Witness Name: Mark Mildred
Statement No.: WITN5258003
Exhibits: Nil
Dated: 9 November 2022

INFECTED BLOOD INQUIRY

SECOND WRITTEN STATEMENT OF MARK MILDRED

I make this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 5 September 2022.

I, Mark Mildred, will say as follows: -

1. **Please provide details of your career as a solicitor, including details of your training and qualifications and your employment history.**

1.1. I obtained a BA in Economics from Cambridge University in 1970 and decided thereafter to become a lawyer. I was admitted as a solicitor in April 1975. In the late 1970s I began acting for the claimants in the litigation alleging that foetal malformations had been caused by hormonal pregnancy tests (Primodos and Amenorone Forte). This litigation was discontinued owing to difficulties in proof of causation in June 1982. In May 1983 I began acting for the veterans of the British Nuclear Weapons tests.

1.2. During this time I was the founding partner of a small general practice in London SW11. In early 1986 I was approached to set up the London office of Pannone Napier and took on that role later that year. My main work was acting as the coordinating solicitor in the Opren litigation. At this time I also worked on the Dalkon Shield litigation and later the Copper 7 litigation.

1.3. Pannone Napier was a joint venture between a Sheffield firm (Irwin Mitchell) and a Manchester firm (Pannone & Partners) the ambit of whose work was restricted to multi-party and international litigation. We worked on transport cases (including the Lockerbie and Kegworth air crashes, the Kings Cross fire, the capsize of the Herald of Free Enterprise and the rail crashes at Clapham, Purley and Cannon Street) and on product liability cases. The Opren litigation was settled in, as far as I remember, late 1988.

1.4. I left full-time private practice in 1995. I became Professor of Litigation at Nottingham Law School on a part-time basis and in addition to teaching and research undertook consultancy for several law firms in complex litigation cases. From 2002 until my retirement in 2018 I was a part-time Tribunal Judge and between 2003 and 2011 I was Vice-Chair of Wandsworth Primary Care Trust. Between 2005 and 2017 I was Chair of the Skipton Fund Appeals Panel in respect of whose work I gave evidence to this Inquiry in March 2021.

2. **Please state the position(s) you held during the course of the HIV Litigation and explain – in broad terms – your role in that litigation.**

2.1. I was not involved in the HIV Litigation at the outset. My recollection is that it was started by Graham Ross, a partner in J Keith Park & Co in St Helens. He was then joined on the generic team by Anthony Mallen, a partner in Mallen & Walton then Deas Mallen Souter in Newcastle upon Tyne.

2.2. I cannot remember the exact date but I would estimate in mid-1989 I was approached by David Watters, then Secretary of the Haemophilia Society, whom I knew from his and my previous involvement in a local advice centre. He knew that I was a specialist in personal injury law and had experience of group litigation. He asked and I agreed that he could add my firm (which also had offices in Sheffield and Manchester) to a list of solicitors which he could give to members of the Society who wanted to instruct a solicitor and join the HIV Litigation.

2.3. We ended up with a large number of clients. Our code numbers for London claimants went up to LPN211. There were many fewer clients in the Sheffield and Manchester offices but the firm's total must eventually have been around 350. I remember going by invitation to a Conference at Michael Brooke's Chambers and then appearing for our clients at the first Summons for Directions that took place after I had become involved. After that I was invited to join the claimants' Steering Committee and accepted.

The Structure and Funding of the HIV Litigation

3. **Insofar as you are able to do so, and without breaching privilege, please describe:**

   a. **how the Plaintiffs' legal teams were organised, including the role of the Steering Committee;**

3. 1. In those days the pattern of organisation would be that one or a small number of solicitors firms would undertake the generic or common liability issue work. It or they would typically act for a large proportion of the individual claimants. Other firms would act for individual clients and receive reports from the generic solicitors on common liability issues. It would clearly have made no economic or organisational sense for every claimant individually to fight all the issues against the defendants. The generic team would typically obtain expert evidence on liability and causation issues, collate the claimants' and review the defendant's disclosure and give advice on generic liability and perhaps on common issues of quantum of damages.

3. 2. In the early days of litigation concerning Thalidomide, Eraldin, Pertussis vaccine and cancer allegedly caused by radiation at Sellafield or by service at the British nuclear weapons tests, the practice was for a very small number of individual cases to be prosecuted to trial in the hope that the judgment in those cases would determine all issues for all or a substantial majority of claims. From Opren onwards it became the practice to serve a

Generic or Master Statement of Claim met by a Master Defence followed by identification of and disclosure on generic issues, the determination of which was intended to resolve all questions between the parties.

3. 3. In order that the defendants had adequate notice of the numbers of claimants, the strength of their claims and likely amount of damages recoverable, short-form particulars of each claim were served which concentrated on the individual characteristics of the claimant (age, underlying health, date of exposure, nature of injury and loss etc). Once the generic issues had been identified a selection of individual claims was made (and those selected known as Lead Cases) whose trial would attempt to resolve all the issues between the parties. This was the procedure agreed and the stage reached in this Litigation by December 1990. We had identified experts in the fields of virology, haematology, haemophilia and AIDS care and perhaps other disciplines which I cannot now accurately remember. Reports from these experts were in at least advanced stages of preparation.

3. 4. Lead claimants had been selected and witness statements from them prepared. Many, perhaps the majority, of the Lead Claimants were clients of my firm. This was partly because we had the largest number of clients and partly because we had in my office a nurse and a doctor who was intending to retrain as a solicitor. Their expertise in medical matters including reading medical records made it possible for individual Particulars of Claim to be drafted and served quickly and without the need to instruct Counsel. I remember that the spread of Lead Cases was designed to include early, middle and late dates of infection, mild and severe Haemophilia, infection of a claimant with Von Willebrand's disease and (I think) probable infection by NHS Factor VIII and by ineffectively heat-treated commercial product. There were probably other criteria that I can no longer remember.

3. 5. I have a clear recollection of many aspects of the Litigation and a less clear recollection of other aspects. I believe that work was allocated between members of the Steering Committee so that Graham Ross led on expert

witnesses, Tony Mallen on the instruction of Counsel and I led on communication with the defendants. By 1990 the litigation had become all-encompassing so that most waking hours were spent on it and responsibilities became less well defined. I worked in an office in Holborn so was more readily available at short notice than colleagues in St Helens or Newcastle.

b. **how the Plaintiffs' claims in the HIV Litigation were funded**

3.6. In the late 1980s civil legal aid was available for claims for damages for personal injury. There were financial and merits-based criteria for the grant of a Legal Aid Certificate. For a person whose income and savings were below a certain level legal representation was free. For those above different financial levels legally aided representation was unavailable. Those whose means were between those levels had access to Legal Aid on payment of a contribution from income (by monthly instalments over a year) or from capital (in one lump sum). In a complex case a Legal Aid Certificate would initially be limited to investigation of the merits then, if those merits were favourable, to exchange of statements of case, disclosure and expert evidence. There would then be a review before the Certificate could be extended to cover trial. At that stage an Advice from Counsel would be required by the Legal Aid Board. A separate application had to be made after trial, if appropriate, to prosecute or respond to an appeal.

3.7. A Legal Aid Certificate gave the holder protection against that person's own costs (which were limited to any contribution payable) and against the costs of the opponent. By convention a legally-aided claimant was never ordered to pay to a successful defendant (who in the ordinary way would be entitled to recover costs from that claimant) more than the amount of any contribution payable by that claimant to the Legal Aid Board for the Certificate.

3.8. A minority of claimants did not qualify financially for legal aid. In my firm's case this was perhaps 10-15%. Each such client would be liable to us for the fees (at agreed rates) and the disbursements incurred in processing their individual cases. This was before the time when conditional fee agreements became lawful. I must have known at the time the overall proportion of claimants without legal aid but cannot now remember it. Claimants without legal aid would not enjoy the costs protection set out above and would in principle be liable to any defendant against whom he did not succeed for their costs of defending the claim. I use "he" and "him" in this statement because the overwhelming proportion of haemophilia sufferers and claimants were male.

3.9. The position was complicated and exacerbated by the requirement that liability for the generic costs and disbursements be shared severally between claimants. Prior to the Opren litigation the practice had developed that the small number of chosen claimants whose claims were first prosecuted would have Legal Aid Certificates with a nil contribution and thus the taxpayer would bear the claimants' costs (unless they won or settled their claims) and the defendants would be unable to recover their costs, if successful.

3.10. This practice was designed to provide access to justice but involved legal difficulties. First, it gave all non-lead claimants a "free ride" in relation to the costs incurred in fighting the generic issues. Second, it contravened the requirement contained in the Legal Aid Act 1988 s. 31 that the existence of a legal aid certificate should not affect the defendant's rights or liabilities: clearly the right of a successful defendant to recover its generic costs was vitiated or at least severely limited by such an arrangement. Third, the arrangement did not make internal sense: any costs awarded against the lead claimant would be a charge on his damages. The same would apply in respect of any work in respect of which there was no order for costs (for example on a Summons for Directions). By the time the Court of Appeal confirmed that generic costs should be shared severally in the Opren litigation the irrecoverable costs incurred by the Lead claimant would have

obliterated any damages he could have hoped to recover many times over and thus there was no incentive for him to proceed and no rational basis for him to carry on receiving public funding.

3.11. Cost-sharing orders became routine and one was made in the Haemophilia Litigation. It provided that generic costs should be assessed quarterly from a commencement date ordered by the Court. Each claimant would be liable for an equal several share of the claimants' generic costs for each quarter from that commencement date (to avoid rewarding late joiners) to the end of the quarter in which he left the litigation. For legally aided clients this would be academic but private clients would be responsible for their individual costs and for a several share of the generic costs as set out above. Whilst the generic approach produced economies of time, money and effort, the sums involved were very considerable.

c. **the effect of the funding arrangements on how the litigation was fought and settled (for example, the need for ongoing certification from the Legal Aid authorities, and what was required for that certification).**

3.12. The generic trial was fixed to begin on 4 March 1991 and expected to last up to 6 months. Clearly the costs incurred in such a trial would be very high, even when split about 970 ways. Private clients would be responsible for their several share of generic costs and disbursements as well as the costs and disbursements of their own individual case. This would be a serious disincentive to any person or family (let alone one facing severe disability then understood to lead inevitably to a grim death) but was the price of remaining in the Litigation.

3.13. The generic and individual Legal Aid Certificates were limited to investigation of the case and would not have been extended to cover trial without advice from Counsel to the effect that the generic case had reasonable prospects of success at trial. At that time the Legal Aid Board did not require quantification of the prospects of success in percentage terms as became required by

subsequent Funding Codes. The scale of the medical disaster and the public interest in the outcome on the part of all concerned would in my experience have encouraged the Board to extend cover to include the trial, if it properly could. It is clear, however, from the Settlement Advice that has been made public that it would not have been easy for Counsel to give such an assurance on the prospects of success. I had not remembered that the Advice put the chance of success at about 20%: on that basis I think it inconceivable that Legal Aid would have been extended to cover the generic trial, albeit removal of Legal Aid would have been highly controversial and politically embarrassing.

3.14. I have not sought (and could scarcely hope to obtain) waiver of legal advice privilege from or on behalf of all the claimants. I believe I can still properly make seven general points (as opposed to giving an account of the advice given to claimants and the reasons underlying that advice) in relation to "the effect of the funding arrangements on how the litigation was fought and settled" as I am asked. Counsel took into account the views of the solicitor members of the Steering Committee. At that time the Board was more inclined to rely on Counsel's advice (rather than solicitors' advice) than may have later become the case. There was real apprehension that the legal difficulties, identified in the Settlement Advice and in Counsel's speaking notes at **NHBT0091946** and **DHSC0003663_042**, might lead to the claimants being denied compensation. It would stick in the craw of a reasonably humane solicitor to require a privately paying claimant to fork out very considerable sums of money for legal costs at that stage of his life. The actual threat of a private client having to pay the defendants' costs, if the trial ended without success, was likely minimal, given the opprobrium that the defendants would incur, if they sought to recover their costs. The greater the proportion of those affected joining and remaining in the action, the more likely in my view was the prospect of a settlement being obtained. Whilst it was open to a solicitor to offer a client modest fee rates for individual costs, that solicitor could not reduce the amount of generic fees and disbursements for which any claimant would be liable by Order of the Court.

The Conduct of the Central Defendants in the HIV Litigation

4. **From your perspective, how would you describe the way in which the Central Defendants conducted themselves during the HIV Litigation? Was there anything that you consider unusual, untoward or inappropriate in their conduct of their case? Please provide as much detail as you can in support of your answer.**

4.1. Although my duty was owed to my clients and the claimants generally it was clear to me that the Central Defendants were in an unenviable position. David Owen's declared aim in 1975 to make the UK self-sufficient in blood products as soon as possible was entirely rational and sensible and the Central Defendants were, in the vernacular, stuck with it. This meant that their most promising escape route from liability was reliance on the policy/implementation dichotomy. There was little doubt that the intention of the drafter of the National Health Service Act 1977 had been to avoid creating any private law duty that would entitle an individual patient to damages for breach of the statutory duties created by that Act.

4.2. In the late 1980s the distinction between the non-justiciability of "high policy" decisions of the Government and the ordinary justiciability of alleged breaches of duty in operational acts and omissions in the implementation of that policy was starker than it is today. Inevitably, therefore, the Central Defendants' line was that the episode had doubtless been a tragedy for all concerned but the Court had no standing to apportion blame or award damages. The creation of the Macfarlane Trust and the top-up payments made in mid-1990 were clearly attempts to compensate injury or alleviate suffering or acknowledge a *parens patriae* responsibility without admitting legal liability (which would have created a precedent for liability for breach of statutory duty in less egregious cases).

4.3. When I first became involved in the litigation and before I joined the Steering Committee I had an informal conversation with a member of the Government's legal team. It was clear to me from that conversation that settlement of the litigation was always likely to be the eventual outcome. In

that context I very much regret that settlement took so long to achieve with the result that many claimants did not live long enough to have access to damages for themselves or the reassurance that their closest family would have an (albeit limited) financial security. The length of the proceedings also put mental and emotional strains and, in some cases, financial pressures on claimants and their families at a time when they should least have been expected to endure them.

4.4. The Government Legal Service was in those days very much less well-resourced than it is now. My recollection is that extensions of time were requested to file Acknowledgements of Service which was unprecedented in my experience. It seemed clear that the individual with whom I corresponded had no authority to take any steps in the litigation without delays presumably for instructions from the Department or the Treasury or elsewhere, even in minor procedural matters.

4.5. The decision to sue the Licensing Act Authority ("LAA") and the Committee on Safety of Medicines ("CSM") had probably been taken before I became involved. They had also been sued in the Opren Litigation. I have not been supplied with the Defence of the Central Defendants and cannot remember whether the Department accepted responsibility for the acts and omissions of the Licensing Act Authority and the Committee on Safety of Medicines. If it did, I cannot see why it was necessary to maintain claims against them in their own names. If it did not, it was inevitable that a claim should have been maintained against the bodies that had granted product licences for and reviewed the safety of imported commercial blood products. Notwithstanding this I had not previously appreciated the force of Justin Fenwick's evidence that the risk of being involved in litigation could have been a serious disincentive to those best qualified to volunteer for service on those bodies. I do not know whether or, if so, how this dilemma has subsequently been resolved. It is also clear from the Settlement Advice and Rupert Jackson's speaking notes that these claims would have been very difficult to make good in law.

4.6. It may be worth adding that the legal difficulties the claimants encountered were in part caused by their inability in almost all cases to sue the manufacturers of the blood products. After the commencement of the provisions of the Consumer Protection Act 1987 concerning liability for defective products there has been liability for damage caused by a defect in a product without proof of fault. Where, as in this case, the product was manufactured outside the EU, liability would fall on the importer into the EU: almost certainly the NHS or commercial companies with contractual arrangements with the NHS. The claimants did not have the advantage of these provisions because the blood products were supplied before the commencement of those provisions of the Act.

4.7. In theory the claimants could have sued the manufacturers of the infective product in negligence. The difficulty with this was that most infected claimants had received multiple units of Factor VIII or IX manufactured in the US by one or more of four then US-owned companies. Given that HIV could not be detected in blood samples until long after the patient was in fact infected, it could never be proved even on the balance of probabilities whose product had infected him. In some jurisdictions there was a "market share" doctrine of liability under which, in this example, the four US companies would have shared liability in the proportion corresponding with their percentage of all blood product sales over the relevant period. In the Netherlands such a doctrine was extended to joint liability so that any of the four companies could be ordered to pay a claimant all of his damages and be left to recover the appropriate share from the other three. There was no such doctrine in England and Wales at that time or now.

4.8. For the sake of completeness I would add that it emerged during disclosure that many patients' treatment records were at least incomplete. This made problems of proof even worse. It also emerged that some batches of Factor VIII had been heat-treated in order to kill viruses including HIV but that that heat treatment had been ineffective. We were able to identify claimants who had received product from one or more of those batches and, to the best of my recollection, some damages were recovered for those claimants from

Armour, the US manufacturer. There was also a later class action by UK claimants attempting to sue US manufacturers in the US courts. I gave evidence on the English law relating to collective remedies and litigation funding in an unsuccessful attempt to persuade the US court to retain jurisdiction over those cases. I believe there may have been a subsequent settlement of those claims but do not know the details.

4.9. Andrew Collins, the highly respected Leading Counsel for the Central Defendants, told Mr Justice Rougier that it was his duty, rather than a choice, to apply for a Public Interest Immunity ("PII") Certificate. Even so I regarded the application as highly tactical. It seemed to me that, if the application was successful, documents that would have shed clear light on how and why self-sufficiency in blood products was delayed so long would not be before the Court. The application also provided a dry run for the argument on "State Liability" or the policy/operation dichotomy. If the claims had no real prospect of success, the public interest in disclosing documents potentially exposing the Government to criticism would be diminished. I remember that the House of Lords gave their decision in *Murphy v Brentwood LBC* on the first morning of the hearing of the application and that we adjourned to read it in the (as it turned out forlorn) hope that the decision would make the answer in our case clear. There is no doubt in my mind that the refusal of the Court of Appeal to categorise our case on breach of statutory duty as without merit was a major catalyst to the eventual settlement: senior civil servants and politicians would have had the unpalatable responsibility for giving evidence at trial about the delay in achieving the target of self-sufficiency and its consequences.

4.10. In the late summer of 1990 I was approached by a senior solicitor who told me that he was instructed by a Regional Health Authority ("RHA") Chair to put out feelers about a settlement. After a scoping conversation with that solicitor I told my colleagues about the approach and we set about attempting to quantify the value of the cases and to discuss the appropriate discount on full liability that I was told any settlement would have to entail. I am asked to deal with this process later in this statement but, in the context of the present question, I would say that I found it very dispiriting to be putting considerable

effort into trying to achieve an acceptable compromise whilst hearing and reading in the media that the Government had set its face against settlement and would see the case through to trial. I suppose that, however unwelcome, was a feature of the adversarial process.

5. **From your perspective, how did the Regional Health Authorities conduct themselves during the HIV Litigation? Was there anything that you consider unusual, untoward or inappropriate in their conduct of their case? Please provide as much detail as you can in support of your answer.**

5.1. Again, the decision to advance a generic case against the RHAs had probably been made before I became involved in the Litigation. It was perhaps inevitable that they should be joined as they provided the technical transfusion and haemophilia care services and implemented, to the extent they could, the policy intentions of the Secretary of State. I cannot imagine that in the real world liability would ever have been made out against the RHAs but not the Central Defendants except in purely clinical negligence cases. The case against the RHAs was, however, probably an essential piece of the legal jigsaw: as with the CSM and LAA a "belt and braces" approach was taken. In a privately funded or commercial context there would have been a considerable costs risk in winning against one defendant and losing against the others but the Legal Aid protection and the public relations considerations for the defendants mitigated that risk in this case.

5.2. The community of experts in haemophilia care in the UK was small and close. I remember when I was first instructed I was introduced by a medical friend to a Centre Director who agreed to see me and make a statement about how everything worked. He then wrote to cancel, saying that all specialists had been told not to speak to the claimants' legal team. Whatever the rights and wrongs of this it made the task of developing good expert evidence for the Court very difficult. I cannot now remember from whom we obtained evidence on haemophilia care. In many product liability cases expert evidence could be obtained from abroad but in this case the

specific NHS context would have rendered such evidence less helpful, although we had no option but to approach experts from abroad in some disciplines.

5.3. As is known, true clinical negligence cases were allowed to proceed against the RHAs after the main settlement. I cannot remember the precise number but I believe we had only a handful in our 350 or so cases and that the overall total of those that were continued (I do not know their eventual outcomes) was in the twenties.

5.4. I remember very well one of my cases including his name and code number. He was a middle-aged man with mild haemophilia who very seldom required haemostasis and had never received treatment with concentrate. One day in the mid-1980s he sustained a minor cut while working in his garden shed and went to his local hospital (a non-specialist facility) where he was injected with commercial concentrate and was infected with HIV.

5.5. This seemed to me a clear case of clinical negligence. I put his case to the RHAs' legal team and suggested that it was a clear enough case for summary judgment, if liability was not conceded. The law in those days was contained in Order 14 of the Rules of the Supreme Court. There was no inquiry into the merits of the case: the mere filing of a defence would ensure that summary judgment for the claimant was not given. A summary judgment against an RHA on these facts would, in my view, have imposed considerable pressure on the Central Defendants to come to the table earlier. I wish I had made the application for summary judgment as my firm could have taken the costs risk on my client's behalf, given that Legal Aid would almost certainly have been refused.

The Announcement of the Settlement of the HIV Litigation

6. **In October and November 1990, discussions took place between counsel for the Plaintiffs and counsel for the Central Defendants in which the possibility of settlement of the litigation was discussed**

[SCGV0000230_018; DHSC0046962_068; DHSC0004365_043]. Insofar as you are able to do so, and without breaching privilege, please explain:

a. your role, if any, in those discussions;

6.1. As mentioned above the first approach I received from the solicitor was in the late summer of 1990. I had a few further meetings with that solicitor after discussions within the claimants' team. I cannot remember the number or dates of these meetings. Thereafter there were discussions between Counsel for the parties. The Steering Committee had long and frequent discussions with our Counsel but, as I remember it, there were no meetings between Counsel and solicitors for the Central or RHA Defendants and Counsel and solicitors for the claimants.

b. **whether you drafted the table and explanatory note dated 17 October 1990 [DHSC0046936_055], and, if you did, the purpose of the note and table.**

6.2. I did draft this note and the table is in my handwriting. The purpose was to show, on the assumptions set out in the note, what various overall lump sums would produce by way of compensation for each of 4 categories of those affected (child, unmarried adult, married adult without children and married adult with children). The note did not suggest an overall value of the claims or an acceptable settlement amount but was an attempt to show the range of outcomes for individuals for different aggregate lump sums. I think (but cannot be certain) that the RHA representative with whom I had been in discussions suggested that the Government might be prepared to pay between £30 and £60 million to settle the Litigation.

6.3. I note that the note refers to 1215 claimants. That is an error as the manuscript "beneficiaries of the MacF trust" makes plain at **DHSC0046936_055**. There were about 970 claimants infected with HIV. I now see that Rupert Jackson QC told Andrew Collins QC in their meeting on 19 October 1990 that the proposed figures were put forward on the basis that

all haemophiliacs were included [**SCGV0000230_018**]. I cannot now remember how this came about.

6.4. As far as I can remember, by the time I was approached we had not computed an overall full value of the claims. In any event I did not have (and would not have sought) authority to put forward a figure. I do remember being told that the settlement proposal must appear to come from the claimants which made our lives difficult but obviously helped the Central Defendants with their public relations. The RHA representative was clear that there would have to be a very substantial discount from full liability damages for a settlement to be attractive or even acceptable to the Government. Even so, the £30-£60 million range must have come from or been acquiesced in by the RHA representative. In the light of that, no properly advised claimant or competent adviser would have settled at the bottom of the range unless the Central Defendants had rejected the range of figures that had been floated (deniably) on their behalf and said that £30 million was the only figure at which they were prepared to settle. This was clearly not the case. I do not wish to exaggerate my recollection of the details of these matters which were taking place almost exactly 32 years ago.

7. **Following those discussions, a proposed scheme of compromise was provided to the Central Defendants, and was stated to have the authority of the *"steering group of the plaintiffs' solicitors"* [DHSC0046962_067, §3]. This proposed that the claims be settled, subject to certain terms, at a figure of £42 million. On 11 December 1990, the Prime Minister, John Major, announced that the Government had been able to agree in principle to proposals put forward by the Plaintiffs' lawyers [DHSC0003654_003]. Later that day, in a written reply to a Parliamentary Question, the Secretary of State for Health, William Waldegrave, provided further details [DHSC0020866_034]. The Plaintiffs' Steering Committee put out a press release on the same day responding to the announcements in Parliament and confirming that the Plaintiffs' counsel had acted on the instructions of the Steering Group when putting the proposal to the Central Defendants. Your name, along with those of Mr**

Mallen and Mr Ross, was given as a signatory of the press release [DHSC0003654_029]. Insofar as you are able to do so, and without breaching privilege, please explain:

a. **the role of the Steering Committee, and your own role, in putting forward the proposals to the Central Defendants;**

7.1. It is clear from **DHSC0046962_067** that the formal proposed heads of compromise were drafted by Counsel and sent to the Central Defendants on or about 8 November 1990, 3 weeks after the note and table at **DHSC0046936_055**. I cannot now remember the details but the Steering Committee and Counsel spent many hours from September to early November reviewing the merits of the claims, attempting an assessment of overall quantum and the merits of the legal and factual arguments in the generic claim. It was always made clear to the Defendants, as the proposal explicitly makes plain, that we had no authority to commit the claimants to those terms and that those claimants had not been consulted. As I have mentioned in the last answer our proposal referred to all infected haemophiliacs and we could not possibly have had the authority to bind non-claimants. I note that the press release at **DHSC0003654_029** refers to the rejection of earlier settlement proposals made on behalf of the claimants. This is presumably a reference to **DHSC0020866_134** where on 7 September 1990 I signed a letter drafted by Counsel requesting a settlement and valuing the claims at between £80 and £90 million.

7.2. As appears from the Settlement Advice the claimants' legal team took the view that the prospects of success did not exceed 50% and might be considerably less. The reasons for this are set out in the speaking notes of Dan Brennan QC and Rupert Jackson QC and the Settlement Advice. I note that Mr Dobson in his covering minute at **DHSC0046962_067** states that the settlement figures added to the £34 million Macfarlane monies, ie £76 million amounted to the full value of the claims. The Settlement Advice describes £42 million as "a little under fifty per cent of the full value in law of most claims" at

ARCH0001127. I think that must refer to all beneficiaries of the Trust. At **ARCH0001127** the value of the claims themselves is said to be £63 million.

7.3. The Macfarlane monies were not compensation as such but their purpose was clearly to assuage the injury and loss caused to its beneficiaries by infection with HIV. The £42 million offered by way of settlement of the liability to all beneficiaries of the Trust corresponded with Justin Fenwick's assessment in his evidence to the Inquiry that the Central Defendants had a one-third chance of losing the case overall and the proportion of that £42 million attributable to the claimants considerably exceeded the 20% of £63 million estimated to be the value of the total claims in the Settlement Advice. These figures seem very low by today's standards but were provided by acknowledged experts in personal injury claims, in particular Dan Brennan QC and Michael Brooke.

7.4. It must also be remembered that 150 of the claimants (and none of the non-claimants) had Category G claims valued at £2,000 each. This brought down the average payment to a claimant. The average payment to an infected claimant and non-claimant alike was £36,620. For 820 infected claimants the total was £30,028,400 which with £3,000,000 paid to non-infected claimants makes a total of £33,028,400, a little over half the aggregate value of £63 million referred to in the Settlement Advice.

b. **whether you or the Steering Committee were given prior notice by the Government of the Prime Minister's announcement;**

7.5. I have a very clear recollection of receiving a telephone call at home on the evening of 10 December 1990 from Rupert Jackson's Clerk asking me to phone him (Mr Jackson) at home. Rupert Jackson told me that Andrew Collins had sought him out earlier that evening and told him that the Government was prepared to settle on the proposed terms and that the Prime Minister wanted to announce the settlement in the House of Commons the next day. I said that I thought it would be polite to ask our clients first. The next day we arranged 3 meetings for our London clients on 12 December to

explain the proposals and take instructions. I think it was the day after that I saw all the Sheffield and Manchester clients for the same purpose. The Steering Committee and Counsel had a meeting with non-lead solicitors for the same purpose.

c. **what your views were at the time of the approach taken by the Prime Minister and the Secretary of State to announcing the Government's acceptance in principle of the proposals in the way that they did;**

7.6. I could understand why the Government, having suffered criticism for failing to settle the claims, wanted to extract maximum public relations benefit from the eventual settlement. I do not know whether they thought an immediate announcement would bounce the claimants into believing that they had to accept the terms. I thought the announcement was highly discourteous to the claimants and their advisers, disingenuous as they knew claimants had not agreed to the terms and foolishly premature as the claimants might have rejected those terms. By that stage 2 or 3 of my clients were dying every week and at least those without dependents might in fact have felt insulted, rather than vindicated by the offer. The Government knew that it needed virtually all claimants to accept the offer to avert the prospect of a trial and that public funding of the claim being ended for those who refused and wanted to carry on to trial would be a public relations disaster.

d. **your views now on the same issue.**

7.7. Now as then I consider this was a striking misjudgement by an insensitive public relations machine.

<u>The negotiation of the final agreement</u>

You may be assisted in answering these questions by considering in particular:

- Draft sent by fax on 12 December 1990: **DHSC0003654_032**, p.3 and p.9, §5

- Draft of 18 December 1990: **DHSC0003655_022**, p.8, §5
- Draft of 21 January 1991: **DHSC0004523_091**, p.11, §5
- Draft of 22 March 1991: **DHSC0003660_019**, p.12, §5
- Covering letter and document dated 16 April 1991 entitled "Plaintiffs' suggested amendments by rider", §4: **DHSC0003661_021** and **DHSC0003661_022**
- Draft of 22 April 1991: **SCGV0000233_040**, p.15, §5
- Minute from Ronald Powell to Mr J C Dobson, 23 April 1991: **DHSC0003662_076**
- Memorandum from Justin Fenwick to Mr Powell, 24 April 1991: **SCGV0000233_038**
- Draft of 24 April 1991: **DHSC0045721_004**, p.14, §5
- Settlement Agreement dated 26 April 1991, sent under cover of letter dated 1 May 1991: **HSOC0023174**, p.20, §5
- Written statement of Justin Fenwick, **WITN7067001**, p.50 to p.53, §48-51.3
- The oral evidence of Justin Fenwick QC, Transcript of 9 June 2022: **INQY1000213** p.145 to p.180 and p.193-205

You may also be assisted by an annex to a Department of Health submission dated 19 April 1991 [**DHSC0003662_090],** which set out what were then regarded to be the main issues outstanding on the settlement [**DHSC0003662_091**].

8. **In the months that followed, representatives of the Defendants and the Plaintiffs engaged in a negotiation over the terms of the final agreement. The terms of what the Inquiry understands to be the final agreement were contained in a letter sent from the solicitor for the Department of Health, Ronald Powell, to the solicitors for the Plaintiffs dated 1 May 1991 [HSOC0023174]. Insofar as you are able to do so, and without breaching privilege, please answer the following questions.**

    a. **The first draft of the detailed terms of the agreement that the Inquiry has identified are those appended to a fax sent on 12 December 1990 [DHSC0003654_032, from p.3]. Are you able to say: (i) whether this was the first draft of the agreement, (ii) who**

initially drafted the document, or whether it emanated from the Plaintiffs or the Central Defendants (or some other source)?

8.1. I think that this was the first draft, very likely produced by Michael Brooke and sent from the claimants to the Central Defendants.

b. **The final terms included a clause to the effect that Plaintiffs seeking the benefit of the settlement agreement would have to discontinue their actions and undertake not to bring fresh proceedings relating to infection with HIV and/or hepatitis viruses through the use of blood products administered prior to 13 December 1990 [HSOC0023174, p.20, §5]. Please explain your understanding of how and why that clause was introduced into the final agreement.**

8.2. The final agreement was sent under cover of a letter dated 1 May 1991, 4 months and 19 days after the first draft of the agreement referred to above. The first draft contained a vague undertaking to "not bring fresh proceedings" and the Department's 18 December version at **DHSC0003655_022** left that as drafted. The waiver clause first appears in **DHSC0004523_091**, a version dated 21 January 2011 but said to incorporate "amendments suggested by Counsel" on 1 March 1991. I presume this refers to Counsel for the Central Defendants. In any event the waiver clause survived in the same form until the claimants' proposed amendments by rider on 16 April 2011. Rider 4 attempted to allow claims by those whose injury caused by blood products was not diagnosed by 13 December 2010 and did not comprise infection with HIV or hepatitis. This amendment appears to have been accepted by the Central Defendants - see **SCGV0000233_040**, p.15, §5 and further drafts until the settlement agreement itself at **HSOC0023174** pages 20-21.

c. **Was the issue of the waiver of the right to bring further litigation for HIV and hepatitis infection a controversial or prominent part of the negotiations between the Plaintiffs and the Defendants? (You**

may be assisted when answering this question by referring to the document cited in question 10 below.)

8.3. As far as I can recall the detailed drafting was done by Counsel, primarily Michael Brooke. Some negotiations of the draft were, I believe, undertaken between Counsel (see at **HSOC0023174**) and others were conducted by letters sent to me for forwarding to Counsel and the Steering Committee.

8.4. Our first draft incorporated the settled principle that we could not make a second claim arising out of the same facts and matters and this was refined in the exchange of drafts until it reached its final form. I do not recall there being much controversy over the waiver. I cannot imagine that the claimants' legal team would have volunteered an unrequested extra surrender of rights to sue (although I agree with Justin Fenwick's analysis that the right to sue for Hepatitis C infection might have been regarded as having very little value at the time).

8.5. I agree with the suggestion that Hepatitis C (then known as Non A-Non B and undetectable by any test until at least summer 1990, if not later) was thought to be of far less consequence than infection with HIV. Although I was not involved when the shape of the case against the Central Defendants was decided I would have taken the same view that infection with hepatitis virus was not a worthwhile separate head of general damages in the context of these claims and adding such a claim would have generated more problems in relation to breach of duty and causation.

9. **A newspaper article dated 2 April 2001 contained what purport to be the words of Mr Mallen, one of the solicitors for the Plaintiffs [WITN1055192]. Mr Mallen is quoted as stating that the clause prohibiting Plaintiffs from bringing claims for hepatitis was included as a quid pro quo for the Government agreeing to disregard the payments under the settlement for the purposes of assessing eligibility for social security benefits.**

a. **Please state whether or not you were aware of such a quid pro quo, or whether or not you understand that there was such a quid pro quo, and provide any details that you can about this matter.**

9.1. I do not remember matters being expressed in this way. It was clearly important that a claimant would not have to spend all his damages before he had the right to claim Benefits and the provisions to protect that right were a necessary part of the overall agreement. To the best of my recollection earlier payments out of the Macfarlane Trust had attracted similar exemption in the assessment of the right to receive Benefits.

b. **The same article quoted Mr Mallen as saying that, *"Our understanding at that time was that hepatitis C was no big deal."* What was your understanding of how serious a condition hepatitis C was at the time of the settlement (1990-1991)?**

9.2. In common with others I knew very little at the time about Hepatitis C for the reasons set out above. I know more now owing to my work on the Skipton Fund Appeal Panel. I do remember that the haemophilia community was used to the risk of hepatitis and, if I remember correctly, was somewhat resigned to living with that risk. Infection with hepatitis viruses could be severe or mild, it could be cleared from the body very quickly in some cases and was thought (as I remember the position) rarely to be fatal. In contrast by the time of the settlement HIV was thought to be certainly fatal (often very quickly so) and incurable. I remember reading some early epidemiology describing very short intervals between infection and death from AIDS in the young and old and longer intervals in those aged between perhaps 18 and 45. As I said above my clients provided empirical evidence of this in their alarming rates of deterioration and death. Further, many clients suffered the most vile abuse including graffiti on their houses, complaints to landlords and head teachers, inability to obtain insurance and the like. By 1990 standards the consequences of HIV infection seemed off the scale compared to those of living with hepatitis viruses. Of course, had I known when anti-retroviral therapy would arrive and how many of our then surviving clients would go on

to live something like normal lives and what we now know about the damage caused in many cases by Hepatitis C, I might have regarded the desirability of including Hepatitis C as a head of damages, the imperative to achieve settlement of this Litigation and its terms very differently. But I did not.

c. **Please provide any other relevant comment that you wish to provide on the newspaper article (without breaching privilege).**

9.3. I had not seen the article before being sent it by the Inquiry and played no part in the Hepatitis C litigation.

10. **The Deed of Undertaking for recipients of funds from the Macfarlane (Special Payments) (No.2) Trust contained an undertaking not to bring proceedings against various defendants where those proceedings involved allegations concerning the *"spread"* of HIV and hepatitis viruses through Factor VIII or Factor IX (whether cryoprecipitate or concentrate) administered before 13 December 1991 [MACF0000086_225]. Insofar as you are able to do so, and without breaching privilege, please answer the following questions.**

a. **Who was responsible for drafting this Deed?**

10.1. It looks to me to have come from a Government source.

b. **What role, if any, did you or other solicitors representing the Plaintiffs play in the drafting?**

10.2. Someone on our team must have approved it. I repeat that my recollection is that Michael Brooke had primary responsibility for drafting and approving drafts.

c. **To the best of your knowledge, was the drafting intended to replicate the relevant clauses of the settlement agreement in the HIV Litigation? If not, please explain what the material differences**

between the documents were, and what they were intended to achieve.

10.3. It certainly looks as if this was the purpose although the document supplied is unusual in that it was clearly supplied for signature by someone who contended for a higher category payment than he had been offered and was effectively accepting £23,500 as an interim payment.

11. **In April 1991, press coverage suggested that *"red tape"* was holding up the conclusion of the settlement agreement [DHSC0002433_108]. This led to a briefing being prepared for No. 10 on this issue by DH officials [DHSC0020822_075; DHSC0041209_050]. A letter was also sent from a DH solicitor to the *Sunday Times* [DHSC0003661_008]. Insofar as you are able to do so, and without breaching privilege, please answer the following questions:**

    a. **Please comment on the reasons given for the delay in reaching final settlement in these Government documents. Do you consider that they are fair?**

11.1. When I began reading these papers I was struck by the interval between 12 December 1990 and the settlement hearing being far longer than I had remembered. To the best of my recollection (and bearing in mind I was only lightly involved in the post-December negotiations) these reasons seem to me to be a fair account for the delay.

    b. Were there any other reasons that you consider caused delay?

11.2. I am reminded by reading **DHSC0003661_013** and **DHSC0003662_086** that Graham Ross was conducting further negotiations on behalf of his clients after the agreement in principle to settle so this may have added to the delay. Otherwise none that I can recall.

General Questions

12. **In your view, what did the HIV Litigation achieve for the Plaintiffs, their families and partners, and others?**

12.1. This is an extremely difficult question to answer. On one level the damages agreed together with the other Macfarlane monies made available amounted to approximately the full common law values of successful High Court claims by the relatively low standards of 1990. I do not think any sensible member of the claimants' legal team would have put the prospects of success at trial above 50% and the Settlement Advice puts the prospects of success considerably lower.

12.2. There is no doubt, however, that, whilst claimants experienced relief at the modest sums they received and their protection from costs liabilities, many considered the length of time taken from the beginning of the case to settlement of the claims was excessive and that, if the Government had intended to settle the claims, this could have been achieved in a much faster and less adversarial way. Those without Legal Aid Certificates had to pay out scarce resources towards legal fees at a time at which they must have been full of fear for their future and concern for the financial well-being of those left behind. The Government, when it decided to settle the claims, properly chose to pay the same amount to claimant and non-claimant alike. The consequence of this, however, was that those who joined the action as private payers undoubtedly (by helping to bring the Government to the table) provided a major benefit to those who did not. This seemed to me to place an additional burden on those who were suffering, or going on to suffer, severe physical and mental distress.

12.3. Blood concentrates promised a new lease of life to those with haemophilia (especially those with a severe condition) and it was a terrible irony that the treatment that appeared to be life-saving turned out for a period of years to be in reality a death sentence. The Litigation was a blunt instrument in the attempted righting of that wrong.

13. **Insofar as you are able to do so without breaching privilege, please provide any additional comment that you wish to provide on the HIV Litigation, or any further matters that you consider to be relevant to the Inquiry's Terms of Reference. Please note that there is no need to repeat evidence that you have already provided to the Inquiry.**

13.1. This Litigation raised challenging social, economic and emotional issues in addition to highly complex legal issues. It felt to me like a time-bomb. I have a vivid recollection of some of the events and of many of my clients, some of whom did not live to see the settlement, whether or not it would have satisfied them. I hope that, should there be a similar therapeutic disaster in the future, a solution can be found that saves very significantly on the time, the expenditure that did not benefit the claimants, and the suffering and distress involved in the HIV Litigation.

Statement of Truth

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

Signed GRO-C

Dated 9th November 2022