.

10 I was not entirely clear particularly why  
 11 people might think that there was an issue with people  
 12 who had had past experience in the NHS. I can see the  
 13 Department of Health, because there was an ongoing  
 14 issue about the campaign to have a public inquiry and  
 15 compensation, and I can see that the NHS was seen as  
 16 responsible, you know, for the way people were treated  
 17 in the early days, but the fact that somebody worked  
 18 for the NHS in a particular role I didn't see created  
 19 a conflict. The NHS is, after all, a vast  
 20 organisation.

21 **Q.** Can we turn then to a document that you authored with  
 22 Peter Stevens on the recruitment of user trustees in  
 23 January 2013.

24 It is CAXT0000109\_122.

25 We can see here:

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1 issue?  
 2 **A.** I'm not sure, to be honest. This is one of those  
 3 issues that I have indicated in my witness statement  
 4 that I think we didn't get right, and I really don't  
 5 know why it took that long.  
 6 **Q.** Was any consideration given or was concern raised  
 7 about the fact that there wasn't anybody from the  
 8 beneficiary community on the board at that initial  
 9 crucial period where the Caxton Foundation were  
 10 drawing up their policies, their strategies, nailing  
 11 down their principles and so on?  
 12 **A.** Certainly there wasn't concern expressed by one on the  
 13 board that that hadn't happened.

14 Just to add, and we may well come on to it,  
 15 very early on I had pushed to have a discussion about  
 16 communication and engagement with beneficiaries, that  
 17 was at the second meeting of the Trust, and I wrote  
 18 a brief paper to try and get discussion going, because  
 19 it hadn't otherwise been on the agenda. That didn't  
 20 pick up on the issue of recruitment of a user trustee,  
 21 but it did try to address the issue of the need  
 22 for active communication with beneficiaries. So  
 23 perhaps we can come on to that as well.

24 **Q.** Yes, certainly. I think that was in September 2011 --

25 **A.** That's correct.

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1 "The possible recruitment of a director with  
 2 experience of living ..."

3 **SIR BRIAN LANGSTAFF:** It should be on your screen,  
 4 Mr Lister.

5 **A.** It is. It is, yes. I was just looking at my own copy  
 6 with scribbled notes on as well.

7 **MS SCOTT:** So it starts by saying:

8 "The possible recruitment of a director with  
 9 experience of living with Hepatitis C."

10 It says:

11 "The campaigners have been urging for a long  
 12 time that we should have beneficiaries on the Board.  
 13 The Department of Health ... are sympathetic to the  
 14 idea. We have reservations, which is why we have  
 15 prepared this paper recommending a solution."

16 Is it right to read this as this is the first  
 17 time that the board has been giving consideration to  
 18 recruitment of a director with experience of living  
 19 with hepatitis C?

20 **A.** Yes, I think so. In the early days Charles Gore was  
 21 a trustee and did have experience of dealing with  
 22 hepatitis C. After his departure, we didn't have  
 23 anyone who could give us any insights into that  
 24 experience.

25 **Q.** Why had it taken until January 2013 to consider this

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1 **Q.** -- and I will certainly take you to that paper. In  
 2 fact, after dealing with this topic.

3 Again, going back to that first paragraph of  
 4 the document there, is it right that the genesis for  
 5 this coming before the board is not the board itself,  
 6 but because the Department of Health seemed to be  
 7 pushing for the idea? Is that the correct way to read  
 8 that paragraph?

9 **A.** I don't think that's the correct way to read it.  
 10 I don't think the Department of Health, to my  
 11 knowledge -- I mean -- were pushing for it --  
 12 I, obviously, was not part of any direct discussions  
 13 with the Department of Health through the Liaison  
 14 Committee. I am assuming that Peter Stevens had  
 15 discussed it with them, which is why he knew they were  
 16 sympathetic to the idea, but I am not sure the  
 17 initiative had come from them.

18 **Q.** Then if we go down to the --

19 **A.** The Department of Health after all -- sorry -- did  
 20 pretty much leave -- well, did leave Caxton to decide  
 21 its own policies, and there was really very, very  
 22 little interference with that, if any.

23 **Q.** Then we go down to the bottom of the page and you set  
 24 out there the concerns that you have about having  
 25 a user trustee. The last paragraph:

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"A problem with appointing beneficiary trustees to Caxton is the absence of a 'neutral' outside body with rights of appointment, which means that beneficiary volunteers for the Board would most likely come from activist groups. Such people are likely to have difficulty with the requirement that they should not represent anybody or any cause outside the charity, but should at all times and only act in the best interests of the charity itself, not of its beneficiaries nor of any outside interest such as a campaign group ..."

It is a little bit difficult to understand what's meant there when it says the user trustees shouldn't be acting in the best interests of the charity or its beneficiaries. Can you assist us with what was meant there?

- A.** I was trying to think about that myself. I mean, certainly it is true that, you know, Boards are there to govern the organisation, not to represent particular groups, and that's sort of clear in Charity Commission guidance, in the essential trustee, for example. So although you are not there as a trustee to represent individuals, clearly, as far as beneficiaries are concerned, their only purpose for being there was to provide a service to those

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that the Trust Deed was written at the time. That's not to say it couldn't have been amended, but I think that might have been an issue.

The other thing that occurred to me, reading this -- are you happy for me to reflect on things from my position now, as well as talk about how it felt at the time?

- SIR BRIAN LANGSTAFF:** Yes, indeed.
- A.** I thought there was a certain arrogance about this paper, to be honest. I was thinking to myself, well, here am I saying "Yes, of course I can perfectly well manage conflicts of interest but, you know, beneficiaries couldn't". I really think, and I did say this in my witness statement, that we could have found a way of having a beneficiary trustee. It might have meant they had to abstain from certain discussions which were about -- they couldn't have been a member of the welfare committee, I would have thought, and there may be other things, as well, that we would have needed to have looked at where it would have been perhaps inappropriate for them to have participated from a conflict of interests point of view, but with an effort, I think it should have been achievable.

**MS SCOTT:** Just as a matter of fact, we understand from

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beneficiaries.

So I think somehow there's a distinction there between -- I am not quite sure. I think this is very badly worded, to be honest. I will admit to that. So there is a distinction between governance of the charity, which is for the benefit of its beneficiaries, and representing particular groups, which is not the role of trustees as a group, and I think maybe that's what it's trying to get at.

- Q.** Then there is a concern raised about the difficulty that such a director or trustee would have in keeping information obtained in that role confidential. If we go down to the bottom half of the page, the solution is that you have, rather than a user trustee, somebody who has hepatitis C but is not a beneficiary of the charity. That's the proposal that both you and Mr Stevens were putting to the Board, was it?
- A.** That is correct. I mean, this paper misses off one other issue that should have been covered in there, I think, on this issue of conflict of interest. Certainly, looking at Charity Commission guidance and the terms of the Trust Deed, I think it might have been difficult to have had someone as a trustee who was also a beneficiary of the charity, in that they were actively receiving funds, at least in the terms

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Mrs Lloyd that interviews were, in fact, open to user trustees?

- A.** Yes, they were. I should have gone on to say the policy developed from this and we did -- when I wrote the job description and we had some negotiation as well with the Haemophilia Society and the Hepatitis C Trust, having agreed with the Board, as you say, this would be open to anybody, regardless of whether they were a beneficiary or not.
- Q.** Just as a question of fact, can you recall whether the only people to apply were, in fact, from campaign groups?
- A.** No. Well, as a result of that, we appointed Margaret Kennedy. So that was not the case. Indeed, my recollection is that I don't think anybody from campaign groups applied.
- Q.** So, in fact --
- A.** I may be wrong about that.
- Q.** So the fear that the only people that would apply to become a beneficiary trustee would be those from campaign groups turned out, in fact, to be misplaced?
- A.** I think so, yes. I think there is another issue here about Caxton's relationship with campaign groups that I think is sort of -- I think we can perhaps talk about later.

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1 Q. Can I just pick up then on another point from this  
2 document? Can we go back up the page, please, Soumik:  
3 "A minor point is that the [Department of  
4 Health] did not wish the Secretary of State to be  
5 asked to approve the appointment as trustee of  
6 somebody whose main activity is campaigning against  
7 Government policy. It would also appear that we were  
8 supporting, or at least sympathising with, the  
9 campaigners."

10 What was the concern about such a trustee being  
11 put forward to the Secretary of State? Was it that  
12 the Secretary of State would not approve the  
13 appointment?

14 A. Yes. I mean, again, just to say in my witness  
15 statement I sort of questioned that that was more of  
16 a supposition about how DH would react than based on  
17 any particular understanding because, although all  
18 appointments had to be approved by ministers,  
19 certainly, in practice, they were pretty much nodded  
20 through.

21 There was always the understanding that Caxton  
22 had not been set up as a campaigning group. That was  
23 something that I think was said to me pretty early on.  
24 I can't remember whether it was at the interview for  
25 the trustee role or whether it was on one of those

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1 a concern about the Caxton Foundation appearing to the  
2 Department of Health as though they are supporting or  
3 at least sympathising with the campaigners. What was  
4 the concern in that regard?

5 A. I don't think it should have been a concern. So I'm  
6 sorry, as one of the joint authors of this, I should  
7 be able to give you a better explanation of that than  
8 I have, but I think it was -- I don't think it should  
9 have been in there, to be honest.

10 Q. Was there a concern that if the Department of Health  
11 considered that that was the attitude of the Caxton  
12 Foundation, that they would be somehow displeased and  
13 that it might impact on the relationship or even the  
14 funding? Was that ever a concern?

15 A. I don't think -- there is -- the Department had made  
16 a commitment to fund Caxton. I'm sure we'll talk  
17 about the fact that, you know, we only had commitments  
18 to funding annually and that was an issue. But it was  
19 a public commitment. They'd, you know, set up Caxton  
20 to do a particular role. I don't think there's any  
21 way that they would show their displeasure by  
22 withdrawing funding. The worst that would have  
23 happened is that ministers would have decided that  
24 they didn't wish to approve a particular trustee.  
25 I don't think there would have been any comeback on

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1 early Board meetings, but there was a sort of very  
2 clear message from the founder trustees to those of us  
3 who were new that Caxton was not there as  
4 a campaigning group, and that, you can argue, is borne  
5 out by the Trust Deed.

6 So to have somebody who was -- I think one of  
7 the -- the main issue, really, for me would be that,  
8 had we appointed somebody who was actively campaigning  
9 against government policy, the issue would have been  
10 for them that, as a trustee, they would have been  
11 expected to have been, sort of, fully supportive of  
12 the aims and objectives of the Caxton Foundation, and  
13 I would imagine that a campaigner would have found  
14 that rather difficult because part of the campaign was  
15 what shouldn't be happening is that people were  
16 expected to come cap in hand asking for charitable  
17 support from Caxton, that they should have  
18 compensation as an entitlement. So with that point of  
19 view, being a trustee of Caxton and campaigning for  
20 a settlement might have put somebody in a difficult  
21 position.

22 Q. This here, though, is talking about the position that  
23 the Caxton Foundation would find themselves in in  
24 these circumstances. What was the concern about  
25 appearing to the Department -- it reads as if there is

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1 Caxton had that been the case.

2 Q. It could be said, in making comments like this in  
3 papers for the board, it shows a lack of independence  
4 from the Department of Health. What would you say in  
5 response to that?

6 A. I think it shows -- you could argue it shows  
7 an awareness of the politics around this, potentially.  
8 I mean, after all when we are looking an independence  
9 from the Department of Health, trustee appointments in  
10 the Trust Deed are for the decision of the founder,  
11 for the Secretary of State. So to that extent we were  
12 obligated to the Department for appointment of  
13 trustees, but the Department did not interfere in the  
14 development of policy or anything else. And, in  
15 practice, they never interfered in the appointment of  
16 trustees either.

17 Q. Can I just pick you up on the point about the Trust  
18 Deed not allowing campaigning? Can we just have a  
19 look at that before we take a break to see precisely  
20 what you mean by that.

21 Can we have, please, Soumik, CAXT0000095\_006?

22 Here we have 28th March 2011 Trust Deed, and if  
23 we go to page 12, we have "Schedule 3, Powers of the  
24 trustees".

25 Now, I am going to take you to the

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- 1 paragraphs I think are relevant but do tell me if you  
2 think there are other relevant paragraphs.
- 3 **A.** Sure.
- 4 **Q.** Can we go it page 13? So, first of all, not strictly  
5 relevant, but potentially so, paragraph 18, the power  
6 of the trustees includes:  
7 "To raise funds for the Charity in such manner  
8 as may be expedient ..."
- 9 **A.** Uh-huh.
- 10 **Q.** Paragraph 21:  
11 "To procure, publish and distribute material in  
12 any form that may be deemed desirable for the  
13 promotion of the Objects and for informing the public  
14 about the work of the Charity."  
15 Then paragraph 24:  
16 "To cooperate with other chart tears, Persons  
17 or statutory authorities and to exchange information  
18 and advice with them."  
19 Just bearing those clauses in mind, why is it  
20 you say the Trust Deed doesn't allow for campaigning?
- 21 **A.** I think you have to relate all of that to the  
22 charitable objects. So I can't remember which  
23 paragraphs they are in now. It is further up.
- 24 **Q.** Can we go back to page 3, please. Sorry, page 4 of  
25 the document.

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- 1 they must be in accordance with the charitable  
2 objects? So if it were a campaign to, for example,  
3 bring to an end the Caxton Foundation, that wouldn't  
4 be in accordance with the charitable objects --
- 5 **A.** Correct.
- 6 **Q.** -- but if it was a campaign to promote the idea of  
7 meeting the charitable need of the beneficiary  
8 population, then there would be nothing -- that would  
9 be within the terms of the Trust Deed?
- 10 **A.** Yes, I think, arguably. So, for example, we could  
11 have -- in the very early days, we could have put out  
12 a number of press statements to draw attention to  
13 Caxton. There was a big argument that I felt at the  
14 time that this was a major human-interest story.  
15 There would be plenty of -- the national media who  
16 would be interested in this, you know, perfect for The  
17 One Show, or whatever, and that would be the best way  
18 to make people aware of our existence. That is  
19 something I am sure we certainly could have done  
20 within our objects.
- 21 **MS SCOTT:** Sir, I note the time. Is now Anna appropriate  
22 time to have a break. I am going to change topics?
- 23 **SIR BRIAN LANGSTAFF:** Yes, it is. We normally have  
24 a break for about half an hour in the afternoon, but  
25 it will be shorter this time, because we have already

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- 1 **A.** So my arguments would be the charitable objects are to  
2 provide financial assistance and other benefits to  
3 meet the charitable need of individuals who have  
4 received blood products, et cetera, their partners,  
5 parents, carers, et cetera.  
6 So it's -- there is the single object to  
7 provide financial assistance and other benefits, and  
8 then the rest of that sets out who should be eligible  
9 for those benefits. There is no reference in the  
10 charitable objects to anything else. So there is  
11 an argument to say that if Caxton had taken on  
12 a campaigning role, and I would argue as well we just  
13 didn't have the resources to do that anyway, that  
14 would have been outside of our charitable objects.  
15 Now I think there is provision in here for the  
16 trustees to amend charitable objects, but that would  
17 need to be with agreement of the founder. So we could  
18 have said "We would like to add a campaigning element  
19 to our objects", but we would have needed the  
20 agreement of the Secretary of State to that, and we  
21 would also have needed to demonstrate to the Charity  
22 Commission that that was -- there was a public benefit  
23 there. That's my take on it anyway.
- 24 **Q.** Is this right, that the Trust Deed allows for what one  
25 might call campaigning or lobbying activities, but

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- 1 had a late start and a small break before we began  
2 your evidence. So 20 minutes this time, and we will  
3 come back, therefore, at 3.55. So 3.55. Time for  
4 a cup of tea, Mr Lister.
- 5 **A.** Thank you.
- 6 **(3.34 pm)**
- 7 **(Short break)**
- 8 **(3.55 pm)**
- 9 **SIR BRIAN LANGSTAFF:** Yes.
- 10 **MS SCOTT:** Mr Lister, I am going to take you to your  
11 beneficiaries communication and engagement paper from  
12 September 2011. It is --
- 13 **A.** Could I interrupt, briefly? Would it be all right if  
14 I just reflected back on one of your earlier questions  
15 --
- 16 **Q.** Of course.
- 17 **A.** -- before we move on? Apologies for interrupting.
- 18 **Q.** Of course.
- 19 **A.** I didn't want to forget myself. You asked why it had  
20 taken until February 2013 to have a discussion with  
21 the Board about having a beneficiary trustee.
- 22 **Q.** Yes.
- 23 **A.** I have been thinking about that in the break. I think  
24 part of the reason involves an explanation of what had  
25 been going on in Caxton in the previous year. You may

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1 want to come on to that anyway, but the fact that, as  
2 well as trying to get the National Welfare Committee  
3 operating in a good way, dealing with issues around  
4 throughput of applications and speed of response to  
5 beneficiaries, which was pretty poor in some places to  
6 begin with, the fact that our Chief Executive, Martin  
7 Harvey, was becoming increasingly ill and decided to  
8 leave partway through the year, so we had a need then  
9 to recruit an interim and then a full-time Chief  
10 Executive. We also needed to find a new chair.

11 There was, I recall, a decision that we would  
12 recruit to those new posts and we would recruit  
13 additional trustees and then the last thing, rightly  
14 or wrongly, that we would do is look at a beneficiary  
15 trustee, someone who could at least provide some of  
16 the experience for the Board that we lost when Charles  
17 Gore left.

18 So that's, I think, a big part of the  
19 explanation about why it happened at this point and  
20 not sooner, if that helps at all.

21 **Q.** If we look now at your paper on "Beneficiaries --  
22 Communication & Engagement", CAXT0000108\_045, so this  
23 is a paper -- we can see at the top it is "30.11", but  
24 if we go to the second page, at the bottom your name  
25 with September 2011. So if we go back to the first

1 cons. Then the third option you identify is  
2 a newsletter/content on website. Again, you set out  
3 the pros and cons. Can you just help us with what  
4 "content on website" means?

5 **A.** I am assuming what I was meaning -- it could have  
6 meant either just the provision of information, which  
7 I think is what I was talking about. I guess it could  
8 have referred to something more like having a forum  
9 but I am not sure I had thought that far at this  
10 stage.

11 I mean, looking at this again, this is a very  
12 tentative paper of mine. I was very new on the Board,  
13 second meeting, and I think, in future, my papers,  
14 they tend to have more of a recommendation. I was  
15 leaving this rather open. There was certainly no  
16 appetite at the Board for having open sessions at the  
17 Board meeting. I think the feeling was that that  
18 would be difficult to organise, given a lot of the  
19 content would be about specific cases, et cetera.  
20 I think that was the argument, although I did suggest  
21 that there would be perhaps a way of managing that.

22 I think I had seen other examples where Boards  
23 of organisations would have a public part of the  
24 meeting and then a closed part of the meeting and  
25 managed their business that way, but there was no

1 page --

2 **A.** Just before then -- this is -- I think I refer to the  
3 fact on 16th August I had had e-mail exchange with  
4 Martin Harvey, because he had circulated the agenda  
5 for that Board meeting, and I said the -- the  
6 communication with beneficiaries wasn't on it, so  
7 I said, "I think we do need early decisions on how the  
8 Board will engage with the beneficiary community", and  
9 suggested that we have this on the agenda and then  
10 I wrote this sort of brief paper to try to get  
11 a discussion going.

12 **Q.** The purpose is to:  
13 "... seek members' views on the most  
14 appropriate vehicle for the Board to use to engage  
15 with beneficiaries."

16 Then the recommendation, paragraph 3, is:  
17 "... the board take a view on how it wishes to  
18 communicate with beneficiaries."

19 Then you set out in the background why it is  
20 important that there is this communication.

21 Then if we go over the page, you set out the  
22 different options as you see them and you suggest --  
23 one of the options is a forum and you set out the pros  
24 and cons. Open sessions in Board meetings is another  
25 of the options, and again you set out the pros and

1 appetite at all for that. So the only things of  
2 interest, I think, were the idea of having a forum,  
3 which, of course, we didn't have. We didn't set up  
4 the Partnership Group until the first meeting of  
5 June 2013, so a long, long time after this, and the  
6 first newsletter was not until even later, in 2014.

7 **Q.** So you are there suggesting -- your conclusion at the  
8 bottom of that page says:

9 "A newsletter/website is the minimum needed."  
10 Presumably you take that view because the cons  
11 of that is it doesn't allow for any direct interaction  
12 with the board. Is that right?

13 **A.** Yes. I think I was being concerned. I think I used  
14 the expression which was sort of picked up on my  
15 written evidence, about the board not wanting to be  
16 a kind of ivory tower kind of body, that it needed to  
17 be accessible and willing to listen.

18 **Q.** Then you say:  
19 "Views are sought on other options or  
20 alternatives that enable two-way communication."

21 **A.** Uh-huh.

22 **Q.** This paper gives the impression that your view  
23 is: well, the starting position is  
24 a newsletter/website, and then what else are we going  
25 to do that allows two-way communication? Would that

- 1 be a fair reading of that?
- 2 **A.** Yes, yes, indeed. I think that's a good way of
- 3 reading it, yes.
- 4 **Q.** As you have identified, you have got no user trustee
- 5 on the board until -- for some time. You have got no
- 6 partnership --
- 7 **A.** Well, we don't ever exactly have a user trustee.
- 8 **Q.** Yes, you are quite right. No trustee with lived
- 9 experience of hepatitis C for some time?
- 10 **A.** We had at this stage Charles Gore on the board, of
- 11 course, but we had a period after Charles left and
- 12 before Margaret arrived when -- it must have been
- 13 about a year -- we didn't have anyone.
- 14 **Q.** No Partnership Group meeting until 2013.
- 15 **A.** Indeed.
- 16 **Q.** No newsletter, I understand, until December 2014. Is
- 17 that right?
- 18 **A.** Uh-huh. That's correct.
- 19 **Q.** No forum on the website at all during your time at
- 20 Caxton. Is that also correct?
- 21 **A.** That's correct as well. I think there was a concern
- 22 about having the staff resource to moderate that, from
- 23 recollection.
- 24 **Q.** Why was that? Given that you in September 2011 are
- 25 saying -- assuming this is going to happen in some

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- 1 on the right priorities. And managing -- I mean,
- 2 I think there is an issue -- for example, we were
- 3 very, very poor in our turnaround time on grant
- 4 applications in the first few months. So we had
- 5 difficulty getting even the basics right to begin
- 6 with. Doing extra things on top of that seemed to be
- 7 too much of an ask in many ways.
- 8 Can I mention as well there was a -- I mean,
- 9 I kept bringing this back. I mean, it wasn't until
- 10 some time later, that in -- in February '13, the same
- 11 board meeting where we discussed that paper on
- 12 beneficiary trustee, I took a paper on issues raised
- 13 by beneficiaries and again tried to sort of address
- 14 some of the criticisms and some of the ways in which
- 15 would he could reach out better. It is not actually
- 16 authored -- the authorship isn't on the paper, but
- 17 I recognise it as one that I wrote. It is
- 18 CAXT0000109\_115.
- 19 **Q.** If you just give me a moment. I'll just --
- 20 CAXT0000 -- sorry?
- 21 **SIR BRIAN LANGSTAFF:** 109\_115.
- 22 **A.** So I think this was at the stage where, after the
- 23 Contaminated Blood Campaign and others had met
- 24 Anna Soubry and made their criticisms of Caxton, which
- 25 we were aware of -- we had not had the opportunity to

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- 1 form or another, that really very little happens for
- 2 quite some time. Why is that?
- 3 **A.** It is a very good question. I mean, you will find,
- 4 going through the board papers, that this issue of
- 5 communication with beneficiaries comes back
- 6 constantly.
- 7 So, for example, in March of 2012 the minutes
- 8 of the National Welfare Committee on 15th March --
- 9 you'll recall this was the first one I chaired -- I
- 10 sort of brought up the issue of having an event for
- 11 beneficiaries, and there was an agreement that
- 12 a notice would be put on the website asking for input
- 13 from beneficiaries, but it does not seem to have
- 14 happened.
- 15 So it was something that trustees pushed for,
- 16 to have better communication, but it kept going down
- 17 the priority list, to be honest.
- 18 **Q.** So are you identifying there a problem with the staff
- 19 for whatever reason actioning --
- 20 **A.** I wouldn't want to just put this on the staff, because
- 21 I think this was something -- you know, if things
- 22 weren't happening, then it is the job of the trustee
- 23 board to ask why not and to continue pushing. So
- 24 I think it is a factor of a lot going on with a very,
- 25 very new organisation and maybe the focus not always

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- 1 meet the Minister ourselves, but I took the
- 2 opportunity to try to set out what I thought were the
- 3 criticisms that were being levelled at Caxton and what
- 4 we should do about them. At paragraph 7, further
- 5 down, you know, I say:
- 6 "These criticisms will all be familiar to
- 7 longer serving members of the Board."
- 8 I mean, this was taking the opportunity to get
- 9 a number of the trustees, the new trustees, and
- 10 the new chair, up to speed with this:
- 11 "There is always a risk that this familiarity
- 12 leads us to not taking complaints sufficiently
- 13 seriously."
- 14 I think this was a concern I had that -- I
- 15 don't know, sometimes organisations just sort of think
- 16 "Oh, well, yes, they will complain, won't they?" and
- 17 don't necessarily take a serious enough approach. On
- 18 the next two pages I just go through the key
- 19 criticisms and some suggestions about what we should
- 20 do.
- 21 **Q.** So if we go over to the second page, please, Soumik,
- 22 so you are talking here about the table that's
- 23 provided?
- 24 **A.** The table, yes.
- 25 **Q.** And down the left-hand side you have got "Issues

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1 Raised with the Minister", and on the right-hand you  
2 have got "Comment". Do we understand that the issues  
3 raised with the Minister are the criticisms that had  
4 been raised about Caxton with Anna Soubry?

5 **A.** Yes, indeed.

6 So this was around staffing levels and how long  
7 it takes to process grants, the length of Caxton's  
8 forms and their complexity, the burden of justifying  
9 charitable need, which was one thing we couldn't do  
10 much about and, you know, the application of the sort  
11 of poverty, and managing read-across and, yes, not  
12 having a beneficiary on the board. So, again, these  
13 were all things that ideally we should have been  
14 having -- you know, I raised with the board that  
15 ideally we should have then have been having an active  
16 dialogue with beneficiaries about this I think.

17 **Q.** Was one of the consequences of this failure to have  
18 formal communication with the beneficiary population  
19 or community -- Soumik, you can take that down -- that  
20 all the policies and principles and indeed strategies  
21 of the Caxton Foundation were set without any  
22 consultation from the beneficiary community?

23 **A.** Yes, that's correct. I mean, there is always  
24 a question in these circumstances about how much  
25 consultation it's reasonable to do, because the board

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1 been having or should have been having much more  
2 active dialogue. I mean, for my own part I have to  
3 confess, you know, throughout that sort of period of  
4 2012 I was very much absorbed with making the whole  
5 grant application process more effective and then in  
6 dealing with the consequences of the Chief Executive  
7 leaving, finding a replacement and finding  
8 a replacement chair as well, and also beginning to  
9 look at the beginning of a regular payment scheme.  
10 I am arguing, I suppose, that I was really busy during  
11 that period, which I was. That's not necessarily  
12 an excuse for not really picking up on the fact that  
13 we should have been doing more in reaching out to our  
14 beneficiaries.

15 **Q.** Can you help us with this: when Mrs Lloyd was giving  
16 evidence, she thought, but she wasn't sure, I think  
17 was the position she ended up in, that there had been  
18 an event, a beneficiary event, during the time she was  
19 at Caxton?

20 **A.** There hadn't. There wasn't.

21 **Q.** Again, do you understand why that was?

22 **A.** We had talked about having events and you will see the  
23 sort of references to things that might be planned.  
24 In the end -- I can't remember when exactly, I will  
25 have to refer to my notes, I think it might have been

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1 of Caxton was responsible for setting its policies and  
2 working out how to best meet the needs of  
3 beneficiaries, and sometimes those are -- you know,  
4 those are certainly decisions we took very much on  
5 a case by case basis. It wasn't as if we had a policy  
6 review about one point and a series of  
7 recommendations. There were changes and new  
8 principles adopted as we learned more about the needs  
9 of beneficiaries. But there was a point I think, by  
10 this stage -- so, for example, there was a paper  
11 I wrote for the board in May 2012 about addressing  
12 beneficiary debt --

13 **Q.** Yes.

14 **A.** -- which looks at the various different types of debt  
15 and our approaches to those. Arguably that is the  
16 kind of paper that, if we had got our act together, we  
17 might well have discussed with beneficiaries. Because  
18 there is nothing in there that gives anything away  
19 about individuals. It just sort of focuses on what is  
20 a reasonable approach to take.

21 **Q.** I am going to ask you some questions about debt in due  
22 course and I can certainly take to you that paper then  
23 if you like me to.

24 **A.** Yes, that would be helpful. Thank you.

25 So yes, in conclusion, I think we could have

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1 as late as 2014 -- we did a survey of our  
2 beneficiaries finally to ask what they wanted and one  
3 of the things we asked them about was whether they  
4 wanted regional meetings, for example, and there  
5 wasn't much enthusiasm for them.

6 So, unlike the Macfarlane Trust, where they had  
7 lots of, sort of, get-togethers of one kind or another  
8 with beneficiaries, sometimes over weekends, sometimes  
9 on certain stances, we didn't do that, partly because  
10 we just didn't. With the new arrangement with one  
11 Chief Executive and a very small staff servicing all  
12 five AHO bodies there was just not the resource to do  
13 that and, as I say, I think my priority immediately  
14 was, you know, we need to speed up on our grant  
15 application process. That was the thing that I really  
16 was focusing on in 2012 because that was entirely  
17 unfair to the beneficiaries who had applied, that some  
18 of them had to wait far too long to get a response.

19 **Q.** Can I ask you now about the reserves policy?

20 **A.** Uh-huh.

21 **Q.** Can we go to a minute of the meeting of the Audit  
22 Committee on 19th July 2012, which is CAXT0000065\_062.  
23 We can see you are in attendance -- sorry, you are  
24 present at the meeting. If we turn over to the  
25 page 2, right at the bottom, the last line there:

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1 "The Chief Executive reported the DH's view on  
2 whether or not [then over the page] the Caxton  
3 Foundation should maintain a retained reserve fund.  
4 He went on to say that the DH were advocating that  
5 each charitable entity in Alliance House should not  
6 maintain a reserves fund but should maintain  
7 an operational balance in the event there was  
8 an interruption to the funding applicable to each  
9 body. The Committee noted that the Charity Commission  
10 require a charity to have a reserves policy even if  
11 there are no retained reserves. The Committee noted  
12 that funding to the Foundation and other Alliance  
13 House entities is a commitment; negating the need to  
14 maintain retained reserves.

15 "Mr Lister agreed to prepare a form of words in  
16 respect of the Reserves Policy in time for the next  
17 meeting of the Board of Directors scheduled for  
18 2nd August ..."

19 I can't find reference to that in the Board  
20 meeting of 2nd August. I confess I haven't chased that  
21 through, but is it right to understand that this is --  
22 this was the forum at which recommendations on  
23 reserves policy would have been made to the Board? It  
24 would have been the Audit Committee that was doing  
25 that?

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1 So if the Department of Health said "We don't want you  
2 to have a reserve", I think we would have probably  
3 pretty much accepted that.

4 **Q.** Can I suggest two consequences to you of the reserves  
5 policy that was adopted by the Caxton Foundation and  
6 see whether you agree with them or whether you have  
7 any comment to make?

8 **A.** Uh-huh.

9 **Q.** It meant, first of all, that any underspend was lost  
10 to the Caxton Foundation, because it was simply  
11 retained by the Department of Health?

12 **A.** Yes. I mean, we were working on that public sector  
13 notion of annuality that, if we don't spend the money  
14 in year, it goes back to the Department or it never  
15 gets drawn down, effectively. We don't get to use it.  
16 I think that might have been the case, even if we  
17 hadn't had a reserve policy. A reserve policy would  
18 normally mean you would have enough money -- for  
19 a normal charity would mean you have enough money in  
20 the bank to ensure if you have to close the charity,  
21 for example, you can pay your staff or you can see to  
22 your liabilities, et cetera, and a lot of charities  
23 will have, say, four months' running costs or maybe  
24 even six months' running costs put into reserves.

25 In our case, you could argue that because we

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1 **A.** That should have been the Audit Committee, absolutely.

2 **Q.** As a matter of fact that was the reserves policy that  
3 the Caxton Foundation settled on?

4 **A.** Essentially that we did not have a reserve.

5 **Q.** Yes. Is it right -- it looks from reading this  
6 minute -- and I appreciate it is only a minute -- that  
7 there really wasn't very much discussion about it. It  
8 was simply: this is what the Department of Health  
9 want, this is what the Charity Commission require, we  
10 will go along with what the Department of Health want.  
11 Is that a fair reading of that minute? Is that what  
12 happened?

13 **A.** It's a bit long ago for me to remember this particular  
14 discussion, I have to confess. This is in the  
15 context, I am sure, of -- and forgive a little  
16 speculation on my part -- the fact that the Department  
17 of Health was unhappy at the level of reserves held by  
18 the Macfarlane Trust and did not want Caxton building  
19 up reserves in the same way, and there was a lot of  
20 discussion about how Macfarlane were going to use  
21 those reserves, if I remember rightly.

22 As the Department of Health was the sole  
23 funder, we would have had to have reached agreement  
24 with them on any reserves policy, because that would  
25 have meant drawing down enough money for a reserve.

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1 were going to be wholly funded by the Department with  
2 a sum of money every year, there was no need to have  
3 a reserves policy, because any plan to run down Caxton  
4 would have to be managed alongside the Department of  
5 Health and the right level of funding provided.

6 So, on top of that, we have got this business  
7 that happens a lot with government funding that  
8 government provides funding for something to  
9 an external organisation and if it is not spent, there  
10 is no facility, generally, on public spending rules to  
11 hang on to that money for the following year and we  
12 were caught by that.

13 So I think I would say that that's a slightly  
14 separate thing from reserves, and sort of tied up with  
15 the way, generally, that public spending rules  
16 operate.

17 **Q.** So we have heard evidence from witnesses that were  
18 concern with the Macfarlane Trust. I think it is the  
19 Inquiry's current understanding that the Department of  
20 Health treated their pot of money slightly  
21 differently. They were given, it seems, their money  
22 and they were able to invest it, hence they were able  
23 to build up such significant reserves. Was that, do  
24 you recall, ever a conversation that the Caxton  
25 Foundation had with the Department of Health?

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1 A. I think, to start with, the Macfarlane Trust was given  
2 a sum -- I mean, right at the start, was given a sum  
3 of money of something like 10 million and it was some  
4 years later then before there were additional sums of  
5 money added to that. By that stage, they had built up  
6 some reserves in investment and then the Department  
7 provided top-up funding and allowed them to keep those  
8 reserves that they had built up in the early days.

9 So I think it was quite different in that  
10 sense, because where we started off with potentially  
11 one year's funding, Macfarlane started off with a much  
12 larger sum intended to last for a longer period.

13 Q. Is there anything that Caxton could have done about  
14 that? Could it have made representations to the  
15 Department of Health to say, "We want to be treated as  
16 the Macfarlane are so we control over our allocation  
17 to spend as we want, if we don't spend it all in year  
18 1, we want to roll it over and be able to spend it in  
19 year 2?"

20 A. I guess we could have done. I mean, I wasn't party to  
21 any of the discussions that the founding trustees had  
22 with the Department during the set-up of Caxton. So  
23 I don't know whether that was discussed at all.

24 Q. But it certainly wasn't discussed your time on the  
25 audit committee?

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1 we were obliged to say, "Please don't rely on this  
2 every year".

3 I mean, that was always one of the concerns.  
4 I am sure you will get on to this issue of dependency,  
5 that was always one of the concerns about a regular  
6 payment scheme, I think, in the first place. That  
7 understandably, if people have got an income coming  
8 in, they will adjust to it. They will adjust their  
9 spending in the light of that. And if there is  
10 uncertainty about future funding, that's a problem.

11 Q. I said I was going to ask you about the second  
12 consequence of not having a reserve policy. Is it  
13 this, that that difficulty, that uncertainty is  
14 compounded by the fact that you don't have any  
15 researches to guard against that cut in funds?

16 A. Yes. I suppose it depends, really, what you want  
17 a reserves policy for. I mean, the Charity  
18 Commission's expectation, as I say, is that charities  
19 have a reserve policy to ensure that should the worst  
20 come to the worst and they have to cease operating,  
21 that they are able to meet all their liabilities.

22 In this case we are talking about something  
23 different. We are talking about building up a reserve  
24 that enables us to guarantee a level of income for  
25 beneficiaries year on year. So that would have

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1 A. No, not at all. At the point where I became  
2 a trustee, you know, we had a funding arrangement that  
3 had been agreed and was not challenged after that.

4 Q. Then the second consequence -- I wonder what you would  
5 say to this -- in your witness statement you say on  
6 several occasions that one of the difficulties the  
7 Caxton Foundation faced was the uncertainty over the  
8 annual allocation?

9 A. Yes.

10 Q. And that one of the consequences of that was that this  
11 became difficult to make long-term plans for Caxton,  
12 because there was a concern that if one set up  
13 disbursement policies to give, for example, regular  
14 payments and then the following year that money was  
15 halved or it wasn't there, then the beneficiaries  
16 would be in a very sticky situation, having been  
17 reliant on that money coming in. Is it right to  
18 understand your evidence in that way?

19 A. That's certainly true. So in 2014/15, when we finally  
20 were able to roll out the regular payments scheme, in  
21 that same year the Department was giving us messages  
22 about how the allocation for 2015/16 could possibly be  
23 reduced, and yes, certainly we were forced to say to  
24 recipients -- well, it wasn't a regular payment at  
25 that stage -- the first one was a one-off payment, but

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1 required more than just the usual four or six months'  
2 running costs. It would have required something much  
3 more substantial.

4 I think one of, you know, the Department's  
5 issues, particularly in that sort of period of public  
6 spending austerity, was that it didn't like the idea  
7 of public money sitting around in a bank account  
8 somewhere not being spent when, you know, it could be  
9 spent on front line NHS services or whatever.

10 **MS SCOTT:** Sir, I am going to move on to a new topic.  
11 I am conscious that it is nearly 4.30. So I wonder if  
12 now is a good time to break?

13 **SIR BRIAN LANGSTAFF:** Well, how long is this new topic  
14 going to detain us roughly?

15 **MS SCOTT:** I would have thought twenty minutes to half  
16 an hour.

17 **SIR BRIAN LANGSTAFF:** Yes. Very well. In that case, what  
18 we will do is we will take a break now and come back  
19 tomorrow morning at 10 o'clock, and I think we can  
20 probably guarantee you a 10 o'clock start. So we look  
21 forward to seeing you then, and 10 o'clock for  
22 everyone else. 10 o'clock.

23 A. Okay. Thank you.

24 (4.27 pm)

25 (Adjourned until 10.00 am on the following day)

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<p><b>Y</b></p> <p><b>yes... [69]</b> 67/11 69/12  71/24 73/4 73/11  75/17 76/12 78/4  79/23 83/13 85/13  86/4 86/6 86/16 86/23  87/8 87/11 94/12  96/12 98/2 100/25  105/19 106/6 108/19  111/2 112/10 116/10  117/14 118/17 118/21  119/11 120/25 121/4  121/10 121/18 121/21  123/17 128/19 134/5  134/20 135/24 139/8  139/11 140/3 140/22  141/14 147/10 147/23  148/9 148/22 152/13  153/2 153/2 153/3  153/8 156/16 156/24  157/5 157/11 157/23  158/13 158/24 158/25  162/5 163/12 166/9  166/23 167/16 168/17</p> <p><b>yesterday [5]</b> 2/20  26/21 44/10 44/23  89/14</p> <p><b>yet [10]</b> 2/3 15/23  17/8 17/11 18/9 32/19  46/14 104/9 105/14  122/2</p> <p><b>you [541]</b></p> <p><b>you would [1]</b> 114/25</p> <p><b>you'll [1]</b> 154/9</p> <p><b>you'll recall [1]</b> 154/9</p> <p><b>your [85]</b> 3/10 3/11  3/18 3/18 4/14 4/17  5/21 6/17 7/9 10/16  12/4 12/19 12/22 14/2  16/6 22/16 23/14  23/14 25/7 30/3 31/4  35/14 36/7 39/21  41/16 45/17 48/17  48/23 49/1 49/13  49/16 50/7 51/6 51/7  53/2 53/6 53/11 54/1  55/3 55/5 55/10 55/20  60/2 60/10 68/12 69/7  74/22 107/20 109/25  111/14 112/4 112/5  118/23 119/20 120/19  121/12 122/15 123/15  124/4 124/5 124/8  124/9 124/24 125/4  126/12 127/15 127/16  128/14 129/8 129/25  132/7 134/3 148/2  148/10 148/14 149/21  149/24 152/7 152/22  153/19 163/21 163/22  165/24 166/5 166/18</p>	<p><b>yourself [6]</b> 9/17 9/20  38/5 93/12 118/14  118/16</p> <hr/> <p><b>Z</b></p> <hr/> <p><b>zero [1]</b> 31/12</p>				
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