Witness Name: Mark Mildred
Statement No.: WITN5258001
Exhibits: None
Dated: 10 February 2021

**INFECTED BLOOD INQUIRY**

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**WRITTEN STATEMENT OF MARK MILDRED**

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I provide this statement in response to two requests under Rule 9 of the Inquiry Rules 2006, dated 14 December 2020 and 27 January 2021.

I, Mark Mildred, will say as follows: -

## Section 1: Introduction

1. I was born on GRO-C 1948. I live at GRO-C London GRO-C I was admitted as a Solicitor in April 1975.

2. I worked in private practice, specialising in liability for defective products and collective remedies in civil proceedings (often referred to as class actions). I published a large volume of work and was a frequent lecturer and broadcaster on these topics. In 1996 I was Co-Agent for the European Commission in Infringement Proceedings against the United Kingdom in relation to the implementation into domestic law of Directive 85/374/EEC, the Product Liability Directive. A list of publications and CV are available, if required. In 1995 I left full-time private practice on my appointment as Professor of Litigation at Nottingham Law School. I worked in this role part-time and undertook consultancy work for several law firms in complex litigation cases and had a variety of appointments in the public sector including part-time Tribunal Judge roles and a Non-Executive Directorship in the NHS.

3. In the summer of 2006, after reading an advertisement in, as far as I remember, the Law Society Gazette, I applied for and was appointed to the Chair of the Skipton Fund Appeals Panel after interview by the NHS Appointments Commission.

4. I estimate that I spent approximately 10 hours per month over the whole of the year in this role.

5. I was appointed by the Department in a quasi-judicial capacity, having no pension or other employment rights for a fixed (renewable) term of 3 years from 1 September 2006.

6. My duties as Chair were to attend and chair meetings of the Panel and write decision letters in respect of each appeal. I arranged for meetings of the Panel when justified by the workload and directed how many appeals should be placed on the agenda for each meeting. In the early days I attended the Fund's office to review the appeal files in order to decide whether any further information was necessary or desirable for the fair disposal of the appeal.

7. I did not attend Board meetings of the SF.

8. I attended occasional meetings at SF (certainly no more than once per year) when occasion demanded. I attended a meeting at the Department of Health in January 2013 after an issue arose about deceased claimants infected with both Hepatitis C and HIV.

9. I did not have any training or induction on my appointment. I arranged to meet Nick Fish and the then Finance Officer shortly after my appointment to introduce myself and agree a system for ascertaining probable workloads, setting up hearings, provision of appeal files and producing decisions. To the best of my recollection I was provided with a copy of the different application forms and (possibly then, possibly later) a copy of the agreement between the Secretary of State for Health and the SF. The only other document was a short (1 or 2 sides of A4) description of the arrangements for the Panel that was sent to me in the application pack. I was told by Nick Fish that there was no other documentation relating to the operation of the Panel. I understood the aims and objectives of the SF to be ex gratia compensation for persons infected with Hepatitis C by NHS blood or blood products before a certain date. Beyond that I was not concerned with what principles or philosophy underpinned the establishment and working of the SF.

10. I have not been a member, past or present, of any committees, associations, parties, societies or groups relevant to the Inquiry's Terms of Reference save as set out in the next paragraph.

11. I was a leading member of the team advising the claimants in the HIV Haemophilia Litigation from 1988 to settlement and the establishment of a new Macfarlane Trust in early 1991. I was a member of the claimant legal team in the Human Growth Hormone Litigation in the second half of the 1990s. I gave informal advice to the claimants' legal teams in the HCV and vCJD litigation.

**Section 2: The Appeals Panel**

12. See under paragraph 3 above.

13. The other members of the Panel were a lay member Annie Hitchman, a hepatologist Dr David Mutimer, a Consultant in Transfusion Microbiology Dr Patricia Hewitt and a GP Dr John Dracass. Short biographical details of Panel members are set out in the press release relating to the appointments [SKIP0000030_023].

14. I was the legally qualified member and sat on every appeal. Except in very rare cases of illness, holidays or other unbreakable commitments all members sat on each hearing. I presume that the Panel was (very sensibly in my view) designed to include access to the critical disciplines of hepatology and haematology to enable it to have expert opinion available and to educate non-specialist members in particular disciplines where necessary. The Panel had no formal constitution. We attempted to work in a collegiate manner to optimise the utility of our various skills and, if possible, achieve consensus. In rare cases of fundamental disagreement we would adjourn for further information to be provided and, if ultimately necessary, we made a decision by majority vote.

15. As is clear from the above, I had no hand in recruiting the original Panel members. Dr Dracass retired from the Panel on the expiry of his three-year term in September 2009 and was replaced by Dr NJ Gourlay. Dr (by then Professor) Mutimer retired from the Panel at the end of 2012 and was replaced by Professor Peter Mills. On the retirements from the Panel of Drs Dracass and Mutimer I was invited to be a member of the NHS Appointments Commission panel that interviewed candidates to replace them and make a recommendation to the Commission. Very near the end of the Panel's lifetime Annie Hitchman effectively retired GRO-C and was not replaced as the SF and the Panel were about to be replaced by new organisations.

16. The Panel had administrative support from the SF in notifying us of appeals, provision of appeal files, arranging meetings, sending out our requests for further information and decision letters and dealing with fee claims. Nicholas Fish was my main contact. The service he provided was first class. The Appeal Panel had no administrative support of its own. Members of the Panel conducted appeal business in their own homes or offices without any IT support.

17. The Panel aimed to meet quarterly and, to the best of my recollection, this was the pattern we achieved from 2006 to 2017.

18. The Panel met at various locations including meeting rooms at the SF, the Academy of Medical Sciences, the Royal College of Physicians and Surgeons of Glasgow and once at my house in order that Dr Dracass's retirement could be celebrated with supper after our meeting. There may have been meetings at other places which I have forgotten. Meeting venues were arranged by Nick Fish. In addition we met by telephone conference owing to the geographical dispersal of members (in London, Birmingham, Glasgow, Surrey and a remote place north-west of Glasgow whose name I cannot remember) when it was impossible to arrange a date to meet in person convenient to all members without undue delay.

**Section 3: Procedural issues: The Appeals Panel**

19. The appeal process was in place when I was appointed and I played no part in designing it.

20. When I was appointed there was minimal guidance from the Department of Health. There was a note about the Panel supplied with the application form. There was also the same description of the Panel's function contained in the press release announcing our appointment [SKIP0000030_023]. This set out that our function was to reconsider decisions of the SF and say on the balance of probabilities, having considered all available evidence and any new evidence provided by the appellant of his or her own volition or at our request, whether chronic Hepatitis C infection of a Stage 1 decision appellant resulted from NHS treatment with blood or blood products. In an appeal against a stage 2 decision the question was whether the appellant had probably gone on to develop cirrhosis or primary liver cancer. The long form of the Qualifying Criteria is set out in Schedule 2 to the Agency Agreement between the Department and the SF [SKIP0000033_058]. I was supplied with a copy of this at some stage. It may have been at my first meeting with Nick Fish at the SF but I cannot be certain. The last 4 sentences also answer questions 23, 24 and 26. As far as I know the Department drafted these documents. I am unable to say whether representatives of the SF were involved in the drafting. The press release at least was in the public domain. [Also question 30]. These documents made clear that the appeals were to be paper-based with no attendance by the appellant or any representatives of the appellant or of the SF.

21. I know from reading the appeal files that an unsuccessful claimant was informed of the right to appeal with a short description of the composition of the Panel and confirmation that the appeal would be dealt with on the papers and of the right to submit further information and documents.

22. There were no time limits on appeals nor were any fees payable by appellants. Every unsuccessful appellant was informed that the appeal could be reconsidered by the Panel at any stage in the light of any new information or documents provided.

23. See under paragraph 20 above.

24. See under paragraph 20 above.

25. It is plain from all these documents that the burden of proof was on the claimant to the ordinary civil standard, that is the balance of probabilities (more likely than not). I do not know what was intended by the phrase "most probably" in the application form. We had no control over this document and in practice ignored the word "most".

26. See under paragraph 20 above.

27. See under paragraph 25 above.

28. I took the chair at Panel meetings. At the first meeting I invited questions about the process to be adopted and gave an explanation of the concept of the balance of probabilities. I asked members whether they had any general queries at the beginning of each meeting. I then took each appeal in turn asking each member for his or her comments on the papers. If there was initially no common view I invited general debate and attempted to test the views of individual members. I then attempted to find a consensus and, in the unusual

absence of consensus, took a vote. I then summed up the basic reasons for the decision for approval. After the meeting I drafted decision letters. On occasion I sent a draft to one or more of the medical members in order to check whether I had correctly explained a technical matter.

29. Papers were provided to the Panel in advance of the meeting by Nick Fish or a member of his staff. No member of the SF was at the meetings to present the SF's case in the appeal or for any other purpose. Early in the life of the Panel we agreed that each medical member would prepare and circulate comments on each appeal before the meeting. This was very helpful in that it drew attention to key documents (or the lack of them), provided explanations of important technical information and gave reasons for the author's provisional opinion that an appeal should be allowed, rejected or deferred for further information to be provided. The opportunity for members to read each other's views and re-read the file in the light of them significantly shortened the time spent discussing each appeal and from memory it was unusual for discussion of a case to exceed 15-20 minutes. I am asked whether the Panel made their own investigations. All medical members clearly looked up medical textbooks and professional journals, if they wished to check matters. I expect that on occasions they also discussed historical issues or medical controversies with professional colleagues although I was satisfied that they were giving their own opinions on the individual cases. I cannot speak for Annie Hitchman but I looked up any terms I did not understand in reference resources such as medical websites and a medical atlas.

30. As set out above we were appointed on terms settled by the Department of Health that stated the Panel would not hold oral hearings. I took the view that we had no power to override this condition. We attempted to compensate any disadvantage to the appellant (or indeed the taxpayer) by extending the right to renew the appeal without limit of time. I was also aware that our decisions would be amenable to Judicial Review.

31. I did not attend the SF Board meeting on 1 August 2007 and have never before seen the minutes of that meeting. Whilst I cannot speak for the author I expect that the passage referred to reflected an approach to appeals by the Panel which I will now describe. From our first meeting onwards it was clear that applications had been turned down by the Fund for the sole reason that there was no document in the medical records of the claimant evidencing the fact of a transfusion. We considered this to be potentially unfair on the appellant who had no control over what was written in the records or whether the records were retained or destroyed. My advice to colleagues was that we were empowered to take a fresh view of the case and were not constrained slavishly to follow the reasoning of the original decision. My view, with which colleagues came to agree, was that we could use the medical context giving rise to the application to the SF as extra evidence supporting or negativing the probable exposure of the applicant to NHS blood or blood products. This criterion became known within the Panel as "clinical plausibility". To give two examples: where a post-partum haemorrhage was documented we accepted that it was very highly likely that a transfusion would have been given, even if not recorded in the medical records. On the contrary, if the documented injury was a cut to the skull, the bleeding caused would have been highly unlikely to have required a transfusion. I accept that there was no formal basis for this approach but (a) our terms of reference from the Department were minimal

and (b) in the absence of such an approach we would have had little or no alternative to rubber-stamping the decision of the SF simply owing to lack of documentation from as many as 30 years beforehand. This would have made the appeal process largely pointless. I cannot now remember whether this approach was made explicit to appellants in advance of the appeal but it was certainly clear from the reasoning set out in the decision letters. The approach was also described in point 8 of the guidance for appellants [SKIP0000030_125 at page 5].

32. I do not know whether any action was taken by the SF to review the eligibility criteria for SF payments, in the light of the decisions made by the Appeals Panel. Presumably that information is available from the SF itself. I have now been shown SKIP0000031_249 in which the Chair of the SF asked me in a letter dated 11 November 2007 whether I would raise the issue of natural clearers with the Department of Health. I had forgotten about this but am confident I decided that this was not a matter I should pursue.

33. In an email dated 20 May 2011, from Nick Fish to me, it states 'As expected, there has been an increase in appeals, already up to 6 new ones'. I am asked why I expected an increase in the number of appeals against SF decisions in 2011. I am unable to answer this as the author refers to his expectation (not mine). As discussed later there were changes to the eligibility criteria in 2011 and this may have been what was behind that view.

34. There was no procedure in place to consider appeals made on an urgent basis and this was not, to the best of my recollection, necessary. Cases were sometimes added at short notice to the agenda for a meeting. I am not aware that there was a problem in appeals waiting over long for a determination.

35. Except for the production of a guidance note for appellants (set out at pages 5 and 6 of SKIP0000030_125) the Panel provided no practical support or assistance to applicants to help them in making appeal applications. In my view this would have been inconsistent with our obligation to make impartial decisions.

36. At what I believe was our third meeting in June 2007 we decided that it would be desirable to look back over the appeals which we had by then already considered to see whether our developing approach to the clinical plausibility of a need for a transfusion in the absence of a record was being consistently applied and whether earlier cases would be decided the same way, if examined again. Dr Dracass volunteered to undertake the audit and circulate with it a draft of the guidance note for appellants. These were considered and approved (I cannot remember whether there were stylistic amendments to the draft note) at our next meeting. I am asked whether further reviews of some of the appeals as recommended by the audit were undertaken. I assume this refers to appeals 5453, 5417, 5943 and 5987 but cannot answer the question from memory. If those cases appeared on subsequent meeting agendas, they were and if not, not. I would be surprised, if those cases did not come back to us but I cannot be sure. No further training or guidance was provided to the appeals Panel in the light of the results of the audit and I cannot imagine what the Inquiry has in mind here. The decisions to refuse cases involving IVDU and Anti-D use were not further reviewed. This was because the Panel had a settled view on advice from Dr Ramsay and Dr Hewitt (an expert on Anti-D immunoglobulin) as to the chances of infectivity with

Hepatitis C. In cases that were judged to be outside the scheme, for example workplace injury, treatment with other than blood or blood products and non-NHS treatment the Panel could not see that a further review or audit would be instructive.

**Section 4: The Skipton Fund Appeals Panel substantive decision making stage one**

37. In the a[[eal at [SKIP0000068_007] the consensus of the Panel, relying in large part on the experience and researches of our medical members, was both that transfusion would have been improbable after a tonsillectomy and that the prevalence of Hepatitis C in 1950 would have been very low. I cannot quote any published authority for these propositions and I have no present opinion on them.

38. In a refusal letter dated 3 November 2009 [SKIP0000048_382] I expressed the view that it took 35 years for HCV to progress to cirrhosis and therefore considered it unlikely that the appellant's liver cancer arose from an infection he alleged had taken place in August 1990. It is clear from the file that the cirrhosis had been diagnosed by June 2009, less than 19 years after the alleged infection. The opinion of Dr Mutimer informed our view as to the likely interval between exposure and cirrhosis. It was put to me by the Inquiry that the report from a panel of experts [EXPG0000001] advised that estimates of the rate of progression from infection to cirrhosis vary widely, but have been estimated at 1-2%/year, with approximately 20-30% with cirrhosis after 20 years (but estimates range from 2-40% in different studies) and 40% at 30 years. If it is suggested that the Panel reached the wrong conclusion I would respond that (a) 2 of the 3 reports cited by the Expert Panel had not been published by the date of our meeting; (b) progression of 1-2% per year suggests in any event that 35 years was a realistic, or at least a reasonable estimate and that after 19 years the chance of transfusion induced infection was 19% to 38% thus literally improbable; (c) the Panel did not consider a transfusion (of which there was no medical record or direct evidence from the appellant) would probably have been necessitated by the finger injury he sustained (d) Dr Carty said no more than that it was possible that a transfusion could have caused the infection and (e) we were aware that the appellant had a history of excess alcohol consumption but that fact did not persuade us that an (unproven) transfusion was the probable cause, even if a co-factor (excess alcohol) had raised the progression of 19-38% over 19 years by an unverifiable amount.

39. In relation to case 7725 the appellant's injury was probably on 6 August 1969 and the date of onset of his jaundice was uncertain but originally described as April 1970. This is an interval of 8 months, longer than the 26 weeks described by the microbiologist Dr Murphy, and very much longer than the mean duration of 8-12 weeks. The Panel accepted Dr Murphy's opinion that longer intervals have been described in the literature and that it was possible that the appellant's jaundice could have been caused by a transfusion in August 1969. That, however, would not have satisfied the probability test and no factor was drawn to our attention that could have bridged the gap between possibility and probability in this particular case.

Missing or incomplete medical records

40. As set out above we applied the ordinary civil standard of proof. We attempted to give due weight to evidence submitted by the appellant, each member giving her or his independent view derived from prior reading of the file and testing each other's views at the meeting. As will be seen from the guidance note we emphasised the utility of personal and witness statements putting the most direct and cogent case for the fact of a transfusion. There were occasions on which we had no confidence in the evidence provided, for example when a saline drip confirmed by medical records and described as a clear fluid was interpreted by the appellant as a blood transfusion.

41. The Panel accepted that treatment with blood or blood products was not inevitably recorded in medical notes or discharge summaries and that there would have been cases in which a record of an actual transfusion would not have been made. The existence of a discharge summary recording a transfusion would have been conclusive evidence; evidence suggesting a serious injury or condition but omitting a reference to a transfusion would have been somewhat persuasive that a transfusion had taken place. A discharge summary suggesting an entirely routine procedure or course of treatment would have tilted us towards deciding that there had been no transfusion. I stress that in these last two cases the evidence would have been persuasive to some degree but not conclusive. I am asked whether the Panel always took at face value an assertion by an NHS body that the records being provided were 'complete' notes. The Panel did not have a general evidence-gathering role and it was made plain to appellants by the SF and by our guidance note that the onus was on them to supply evidence to support their case. We did not go behind evidence supplied that there were no or no more records available. In case the question seeks a view on the suspicion of dishonesty on the part of an NHS body I can say that I cannot remember any appeal in which we had grounds to suspect suppression of or tampering with medical records.

42. There was clearly a difficulty in determining a dispute without complete written or any oral evidence. I can remember in general terms that there were cases in which we found evidence from the appellant or a friend or family member highly persuasive and allowed the appeal. In many cases there was very little, or even no evidence in the appellant's case to support the probability of a transfusion. In cases in which there was no persuasive evidence either way we resorted to the concept of clinical plausibility in what I hope was an even-handed way.

43. The application form in case WITN4426 [GRO-A] (and exhibits and SKIP0000047_009) says about a transfusion "?We think so blood t/f for anaemia 11/9/70" and at page 58 "She doesn't know whether she had a transfusion for hysterectomy" By the time of the appeal the appellant's case was that a blood transfusion was given at the time of a termination of pregnancy. The file contains a letter from her GP, Dr Carter, claiming that her Hb was 8.5 on the day of the termination. Our medical members thought Dr Carter had misunderstood the laboratory reporting and that in fact her Hb was 12.4 g% and considered that a blood transfusion for an early termination in a woman with Hb of 12.4 g% would have most unlikely. On the general issue I hope this description illustrates that we attempted to assess the cogency of evidence on both "sides" of the dispute.

44. If there was no other known potential cause of infection, that would weigh in the balance but would not of itself be conclusive and would be less persuasive, the more unlikely the clinical indication for a transfusion. Some of the events we considered went back to the 1950s and, without any imputation whatsoever of dishonesty, we accepted that memories are not infallible or all-encompassing.

45. The membership of the Panel of 3 doctors was presumably deliberately designed by the Department of Health to provide an informed view on areas of knowledge unavailable to a lay and legal member and crucial to the issues before the Panel. To that extent all 3 medical members were extremely valuable as they were able to interpret complex technical matters. None of them assumed a monopoly of knowledge and were open to further or alternative views from medical colleagues and to testing of their opinions by the lay member and myself. Expert advice was taken form Dr Ramsay (covered later on at paragraphs 47-50) but I cannot remember any other formal advice being taken from non-members of the Panel. I have no doubt that medical members would have used specialist libraries or internet searches to inform themselves or confirm or alter their provisional views. All medical colleagues were aware of and repeated to the Panel that attitudes to transfusion had changed over the years in favour of a more conservative approach and this was mentioned at almost all, if not in fact all our meetings and was borne in mind in the decision-making process.

Anti-D immunoglobulin

46. We were provided with the document [SKIP0000031_071] and its author was of course a member of the Panel and an expert in the field. I would accept that infection with HCV by anti-D immunoglobulin in the UK cannot be entirely ruled out but only in cases in which non-UK manufactured product was administered. My recollection is that Dr Hewitt told us and we accepted that only a very small proportion of women requiring anti-D immunoglobulin would have received non-UK manufactured product. In each relevant case the records were examined for any use of non-UK manufactured product. As far as I remember no such use was identified. In the absence of any evidence of such use I believe that the overwhelming probability was that UK-manufactured (and so non-infective) product was used. I do not know whether the SF shared this report with claimants. I attempted to explain our reasoning in any decision letter.

47. The ordinary civil standard of proof was applied when determining whether an infection was as a result of IV drug use as opposed to treatment with blood or blood products.

48. On the agenda for our first Panel meeting in September or October 2006 were a number of cases in which an award had been refused on the ground that infection was more likely to have been caused by IVDU than by NHS blood or blood products. The feeling of all 3 medical members of the Panel was that in general IVDU was a more common cause of infection than transfusion. We concluded that it was desirable to attempt to quantify the true position rather than rely on even an informed "hunch". I suggested that we attempt to obtain an epidemiological opinion and Dr Hewitt suggested we approach Dr Ramsay at the UK Health Protection Agency Centre for Infections whom the medical members considered the best informed authority on the subject. From memory Dr Hewitt and I collaborated on the

letter of instructions sent to Dr Ramsay by Nicholas Fish. It should be remembered that the Panel had no secretarial or IT support. This was the only report we received – I do not know whether the SF obtained any other evidence.

49. My best recollection is that this report was not routinely provided to appellants. My recollection was that there was an explicit reference to Dr Ramsay's report in the guidance note provided to appellants but, on re-reading [SKIP0000030_125] I see that this was not the case. I see that the SF also referred to the Ramsay report in refusal letters (see SKIP0000018_004 at page 21). As far as I can recall there was no objection to disclosure of the Ramsay report and it would have been supplied on request, including after the rejection of an appeal. It is a complex document and the great majority of appellants were unrepresented.

50. In case [SKIP0000018_004] the Panel noted the evidence of the appellant that she bought heroin every other day for a period variously less than a year or about 6 months. She smoked heroin with foil but also obtained needles (note the plural) from a needle exchange and injected twice. She did not mention the source of other paraphernalia. The appellant's evidence was that Dr Riad told her in 2009 that her Hepatitis C resulted from her drug use and that Dr Grimes had told her that the source of the infection did not matter. The appellant's father's evidence was that she did not use dirty needles or equipment but says no more about the injecting. Dr Grimes says at page 20 that her infection with Hepatitis C resulted from her intravenous drug use in her late teens. The admission for the incident said to give rise to a transfusion was documented in primary care records but the relevant hospital records were unavailable. The Panel carefully considered all the evidence in the case but could not conclude that a transfusion was a more likely cause of Hepatitis C infection than intravenous drug use. Transfusion was certainly a possibility but the likely infectivity of any blood transfused, in the Panel's unanimous view, was exceeded by the risks inherent in the admitted IVDU. In case SKIP0000068_010 there was evidence that 1 unit of blood had been transfused on 28 July 1986. There was also evidence from the specialist liver nurse that the appellant and his wife had used drugs intravenously. The evidence was that the appellant "admitted to only ever using once" and "his wife also experimented with drugs at the same time and she has proved to be Hepatitis C RNA not detected". In the light of the risk levels evidenced in the report of Dr Ramsay my recollection is that this appeal failed on the burden of proof. Dr Ramsay referred to under-reporting of use and we were conscious that a claim that clean needles were used did not answer the questions of the origins and condition of the drug itself and the syringe from which it was injected. Dr Ramsay reported that the probability of being infected with Hepatitis C in those who denied sharing needles and syringes was 7.7% up to 12 months. This compared to a risk of 1 in 200 of being infected by a single transfusion. More extensive disclosure and oral evidence tested by cross-examination might have given a more detailed picture and a better informed basis for the assessment of credibility but these were not open to us.

Independence from the SF

51. The Ramsay report was dated 19 March 2007 and was first discussed by the Panel at its April 2007 meeting. We were impressed by the quantitative approach which we (and particularly our specialist members) considered to be rigorous and the conclusions to be in

accordance with their professional opinions. We knew that the Fund had commissioned and had paid for and received the report. The Panel saw a distinction between the policy approach of our considering (in the absence of a documentary record) the clinical plausibility of a transfusion having being given and the reliance on hard evidence of prevalence based on peer-reviewed epidemiological evidence. In hindsight, having asked whether the SF intended to use the Ramsay report in making its decisions, I accept that I should not have expressed the Panel's opinion that it should use the Ramsay report in the interests of consistency. To the best of my recollection this was the only occasion on which the Panel gave advice or expressed an opinion to the SF.

52. The meeting referred to in this minute was a conference at Blackstone Chambers with Mr Pushpinder Saini (as he then was), an instructing solicitor (I think from Berwin Leighton), the Chair of the SF and Nicholas Fish. My recollection is that solicitors for an unsuccessful appellant had threatened an application for Judicial Review, I think on the basis that the Panel had seen a document which the appellant had not. I cannot remember the details. To the best of my recollection I suggested and it was agreed that we should give the appellant sight of the document and offer to reconsider the appeal. I am slightly confused as I remember that there was another Judicial Review which went to a judicial decision and my recollection is that that was the attack on the provision to exclude natural clearers from compensation. Neither I nor, as I understand it, any other member of the Panel was at all involved in that case.

**Section 5: Relationship with Government**

53. I am asked whether the Department of Health (or any other Government Department) had any influence or played any part in how the Appeals Panel operated or the decisions it took. There was no influence over the Panel by any Government Department except for the restrictions placed upon the Panel by the decision of the Department of Health that there should be no oral hearings of appeals.

54. I am also asked whether I, or others on the appeal Panel, raised any concerns and issues with the Department of Health about the SF Appeals Panel, or the SF criteria for eligibility. Eligibility criteria were changed in 2011 by the Department of Health to include, in effect, those with haemophilia who died before 29 August 2003. The changes prompted a query which Professor Mutimer raised with the Panel at or before our August 2012 meeting. The Panel had been asked to consider appeals in cases of patients with haemophilia who died before 29 August 2003 and were co-infected with HIV and hepatitis C virus. In each case there were no liver biopsy results and no post mortem examination had been carried out. In each case the recorded main cause of death was a consequence of HIV infection. Professor Mutimer considered that a reasonable inference was that a co-infected patient would probably have had cirrhosis after a certain lapse of time. I therefore on behalf of the Panel asked Ben Cole of the Blood Policy Unit at the Department whether it had been the intention of the Secretary of State that a patient who was in fact suffering from cirrhosis (albeit unconfirmed by biopsy, other test or post mortem examination) when dying from AIDS should be eligible for a Stage 2 payment. After Professor Mutimer's retirement Dr Hewitt, Professor Mills and I attended a meeting at the Department to discuss the issue with officials and Professor Thomas and Nicholas Fish from the SF. This was in January

2013. There was a discussion and then a response in writing from Ben Cole. Technical discussion between Professors Mills and Thomas and, I believe, the Department ensued and various formulas to measure the probability of cirrhosis developed. The SF adopted its own approach to cases of co-infection the details of which I cannot fully remember. The Panel had in mind that it should adopt an independent approach and give fresh consideration any of these applications rejected by the SF according to their own criteria. My recollection is that there were then few appeals in these cases as most of the claimants were satisfied with the decisions of the SF.

**Section 6: Complaints**

55. The Panel did not have a formal complaints procedure. Any indication of dissatisfaction with the procedures of the Panel would be addressed to Nicholas Fish who would forward them to me and I answered them by letter. My recollection is that there were few such complaints. I cannot place a number on them but they should be discoverable from the various files.

56. See under paragraph 55 above.

57. See under paragraph 55 above.

58. Some unsuccessful appellants expressed dissatisfaction with the outcome of their appeals. In what I remember as a very small number of cases in which there was a substantive point, rather than disappointment with the outcome I would attempt to address the concern in a further letter. I cannot remember anyone expressing a concern about the SF to me.

**Section 7: Other**

59. I do not know whether the SF was well run. The staff who serviced the Panel were highly efficient, helpful and courteous. I would like to think the Panel had a collegiate and respectful atmosphere and did its best to be even-handed despite its lack of resources.

60. I would not have been aware of any difficulties or shortcomings in the way in which the SF operated or in its dealings with beneficiaries and applicants for assistance.

61. In March 2016 SKIP0000030_061 it was reported at a SF Board meeting (at which I was not present) that although cumulatively the success rate of appeals was 50% since the SF had appointed medical directors "only approximately 2 or 3 out of the approximately 12-15 cases considered at each meeting were overturned". I would like to think that this vindicated our "clinical plausibility" approach to appeals.

62. I would be happy to attempt to add any further information required by the Inquiry.

**Supplementary Questions**

63. I am asked in a supplementary question to explain what were the terms of reference that I described as "minimal". I have set this out under paragraph 20 above. In addition I have been sent a copy of GLEW0000490. This undated document emanates, I assume, from the Department of Health and contemplates the establishment of the Appeals Panel. It contains little, if any, more in the way of detail but it is worth noting that it proposes the establishment of a pool of medical experts (including possibly 5 consultant hepatologists) as a resource for the Panel in addition to a GP, a lay member, a hepatologist and a legally qualified Chair (but no haematologist) who would comprise the Panel. This is the first I knew of this original proposal which was, of course, not implemented.

64. I am asked in a supplementary question whether Dr Mutimer provided any material / supporting evidence to the Skipton Fund Appeals Panel to inform his view. As far as I remember he did not. Dr Mutimer was and is a hepatologist of international repute, highly experienced in clinical practice in addition to his research interests. Clearly his view (which was the best basis for a decision available to us) was not that in every case the interval was exactly 35 years but that the average interval for members of the patient cohort was of the order of 35 years.

65. I am also asked upon what material I based my view on about the rates of progression of HCV set out in the refusal letter on 3 November 2009 and whether this remains my view. I can only repeat that the Panel (including the other medical members) accepted Dr Mutimer's expert opinion. It is over 11 years since this meeting during which I have had no cause to consider the question which might better be addressed to Dr Mutimer.

66. I am asked as a supplementary question whether there were difficulties or shortcomings in the way in which the Skipton Fund Appeals Panel operated or in its dealings with beneficiaries and applicants for assistance. I do not think I can add to the second and third sentences of paragraph 55 above.

**Statement of Truth**

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

Signed ___Mark Mildred_____

Dated ___10 February 2021_____