Witness Name: Malcolm Chisholm
Statement No.: WITN0794001
Exhibits: N/A
Dated: 5 July 2022

# INFECTED BLOOD INQUIRY

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# WRITTEN STATEMENT OF MALCOLM CHISHOLM

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I provide this statement in response to a request under Rule 9(1) and (2) of the Inquiry Rules 2006 dated 3 March 2022.

I, Malcolm Chisholm, will say as follows: -

## Section 1: Introduction

**Q1. Please set out your name, address, date of birth and any professional qualifications relevant to the duties you discharged while Deputy Minister for Health and Community Care (November 2000 - November 2001) and Minister for Health and Community Care between November 2001 and October 2004.**

1. My name is Malcolm Chisholm. I was born on GRO-C 1949 and my address is known to the Inquiry.

**Q2. Please outline your employment history and the various roles and responsibilities that you have held throughout your career, as well as the dates.**

2. After graduating from Edinburgh University, and following a short period of postgraduate study, I worked for six months as a porter at the Royal Infirmary

of Edinburgh (March to September 1973) and for nine months as a nursing auxiliary at Addenbrooke's Hospital in Cambridge (December 1973 to September 1974). Then I underwent teacher training and thereafter had various temporary teaching jobs between August 1975 and July 1976 before working as an English teacher at Castlebrae High School (August 1976 to July 1987) and Broughton High School (August 1987 to October 1990).

3. From April 1992 to April 2001 I was MP for Leith, subsequently North Edinburgh and Leith. From May to December 1997, I was also Scottish Office Minister for Local Government, Housing and Transport. From May 1999 to March 2016, I was MSP for Edinburgh Northern and Leith. I was Deputy Minister for Health and Community Care from November 2000 to November 2001, Minister for Health and Community Care from November 2001 to October 2004 and Minister for Communities from October 2004 to December 2006.

**Q3. Please identify the other Members of the Scottish Government holding ministerial roles relevant to the Inquiry's Terms of Reference between November 2000 and October 2004.**

4. Susan Deacon was Minister for Health and Community Care when I was deputy. The deputies when I was Minister were Mary Mulligan (November 2001 to May 2003), Hugh Henry (November 2001 to May 2002), Frank McAveety (May 2002 till May 2003) and Tom McCabe (May 2003 to October 2004). All Cabinet members, led by First Minister Jack McConnell, were also relevant people because major policy and financial decisions had to be agreed by Cabinet.

**Q4. Please describe your working relationship with your counterparts in the other UK jurisdictions during your time as Minister for Health and Community Care and the extent to which you had regular dealings with them**

5. There were meetings once a year or so involving the Health Ministers of all four UK nations. There were also very occasional meetings with the English Health

Minister. Otherwise, it was a phone call for a specific purpose and that was not very frequent. Alan Milburn and John Reid had been MP colleagues of mine at Westminster but were not close, politically or personally.

**Q5. Please identify by name the senior civil servants involved during the time you were Deputy Minister for Health and Community Care and Minister for Health and Community Care in decisions about blood and blood products, the assessment of the risks of infection arising from blood and blood products, and the response to such risks (including the provision of financial support), and in providing advice to ministers in relation to such issues.**

6. The relevant civil servants were Godfrey Robson, Ian Gordon, Dr Aileen Keel, Andrew Macleod, Bob Stock and Sandra Falconer.

**Q6. Please set out your membership, past or present, of any other committees, associations, parties, societies or groups relevant to the Inquiry's Terms of Reference, including the dates of your membership and the nature of your involvement. In particular please describe your role in the Health and Community Care Committee as i) a member and ii) the Deputy Convener, and whether your involvement with the Committee had an impact on your roles as Deputy Minister for Health and Community Care and Minister for Health and Community Care.**

7. I was a Deputy Convener of the Health and Community Care Committee from the start of the Parliament in May 1999 till the end of October 2000. My role as Deputy Convener was no different to that of an ordinary member, except that I would be required to chair meetings if the convenor was unable to attend, although in reality I don't recall the Convener ever being absent.

8. The Committee had initial discussions about two petitions concerning Hepatitis C from contaminated blood products, but the view of the committee was that substantive consideration of these petitions would not commence until the Executive's report on the heat treatment of blood products in the 1980s had been produced. The Minister, Susan Deacon, was questioned about that report

at the 25 October meeting which also happened to be my last meeting before becoming Deputy Minister. Detailed consideration of the petitions only started after that meeting.

**Q7. Please confirm whether you have provided evidence to, or have been involved in, any other inquiries, investigations or criminal or civil litigation in relation to human immunodeficiency virus ("HIV") and/or hepatitis B virus ("HBV") and/or hepatitis C virus ("HCV") infections and/or variant Creutzfeldt-Jakob disease ("vCJD") in blood and/or blood products. Please provide details of your involvement and copies of any statements or reports which you provided.**

9. I have not provided evidence or been involved in any way in earlier inquiries or investigations into these matters.

<u>Section 2: The Macfarlane Trust and the Eileen Trust</u>

**Q8. What if any contact did you have (in broad terms) with those who had been infected or affected by infection with HIV or HCV as a result of their treatment with blood and blood products, either before or during your tenure as Minister for Health and Community Care?**

10. Prior to becoming Deputy Minister I had met people in Edinburgh who had acquired Hepatitis C from blood transfusions or blood products, including GRO-A GRO-A. I also met GRO-A on several occasions when I was Minister when he headed up the Scottish Hepatitis C Group and he became a member of the Expert Group. I also met various people from the Haemophilia Society including Philip Dolan, also a member of the Expert Group, with whom I talked on several occasions.

**Q9. What, if any, briefing were you given about the existing financial support schemes (the Macfarlane Trust and the Eileen Trust) for those infected with HIV upon first taking office as Minister for Health and Community Care?**

11. I first came to know about the Trusts, in particular the Macfarlane Trust, during my time as Deputy Minister. I am not sure if it was at the very start of that period, but it was certainly soon after being appointed because the Macfarlane Trust in particular came up in debates and discussions about compensation.

**Q10.Please explain the involvement you had (if any) with the Macfarlane Trust and/or the Eileen Trust as Minister for Health and Community Care.**

12. I had no involvement with the Macfarlane or Eileen Trusts.

## Funding of AHOs

**Q11. What if any role did you understand the Scottish Government played in setting funding levels for the Macfarlane Trust and/or the Eileen Trust?**

13. I knew of no involvement of the Scottish Executive in setting funding levels for the Macfarlane or Eileen Trusts and they had no such involvement as far as I know.

**Q12. What role, if any, did you play in this as (i) Deputy Minister for Health and Community**
**Care and (ii) Minister for Health and Community Care?**

14. It follows from the last answer that I had no role.

## Section 3: Hepatitis C Litigation

**Q13. Please explain what if any measures the Scottish Executive took in response to the judgement of Mr Justice Burton in *A & Others v The National Blood Authority & Others* and what involvement, if any, you had in the response. You may wish to consider [PRSE0003333 - full judgement], [SCGV0000242_077] and [SBTS0000357_013].**

15. The Scottish Executive decided it would give effect to the judgment using exactly the same criteria. Susan Deacon was Minister at the time, and she therefore took the decision on that although I was involved in discussions about it and, leading for the Executive in an Opposition Day debate on 26 April 2001 before a decision was made, I said that the Executive was considering carefully what the implications of the judgment might be for a small number of similar Scottish cases.

**Q14. Following this judgement, did you consider that those who had been infected with hepatitis C through blood or blood products, should receive financial payments? Please explain the reasons for your views.**

16. The view of the Executive was that the judgment was only relevant to a small number of similar Scottish cases involving blood transfusions during a particular period. At that time I did not think a case had been made for payment to a wider group of people because at that time I accepted the Executive view that payment should not be made where no fault was involved.

## Section 4: Scottish Health and Community Care Committee

**Q15. On 25 October 2000, you stated in the Committee that you were "persuaded that there has been no negligence" in relation to the heat treatment of blood products [MACK0001929_021]. Please explain how you came to that conclusion. To what extent had you and the Minister, Susan Deacon, as ministerial colleagues, liaised on the questions to ask during the committee meeting?**

17. I came to that conclusion from reading the Executive report on that specific subject. My second question homed in on what I regarded as a key point in the report about how soon it would have been possible to have batches of factor 8 heated to the right temperature and with clinical trials completed. Susan Deacon and I were not Ministerial colleagues at that time (Ministers can't be members of committees) and there was no collusion or liaison in the questions.

**Q16. On 2 October 2001, the Health and Community Care Committee called for financial support for people infected with HCV through blood, arguing that as a matter of fairness, HCV infected blood recipients should receive the same kind of assistance as those infected with HIV [MACK0001929_001]. Please describe the process the Health and Community Care Committee undertook in order to produce this recommendation and your role (if any) in it.**

18. The Health and Community Care Committee took up the issue of Hepatitis C from contaminated blood products after receiving two petitions about that, one calling for compensation for those who had been affected in this way and the other requesting an inquiry into why blood products for haemophiliacs were contaminated in the first place. The petitions were discussed on four occasions, fairly briefly, during my time on the committee and it was decided to put more detailed consideration of the petitions on hold until the Executive's report on the heat treatment of blood products was available. Susan Deacon was questioned about that report on 25 October 2000 which also happened to be my last meeting on the committee. Thereafter the Committee carried out substantive work on the petitions, including taking oral evidence from the Haemophilia Society and the Scottish National Blood Transfusion Service, before producing its report in October 2001. In relation to this topic, my role as Deputy Convener of the committee up to the end of October was no different to that of the ordinary members

**Q17. Did you agree with the recommendations made by the Health and Community Care Committee regarding financial support for those infected? If not, why not?**

19. I was concerned about the implications of the recommendation which appeared to establish the principle that all injury caused by NHS treatment should be compensated irrespective of whether there was fault or blame. At the same time, I did not wish to reject the recommendation outright which is why an Expert Group was set up to consider, among other matters, whether principles for non-fault based compensation could be established.

**Q18. What was the Scottish Executive's response to the recommendation? In particular, what were the reasons for rejecting the recommendation to provide financial support? You may find [SCGV0000247_030], [SCGV0000247_002], [HSOC0009470], [SCGV0000044_012] and [SBTS0000358_040] of assistance.**

20. The final decision about how to respond to the Health and Community Care Committee report fell to the new cabinet which was appointed on 27 November 2001. The previous cabinet had confirmed, at its July meeting [SCGV0000280_012], the existing policy of not paying compensation when the NHS was not at fault. This was reaffirmed by the new cabinet [SCGV0000247_002 - Page 3], fearing that a new principle would be established with far reaching implications including a more risk averse NHS. At the same time however, the cabinet accepted the proposal for an Expert group which would look further into the matter [SCGV0000247_002 - Page 4]. In particular, it was decided that if there was to be a place for compassionate financial support where people had been harmed but the NHS was not at fault, it should be against agreed and published criteria and the Expert Group would explore that possibility.

**Q19. With reference to [SCGV0000248_109], what action did you take following receipt of this letter? In addition, please explain what systems you considered to already be in place to ensure good governance when an internal executive inquiry was undertaken.**

21. I responded to the various points as requested [SCGV0000100_013]. On the remit, I couldn't give a definitive response at this time, but it would consider a range of dispute and compensation mechanisms including no fault compensation. The intention was that the expert group would report within six months and that the membership would certainly include patient representatives. Retrospective application of the group's findings was not ruled out. I noted that no-fault compensation would be within the competence of the Scottish Parliament, though a common UK position would be easier because of the social security issues. Outcomes from the Financial Services initiative could not be predicted and an essential part of it was exploratory talks with

patients and patient groups. Action would be taken to ensure the Clinical Standards Board standard on patient involvement operated effectively in relation to blood transfusions, blood products and related matters which were a matter of particular concern in the Health and Community Care Committee report. Finally, the Convener expressed concerns about the failure to consult the Committee on the remit of the 1999-2000 internal inquiry. I had had no involvement with that, not being a Minister at the time, and since there were no other internal inquiries in the pipeline it was not a subject to which I had devoted attention. I did however take on board the point about consulting the committee and undertook to do that in relation to the membership and remit of the Expert Group.

**Q20. It appears from [SCGV0000247_030] that you consulted with the Department of Health in Whitehall, who confirmed their support for the decision to reject the Health and Community Care Committee's proposals on compensation and to support the expert group proposed. What was the reason for consulting on this issue?**

22. The particular piece of cabinet correspondence referred to in the question was just before my time in Cabinet and so I cannot be entirely certain why that was done. During my time as Deputy Minister for Health and Community Care one of my main tasks was chairing the Care Development Group on the implementation of Free Personal Care and we certainly weren't interested in keeping in step with the UK Government on that. However it is fair to say there were more sensitivities about going our own way on compensation issues because of the immediate problems it would cause for all three other administrations in the UK. Although, as later answers will make clear, at the end of the day I was prepared to ignore UK objections on this issue.

**Q21. In a Scottish Parliamentary Debate on 10 January 2002 [HSOC0009470, page 14], a Scotsman article from 1995 was quoted as saying 'Mr Chisholm was one of 259 MPs who signed a Commons motion in 1995 asking the Tory**

**government to pay compensation to all those infected as a result of NHS blood transfusions'. As to this:**

> **a. Is it correct that you signed this Commons motion in 1995?**
> **a. When and why did you change your mind about the payment of compensation to those infected with hepatitis C as a result of NHS blood transfusions?**

23. The motion in question actually asked the UK Government to consider paying compensation, an important distinction, and in the debate that followed the person who put down the motion actually proposed a far more limited scheme than the one I proposed in January 2003. Notwithstanding that, I clearly knew much more about the complexities in January 2002 than I had done when I signed the motion in 1995. In addition, in establishing the Expert Group, I was continuing to give consideration to payment with the proviso at that time that it should be grounded in general principles. As the terms of reference for the Group put it, "To consider circumstances in which a system of financial and other support might be available to people who have been harmed by NHS treatment in Scotland in circumstances where there is unlikely to be liability on the part of NHS Scotland and to apply general principles which are consistent, equitable and transparent for all."

**Q22. In the same debate on 10 January 2002 [HSOC0009470] you stated that:**

> ***'The financial services providers also have their role to play through the provision of mortgages and insurance. That area is complex, but I am committed to working with patient groups to improve it. I intend to have exploratory talks with patients and patient groups in the coming weeks on that matter as well as on others. Following those talks, I intend to host a summit on the issue with the leaders of financial services providers.'***
>
> **What steps did you take in this regard, and what was the outcome? You may find [SCGV0000192_005] and [DHSC0042275_136] of assistance.**

24. In my initial response to the Health and Community Care Committee I offered to explore whether the Executive could help to overcome the problems many with Hepatitis C faced in relation to insurance and mortgages. The first part of that initiative was seeking information and views from patient groups, particularly through GRO-A of the Scottish Hepatitis C Group and Philip Dolan of the Haemophilia Society. It was clear there were many problems, particularly in relation to insurance, with high premiums, rejection and intrusive questioning all being emphasised. These two patient representatives then attended the summit I held with representatives of the Association of British Insurers and the Council of Mortgage Lenders in December 2002 [DHSC5541441]. The importance of better information for patients was highlighted and the ABPI representative undertook to work towards a fact sheet in that regard. Better information for providers was also emphasised so that, even if higher premiums proved to be unavoidable, providers would have a more realistic view of disease progression based on best available medical evidence. Both the ABI and CML representatives undertook to have continuing dialogue with Philip Dolan and GRO-A, who said at the end that it had been a very useful meeting. Notwithstanding that, I realised it was going to be very difficult to bring about change and I'm told some of the problems persist to this day.

## Section 5: The Expert Group on Financial and Other Support

**Q23. Why was an Expert Group appointed to report on the financial and other support that might be available to people who had been harmed by NHS treatment in Scotland? What was your role in this decision?**

25. The origins of the Expert Group proposal can be seen in one of the recommendations in the Health and Community Care Committee report [MACK0001929_001] and the Scottish Executive's response to that [SCGV0000247_002]. The Committee recommended that the Executive should establish a commission to examine the current system of negligence and fault based compensation and to propose alternatives. The Executive in its response said there was merit in setting up an expert group to explore difficulties that are specific to disputes that involve health issues. On remit it said in particular that

the group would "examine the pros and cons of a universal system for administering financial and other support in situations where people have been harmed but the NHS is not at fault". The initial decision to set up an expert group was taken when Susan Deacon was still Minister and I would not claim a major role in that regard.

**Q24. How were the members of the Expert Group chosen? What if any role did you have in this process?**

26. I took a close interest in who was on the group as I did for other expert groups during my time in office. I also consulted the Health and Community Care Committee during its meeting on 30 January. At that meeting the committee and I concurred that there should be two members from patient groups that had a direct interest in Hepatitis C, one to be chosen by the Haemophilia Society and the other in recognition of many non-haemophiliacs similarly affected. We also agreed that there should be three lawyers and, crucially, including one who had worked with people pursuing claims because of how they had suffered. I think it was a group full of excellent people and I am pleased I had a significant role in appointing them.

**Q25. What was the process for setting the terms of reference for the Expert Group? In particular which organisations were consulted? You may wish to refer to [MACK0001936].**

27. The Health and Community Care committee was consulted on the remit of the Expert Group. The first part of the remit, relating to the general principles that could apply where people had been harmed by NHS treatment but where there was unlikely to be liability, had been highlighted in the response to the committee's report on 11 December. The second section of the remit, relating to the specific situation of patients who had contracted Hepatitis C from treatment with blood products, was agreed with the Health and Community Care Committee at its meeting on 30 January. One or two members of the Committee also wanted reference to the experience of Ireland in the remit and

I included that in the notes to the remit instead, which in practice ensured that it was not overlooked.

**Q26. A chronology prepared by the Department of Health [DHSC0006217_027] states that on 4 November 2002 you phoned the Secretary of State (Alan Milburn) to inform him that the Expert Group was about to publish a preliminary report [HSOC0003349] calling for financial help for all people infected with HCV through blood, blood products and tissues and that Scottish Ministers felt that they had to offer something. The chronology states that Mr Milburn said this would be a grave mistake and a slippery slope to payments running into millions and that you needed to tough it out. Please set out, in as much detail as you are able to, your recollection of this discussion and of your reason for contacting Mr Milburn.**

28. I cannot recall the conversation in detail but, given the knock on effects and pressures it would create for the UK Government, I thought it a matter of courtesy to inform my UK Government counterpart Alan Milburn of what we intended. Moreover, at the end of the day we could not act without involving the UK Government because of the reserved or devolved powers issue and the possible consequences for social security benefits. The key points I made were that the Expert Group report was going to be published in two days' time and that I was minded to provide payments of some kind. Unsurprisingly, given the UK Government at that time took a hard line against any such payments, this elicited a negative response, not just because of the principle involved but because of the extensive public expenditure it could potentially lead to. He certainly tried to persuade me not to proceed with the announcement I intended to make two days later. There were also unresolved issues about whether such payments were possible within devolved powers and that point was also emphasised by Alan Milburn.

**Q27. The chronology [DHSC0006217_027] states that "SoS subsequently asked officials to find some way of showing that the Scots don't have the devolved power to go it alone on this, and thereby prevent them from going ahead with**

**any kind of announcement on 6 November". Did the SoS or the Department of Health take steps to persuade you of this? Please give details.**

29. The only conversation I remember was the one described in the previous answer which included coverage of the devolved powers issue.

**Q28. The same chronology [DHSC0006217_027] states, by reference to 5 November 2002 [WITN6942015], that you wrote to Andrew Smith about the possibility of ex gratia financial payments; that legal advice was obtained from DH and DWP lawyers; that a response from Andrew Smith suggested that this was a reserved matter was sent on 6 November; and that "SofS made further attempts to persuade Scottish Ministers not to make any undertakings on a payment scheme but was unsuccessful". Is this correct? Please set out your recollection of these events.**

30. I certainly wrote to Andrew Smith on 5 November [WITN6942015], outlining my intention to make payments and asking for his support in ensuring payments were discounted for social security purposes. His reply stated that the whole issue of payments was a reserved matter and this was certainly a central argument used by the UK Government at that time. I have been unable to locate a copy of Mr Smith's reply. Apart from the phone call with Alan Milburn described in paragraph 26, and the response from Andrew Smith, I don't recall other attempts to persuade Scottish Ministers not to proceed with an announcement, although obviously I can only speak for myself.

**Q29. On 6 November 2002, the Expert Group published its preliminary report [HSOC0003349]. What was your view of the preliminary recommendations made in that report? You may find [SCGV0000192_005], [SCGV0000250_027], [SCGV0000250_022] and [SCGV0000250_019] to be of assistance.**

31. I welcomed the Preliminary Report, sharing the group's concern for those who, through no fault of their own, were suffering serious long term harm and wanting to find a way to do something to help them. In the press release issued on the day the report was published I went on to say that "what we need to do now is

think carefully about who needs help and what is the best way to design a scheme and structure payments so that the individuals involved benefit fully, while taking account of the costs of any payment scheme in the light of other health priorities". That was what we did during the following few weeks, culminating in the more detailed announcement to the Health and Community Care Committee on 29 January. The second recommendation of the report asked the Executive to give other practical support in a number of areas and I responded positively to that as well saying that a considerable amount of work was already taking place in that regard. For example, money had been given to establish a Hepatitis C Resource Centre and a Managed Clinical Network for Hepatitis C was being developed. I also said that we were exploring the scope for removing some of the barriers that made it difficult for Hepatitis C sufferers to obtain insurance and mortgages and that we had gathered from patient groups specific examples of unacceptable behaviour before a meeting I was to hold soon with key financial institutions.

**Q30. What steps did you take in response to the recommendations made in the preliminary report? In particular was the purpose of the announcement before the Health and Community Care Committee on 29 January 2003 to avoid the Health and Community care Committee 'instigating a debate in the Scottish Parliament which the Executive would almost certainly lose' as alleged in an email from Charles Lister to Sammy Sinclair of the Department of Health, 4 February 2003 [DHSC5110387]? You may also find [DHSC0004601_003] of assistance.**

32. I'm not sure that a Department of Health civil servant in London was best placed to understand why I made the announcement although perhaps a Scottish civil servant thought this a good line to feed, to make the UK Government less hostile to what we were proposing and it did have a certain plausibility. The fact of the matter however is that we were keeping the door to payments open by establishing the Expert Group and I was keen and very pleased to be offering something in response to their report. The bottom line, as will be explained in more detail later, was that I didn't have the money to implement the Group's proposals in full given other health pressures and priorities but I wanted to offer

what I could, something that set the ball rolling and which could potentially be built on in subsequent years. The Health Committee would have liked higher payments but there was no debate demanding them and it is likely the Executive would have won such a debate given the strong whipping system in the Scottish Parliament.

**Q31. Please explain the process by which you set the payment figures announced on 29 January 2003 to the Health and Community Care Committee. In particular:**

**1. How did you set the amounts to be provided for financial support to those infected with hepatitis C?**
**2. What if any consultation took place regarding the amounts announced either with the Scottish Executive, the UK Government or the infected and affected communities?**

**You may find [RLIT0001091] and [SCGV0000251_010] of assistance.**

33. The amounts were determined by what was affordable for the Health budget at the time. The Health budget was increasing but not by nearly as much as it did in the subsequent few years and there were enormous pressures in other areas. Apart from essential action on waiting times, the most pressing problem in the Health Service at the time, the key clinical areas were services for cancer and for coronary heart disease and stroke. The £60 million that had been allocated for improvement to cancer services over three years, and the £40 million to improvements in coronary heart disease and stroke services over three years, provide the necessary context for the up to £89 million proposed by the Expert Group. Notwithstanding that, I was pleased to be able to offer a first payment of £20,000 which was twice the initial payment offered by the Expert Group. And for the avoidance of doubt about who was to receive the first payment, I made clear on 29 January that "if people have the virus, they should get the first payment". The second payment of £25,000 was to go to those affected in a similar way to those in the Expert Group's third category, medical

advice having been given to me that there were problems with identifying people in the Expert Group's second category without invasive liver biopsy.

34. There was no consultation with the affected communities because the amounts were determined by what was affordable for the Health budget at the time. There was no consultation with the UK Government which didn't want any payments to be made at all. As for the Scottish Executive, there was the discussion with Cabinet Ministers which was usual for important policy and financial decisions

**Q32. Why did you reject the Irish scheme as a comparator for the Scottish scheme when setting the level of payments? You may wish to refer to [DHSC5335287],[DHSC5973529], [DHSC6701557], [MACK0002418_002], [SCGV0000258_085], [DHSC6701556] and [RLIT0001091].**

35. As explained in the previous answer, it would have been very difficult for me to find up to £89 million to implement the Expert Group proposals and so it was out of the question to find the even greater sums that would have been required for a scheme comparable to the Irish one. Moreover, there was a major difference in that payments had first been set in Ireland following an openly admitted fault by the Irish Blood Transfusion Service which was not the case in Scotland. The Expert Group established in Ireland concluded that the Irish Blood Transfusion Service had breached its own standards in Anti-D immunoglobulin production and had compounded the problem by failing to withdraw the contaminated product. Moreover, a subsequent Judicial Committee of Inquiry also concluded that the Irish Blood transfusion Service had committed wrongful acts. This was a completely different situation to that pertaining in Scotland.

**Q33. How did (i) the Health and Community Care Committee and (ii) the UK Government respond to your announcement on 29 January 2003?**

36. The Health and Community Care Committee clearly wanted larger payments to be made but responded positively to my announcement on 29 January 2003. For example, Nicola Sturgeon, lead SNP member on the Committee at that time, said at its meeting on that day, "This is a significant breakthrough. I repeat my warm welcome for this announcement and congratulate him (me) for having moved forward on this issue". The UK Government was clearly not happy, but I am not aware of public statements it made at that time.

**Q34. In March 2003 the Expert Group published its final report [HSOC0020367]. What was your view of their recommendations?**

37. I was very impressed with the range and detail of the Expert Group report and the only fundamental problems I had with it were that I didn't have the resources to implement their payment proposals in full and was advised that it was clinically easier to have two categories of recipients rather than three.

**Q35. Why were the recommendations made by the Expert Group not implemented by the Scottish Government? [WITN2287032, page 52]. In particular:**

**1. To what extent were budgetary constraints a factor in rejecting the Expert Group's recommendation on the Hepatitis C scheme payment amounts? [SCGV0000250_019, page 23]**

**2. Why was 'assistance only directed at those who had suffered 'long term harm or hardship' rather than those with chronic HCV? You may wish to refer to [SCGV0000250_019] and [DHSC5322232].**

**3. Why were dependents excluded from receiving financial assistance?**

38. As stated in the last answer and previously, there were two main problems with the Expert Group recommendations. The first relates to their affordability which was a massive problem because of other pressures and priorities within the Health budget. For example, there were major problems within cancer services

at the time I became Minister in November 2001 and my first engagement was a highly publicised visit to the crisis stricken Beatson Cancer Centre in Glasgow. £60 million extra over three years was in due course allocated for a revamped cancer strategy. The position was similar for the other major clinical priority of Coronary Heart Disease and Stroke though in this case it was £40 million extra over three years for improvements in those areas. I give these examples as necessary context for the up to £89million that the Expert Group was recommending and of how difficult it was to find large extra sums of money when most of the budget was necessarily committed to staffing, buildings, medicines and other unavoidable expenditure. Another way of illustrating that is that the total reserve of the Health Department at that time for all unexpected pressures was £25 million. I was open then and I am open now that budgetary constraints were the main reason for not implementing the Expert Group's financial proposals.

39. In relation to the chronic HCV category, I received medical advice that it would not be possible to diagnose that without a liver biopsy whereas cirrhosis and other advanced stages of disease could be more easily identified for a second category. As far as the first stage was concerned, long term harm or hardship ultimately meant anyone who had the virus. "If people have the virus, they should get the first payment", as I said at the Committee on 29 January.

40. I wanted to concentrate on those who were suffering now as a result of contracting the virus in the way in question. When the overall sum of money available was less than proposed by the Expert Group I thought it right to target resources on those people in particular.

**Q36. To what extent did discussions with the UK Government impact on the decision not to implement all the recommendations made by the Expert Group? You may find [SCGV0000250_019] and [DHSC0042275_136] of assistance.**

41. Discussion with the UK Government was not a relevant factor in the decision not to implement all the recommendations of the Expert Group. At that time the UK Government was totally opposed to any payments so there could not be

any issue of keeping in step with them. As demonstrated later in the year, it was the UK Government ultimately following our lead rather than the other way around.

**Q37. Lord Ross noted, upon meeting you before the Expert Group finalised its report [SCGV0000250_019] that, 'From that discussion, my impression was that he was not very sympathetic to the idea that there is a psychological effect on everyone who develops the infection'. What do you recollect of this meeting? What was your view about the psychological impact on those infected with hepatitis C?**

42. I do not have a detailed recollection of the meeting but I know I was most concerned about the effect of Hepatitis C, physically and psychologically. I think that was borne out by my announcement on 29 January that all of those with the virus should get the first payment. It was not necessary to demonstrate a particular level of physical suffering.

## Section 6: Establishment of a scheme to make financial payments

**Q38. What if any discussions regarding the establishment of a scheme to make financial payments to those infected with hepatitis C did you hold with Northern Ireland and Wales? You may wish to consider [SCGV0000255_051].**

43. I didn't hold discussions with Northern Ireland and Wales but officials did in due course. Scotland led the way with my announcement about the basics of the scheme on 29 January 2003. England came on board next at the end of July with an announcement to that effect at the end of August and it was some time during the period between those two dates that Northern Ireland and Wales also decided to proceed on the same basis. Thereafter discussion about the parameters and administration of the scheme involved officials of all four administrations.

**Q39. What if any discussions or consultation did you hold with the potential beneficiary communities when making decisions about the way the scheme would operate?**

44. As indicated at the end of the previous answer, discussions about the way the scheme would operate involved officials of the four administrations rather than Ministers. Crucially however they also involved patient representatives. At the Health and Community Care Committee on 4 May 2004 [MACK0002371_002] I gave the example of patients' concerns about the forms to be used and how officials were revising the forms accordingly.

**Q40. What input did you and the Scottish Executive have into the way the Skipton Fund was eventually set up? You may find [SCGV0000251_043] of assistance.**

45. The parameters of the Scheme were very firmly based on the proposals I had announced to the Health and Community Care Committee on 29 January and so, in that sense, we had more input than the other three administrations. From the end of August however all four administrations had equal influence in deciding the parameters and administration of the scheme. It was clarified at this stage, for example, that a Trust would be set up to administer the scheme and that those clearing the virus as a result of treatment would still be entitled to payment.

**Q41. How did you understand the application process for the Skipton Fund would work, particularly for those who, given the passage of time, would not have access to their medical records? You may find [SCGV0000186_229] and [MACK0002325_004] of assistance when answering this question.**

46. As I said in the press release of 23 January 2004 announcing the details of the scheme, "Bureaucracy will be minimised for people making a claim in recognition that it will be difficult for some people to gather evidence from twenty years ago". Generally, evidence was to be based on the balance of probabilities and it would be presumed, for example, that people with hepatitis C who

received pooled products, virtually all haemophiliacs, were infected by the product.

**Q42. What do you understand to be the reason why it took from 11 December 2002 (when you first announced your intention to set up a scheme to provide financial assistance to those infected with hepatitis C from blood or blood products), to mid-2004 for the Skipton Fund to open for registration? In particular what if any role did the UK Government have in that delay? You may find [DHSC5312836], [DHSC0004421_125], [DHSC5314715], [DHSC5344827], [SCGV0000251_050] and [DHSC0016728] of assistance.**

47. The biggest delay was during the first half of 2003 when no positive response had been received from the UK Government on the issue of devolved competence. That was finally conceded at the end of July but announcement of it was delayed for a month pending the other UK administrations coming on board for the scheme. One advantage of this was that it would be easier on a UK basis to resolve the other uncertain issue concerning consequences for social security benefits that could jeopardise the scheme. Thereafter there was necessary work on the parameters of the scheme followed by work during the first half of 2004 on administrative arrangements, involving patients' representatives as previously outlined, which was certainly the right thing to do even if it took a little longer.

**Q43. What was your response to the criticisms of the haemophilia community regarding the terms of the scheme? You may find [DHSC5187538, page 12] and [SCGV0000186_154] of assistance.**

48. The letter from the Haemophilia Society dated 30 September 2003 made several points. On establishing a scheme on a UK basis, on inclusion of HIV/HCV coinfected people and on some provision for those who had cleared the virus, I was in total agreement. On no requirement to sign a waiver, action was taken as described in the next answer. On the implementation of the Expert Group financial proposals including provision for dependents I had the same financial constraints as described in several previous answers.

### *Skipton Fund Legal Waiver*

**Q44. What role did you have in addressing the question as to whether or not beneficiaries of the Skipton Fund would have to sign a waiver? You may find [RLIT0000600], [DHSC0003606_099], [SCGV0000257_004], [WITN2050070], and [SCGV0000258_098] to be of assistance.**

49. Scotland certainly led the way on the waiver. I was very concerned about people having to sign that and in discussion with the First Minster we decided that no such waiver should be required as announced on 1 April at First Minsters' Questions [RLIT0000600]. The other UK administrations came on board for that though I am not sure on what date precisely.

## Section 7: Calls for a Public Inquiry

**Q45. Did you, as Scottish Minister for Health and Community Care, or your Department, at any time during your tenure, consider the case for holding a full and independent public inquiry into infected blood/blood products? If so, please explain the considerations given to this and why this was not instructed.**

50. We certainly gave thought to a public inquiry, what its purpose would be and what it could hope to achieve but didn't think the circumstances met the criteria for such a course of action. We considered that a common starting point for most public inquiries is that something has gone wrong that could clearly have been done differently. This was a key point because the relevant state of knowledge in the 80s and before made it difficult to see how much that had happened could have taken place in a fundamentally different way. A related aspect was that there simply wasn't any consensus until the mid 1980s about the seriousness of Hepatitis C infection with a large body of medical opinion not taking that fully on board. Notwithstanding all that, it was possible that an inquiry might allow important lessons to be learned, though the feeling we had was that some had been learned already. For example, we were strongly committed to better communication between clinicians and patients and an end to the

paternalistic, doctor always knows best attitude which I had talked about in the debate concerning the Committee's report on 10 January 2002. One of my key priorities as Health Minster was the whole Patient Focus and Public Involvement agenda, including learning from patient experience which I talked about in detail in a debate on 17 June 2003. It's also worth remembering that the Health and Community Care Committee was not pressing for an inquiry. In its own words, "Despite the fact that a case could be made for further investigation either by itself or through an inquiry, it questioned what it would seek to achieve. We decided that the key priority was for the hundreds of individuals and their families to be given financial and other practical assistance rather than for a further two to three years to be spent on an inquiry seeking to apportion blame and prove negligence". We were in agreement with the Committee in that regard.

**Q46. Please consider document [HSOC0008876]. How did you and/or your department and/or the Executive react to the protest at Parliament? In what way were the issues of the protest, ie, the demand for an independent public inquiry and the lack of access to medical records, considered by you and your department or the Executive?**

51. Access to medical records was certainly a big issue and we took action in relation to that as described in answer to question 52. Consideration of a public inquiry was as in the previous answer. I was sympathetic to those who were protesting and tried to understand their experience and where they were coming from, but a public inquiry would have been an expensive, long drawn out process for which certain criteria had to be met and the Executive didn't believe that those were met in this case.

**Q47. As to the decision not to hold a public inquiry:**

**1. On 9 September 2003, when you informed the Committee that there would be no public inquiry but that "if new evidence emerges, I am happy to consider it with an open mind" [DHSC5325070], were you content that you had adequate information to make that decision?**

**2. Were the additional papers referred to in The Sunday Times article subsequently provided to you? [HSOC0029317 and DHSC5325070]**
**3. If they were provided, what were those papers?**

**4. Why did you consider that they did not necessitate a public inquiry to be established? [SCGV0000256_075 and MACK0002371_002 may be of assistance].**

**5. Did you report your position in relation to the need for an Inquiry to the Committee, as suggested by the Convenor?**

**6. What sort of evidence did you consider was required such that you would have established a public inquiry?**

52. I would make such a decision after receiving information and advice from civil servants and medical officers. Collectively I think we did have adequate information to form the basis of a decision.

53. The report in question was provided to me and my officials.

54. It was the Haemophilia Directors' Hepatitis C Working Party Report for Year 1980-81.

55. I was assured this did not constitute new information or evidence since its contents were very similar to those in many other medical sources. For example, from as early as 1974 the Directors were aware that treatment with blood clotting factors carried a risk of infection with what we now call Hepatitis C. I was told this awareness was clear from many articles in the Lancet and other journals during the 1970s and that from at least 1976 product information leaflets also contained statements that the risk of transmitting hepatitis could not be excluded. In relation to the point in the Report about a greater risk from some concentrate products than from others, I will quote from my letter of 6 October 2003 to the Convener of the Health and Community Care Committee

[SCGV0000256_075] "This information has to be viewed against the actual circumstances prevailing in 1982,namely the background of conflicting expert opinion on the seriousness of Hepatitis C infection, variations in the efficacy of different products in treating haemophilia in different patients, variations in the side effects, the fact that both commercial and NHS products were licensed by the Medicines Division of the DHSS(the predecessor of the Medicines Control Agency) and the inability of the NHS to meet UK demand. However, concern about the unknown long term outcomes for Hepatitis C infection was a driver for the initiative for UK self-sufficiency in blood products."

56. I wrote a fairly detailed letter to the committee [SCGV0000256_075] Some of that letter is quoted in paragraph 55 above.

57. The basic issue was evidence in relation to fault or negligence, evidence of something going badly wrong that could reasonably have been done differently given the state of knowledge at the time.

**Q48. With reference to document [SCGV0000262_120], please outline what was discussed during your meeting with Philip Dolan in respect of his calls for a public inquiry, and the responses you gave; please provide any notes you or your department may have of this meeting. Did you find the meeting "gruelling"? If so, please explain why.**

58. I had several amicable meetings with Philip Dolan and always thought we got on well even when disagreeing. Personally I certainly wouldn't use the word gruelling of any meeting with him. The meeting covered a whole range of topics including the financial package and the public inquiry issue. On the latter the responses I gave were very much along the lines of the points I made in response to questions 45 and 47. I don't have any notes of the meeting.

**Q49. Why did you believe that the 'MCA argument' was a 'strong card' for arguing against a public inquiry? [SCGV0000262_202]. Were you seeking to find reasons not to hold a public inquiry, rather than considering whether one ought properly to be held?**

59. I wasn't seeking to find reasons not to hold a public inquiry since, as answers to questions 45 and 47 above make clear, there were several already. The point about the MCA argument was that it was a different kind of reason that might be more effective in persuading those in favour of a public inquiry to understand the difficulties. The fact that a public inquiry would intrude on reserved areas was certainly a complicating factor but not one of the main reasons.

**Q50. Did you and/or your department ever consider that a public inquiry could be of benefit to the Executive and the country, for example, in attempting to draw a line under allegations of cover-up and wrongdoing, given that the campaign for an inquiry had persisted for so many years? [HSOC0009130] may assist you in answering this question.**

60. We didn't think of it in that way and I don't remember considering it from that point of view, perhaps partly because there was no guarantee it would draw a line under the allegations but more fundamentally because there were other criteria which had to be met as outlined in the answers to questions 45 and 47 above. The expense of a public inquiry and the time it would take were additional considerations but not the fundamental ones since we accepted there were occasions when inquiries were the right course of action, and this could potentially be one of them if new evidence emerged.

**Q51. To what extent, if at all, was the decision not to establish a public inquiry because of a need, whether actual or perceived, to align with the position in Westminster? [HSOC0028473] and [DHSC0006216_136] may be of assistance.**

61. There were several reasons as outlined previously but this was not one of them. We had already gone our own way by offering ex gratia payments and had done so on other issues, though the reserved dimension of any inquiry would have been a complication as mentioned in the answer to question 49 above. That was quite a separate issue however from aligning with Westminster and the latter was not a significant factor in the decision not to hold a public inquiry

## Section 8: Medical records

**Q52. According to [HSOC0008876], you told the BBC that you would follow-up on the issue of missing medical records. Please explain what efforts you made to investigate or resolve the issue of infected persons unable to obtain their medical notes, including the outcome of your notification to hospitals that they must provide the records requested. You may also find the following documents of assistance: [SCGV0000195_132; SCGV0000255_081; SCGV0000195_041; SCGV0000195_007; HSOC0011855_004 and SCGV0000195_096].**

62. I made clear to hospitals that they must respond positively to requests for medical records and on more than one occasion said that anyone having a problem accessing their records should contact the Health Department. Every letter we received which indicated a problem was followed up meticulously by officials and with positive outcomes as far as I know. Document [SCGV0000195_041] gives a summary of the letters dealt with in each Health Board area

**Q53. Please refer to document [SCGV0000195_010]. Did you meet with Ms Wintle and Ms Grayson as requested and if so, please outline the discussion that took place. If not, why not?**

63. This letter of 1 July 2003 was replied to by an official on 31 July after follow up with the North Glasgow University Trust. Letters from members of the public were and are routinely answered by officials, though I would sometimes ask to see replies if a letter had been drawn to my attention. The reply in this case, which I saw for the first time among your documents, dealt with the particular problem as far as I can see. I also see that the letter proposed a meeting with John Reid and myself and I don't recollect being asked about that, perhaps because such a meeting involving both English and Scottish Health Ministers would have been without precedent.

## Section 9: vCJD

**Q54. What if any information were you given about vCJD and recombinant Factor VIII when first taking office?**

64. I was aware of general issues concerning vCJD and blood products from early in my time as Deputy Minister but can't recall if I was given information immediately on taking office.

**Q55. The Department of Health announced the decision to import fresh frozen plasma for certain patients during your tenure. What if any consultation or input did you have into this decision? You may find [NHBT0017731] of assistance.**

65. This decision was taken on the advice of the relevant expert committee and, entirely appropriately, it wasn't one for non experts in this area such as myself to have input into.

**Q56. The Inquiry understands that in November 2002 some 300 haemophiliacs in Scotland given Factor VIII/IX between 1987 and 1989 were notified that they might have received blood products from a donor who later developed vCJD. Please answer the following questions.**

1. **What role did you have in the decision to notify these patients?**
2. **Was there a concern as stated in [NHBT0008986_002], about disclosing the number of patients affected? Please explain what the concern was.**
3. **What ethical issues were considered when making this decision?**
4. **What psychological or other support was offered to those notified?**

**You may find [SCGV0000039_137] of assistance.**

66. Unlike the situation in the previous answer, this was an ethical rather than an entirely medical matter and Ministerial involvement was therefore appropriate.

When I first heard about the risk in November 2002 it didn't seem right to me to hide it from those who might be affected, no matter how small the risk.

67. Concern about disclosing the number of people affected was not a major issue, not for me in this case certainly, though it was sometimes a matter of concern in situations where a much smaller number of people was involved. I'm not sure why it might have been thought a matter of concern in this instance.

68. It is possible to see both sides of the question when considering whether individuals should have been contacted. The advice of the vCJD Incidents Panel was unclear though it had said that patients should not be informed when the risk was minimal. While some might think it was better for people not to know, it seemed to me it was the views of people potentially affected that mattered most and what transpired gave primacy to their views as far as possible.

69. Letters were sent out advising of the theoretical risk of contracting vCJD and suggesting they contact their local Haemophilia Centre if they wanted to find out whether they had received the affected blood products. It was the responsibility of the Centres to provide the information and support that was required.

**Q57. In December 2003, the first case of transfusion-implicated vCJD was reported. Please outline any steps which were taken by you and your department in response to this. You may wish to consider [DHSC0004555_177]; [DHNI0000007_019] when providing your answer.**

70. When I was told in the middle of December of a possible vCJD transfusion transfer from donor to recipient I made a statement to Parliament outlining what further action would be taken [DHSC0004555_177]. In Scotland there were two people who had received blood from a donor who subsequently developed vCJD and the Scottish Centre for Infection and Environmental Health, supported by the Health Protection Agency, was in the process of contacting

the affected patients. The Advisory Committee on Microbiological Safety of Blood and Tissue was to review whether blood should continue to be donated by those who had received a transfusion since 1980 and, pending that, I asked the Scottish National Blood Transfusion Service to assess the implications, if that were no longer to be permitted, and to prepare a plan accordingly. Once the committee had made the decision to prohibit blood donations in those circumstances the Scottish National Blood Transfusion Service continued to undertake a considerable amount of work to ensure the smooth and safe introduction of its plan on 5 April. An estimated ten per cent of donations would be lost and the existing recruitment campaign was stepped up accordingly along with the Better Blood Transfusion Programme. Information and support for those who had concerns arising from the change was an important part of the way forward and there was a well publicised dedicated team on the National Helpline number.

71. In my statement in December I also pointed out that other patients, including haemophiliacs, would have received plasma products before a decision was taken in 1999 to source plasma products from the US and Germany. The UK wide CJD Incidents Panel considered the risk for this group to be even lower than for those who'd received blood transfusions and would be advising on a case by case basis which recipients would need to be contacted as the necessary information became available.

**Q58. What if any input did you or the Scottish Government have in the notification exercise carried out by the Health Protection Agency in 2004, notifying those at risk of vCJD? The announcement made in Westminster can be found at [HCDO0000660].**

72. The Health Protection Agency, on behalf of the CJD Incidents Panel, reported in June on an assessment of the risk associated with each batch of blood products and advised on which patients needed to be assessed and possibly contacted subsequently. In Scotland there were fifteen implicated batches and it was the Scottish Centre for Infection and Environmental Health which initiated a process to notify any patients identified as being at risk. It sent information

packs to Haemophilia Directors and other clinicians and it was their responsibility to communicate with relevant patient groups and the particular patients affected, offering the opportunity for discussion with an expert on an individual basis. The notification exercise was essentially a UK wide exercise overseen by the Health Protection Agency but with a particular role in Scotland for the Scottish Centre for Infection and Environmental Health. It was an exercise directed by medical and scientific experts and it was therefore appropriate that the Scottish Centre for Infection and Environmental Health took the lead in giving press statements in Scotland. I answered a Parliamentary Question [SCGV0001056_039] about the notification exercise but had had no input into the exercise itself and neither had the Scottish Executive more generally to any significant extent.

**Q59. What if any consultation or input did you have into the announcement to prevent those who had received a blood transfusion since January 1980 from donating blood? You may find [DHSC0004555_057], [DHSC0004555_127] and [NHBT0035101] of assistance.**

73. There was no issue about consultation on the substance of the announcement since this was rightly the prerogative of the Advisory Committee on Microbiological Safety of Blood and Tissue on which Scotland was represented. The issue was more to do with the coordination of announcements, and ensuring there was no leak, since I had given an undertaking to report to the Scottish Parliament following a decision by the committee. There were concerns about insufficient notice from the UK Government in December but there was adequate liaison for this subsequent announcement in March.

## Section 8: Other

**Q60. In a statement from campaigner Bruce Norval [WITN2235003, para 13.29], he noted that both yourself and Shona Robison attended the play 'Factor 9.' Referring to you, Mr Norval stated that 'he hadn't known any of the information in the play when he was health minister...ministers were not always passed information by civil servants.' Was this your experience? In particular, to what extent did the civil servants dealing with blood and blood products have an**

**understanding, in your view, of the experience of those infected and affected by contaminated blood?**

74. Factor 9 is an incredibly powerful play and nobody who sees it can fail to be moved by it. Clearly it gives a different interpretation of events in the 1980s and earlier from the one I was familiar with as Health Minister and it is certainly true that I was unaware of much of the information within the play. I suppose however that civil servants would have regarded it as contested information and perhaps that was why I was not made aware of it. They were accepting the prevailing view of what happened in earlier times and I myself take full responsibility for any lack of understanding I had of the experience of those infected and affected by contaminated blood.

**Statement of Truth**

I believe that the facts stated in this witness statement are true.

Signed **GRO-C**

Dated 5-7-22