Witness Name: Mr Robert Stock

Statement No: 1

Exhibits:N/A

Dated: 30 June 2022

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF MR ROBERT STOCK

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 13 April 2022.

I, Robert Stock, will say as follows: -

Section 1: Introduction

1. Robert Geoffrey Stock

GRO-C

Date of Birth: GRO-C 1944

2. BSc Chemical Engineering July 1966

Chemical Engineering:

12 May 1966 to 27 September 1974 – Process Design Engineer at Foster Wheeler Ltd., London

Agriculture:

August 1975 to August 1976 – Dairy farm, Kent

1976/77 – Warwickshire College of Agriculture (National Certificate in Agriculture)

July1977 to May 1978 – Pig Farm, Warwickshire

May 1978 to June 1984 – Farrowing Manager, Ardencote Pigs Ltd., Gloucestershire

Health and Safety Executive, Field Operations Division: 1984 to 2001

Agricultural Inspector (including obtaining Postgraduate Diploma in Health& Safety at The University of Aston in Birmingham); Forestry & Arboriculture National Interest Group; Regional Development Manager Scotland (Principal grade); Section Head in Occupational Health and Environment Unit (Principal grade).

Scottish Executive: 8 May 2001 – 25 November 2004

Head of Ancillary Services Branch, Health Planning & Quality Division.

This branch dealt with a wide variety of health service provision that did not fit neatly into the remit of other branches. The Head of Branch reported to the Head of Health Planning & Quality Division – who, in turn, reported to the Head of the Health Department. Part of the Branch's remit was to oversee issues relating to the use of blood and blood products within NHSScotland – including the operations of SNBTS.

My duties included ensuring that the parts of the NHSScotland within my Branch's remit operated in a way that was consistent with the strategic and policy aims of SEHD and to report any important developments or area of concern to SEHD management. Also, to prepare and submit draft responses to Parliamentary Questions (PQs) and ministerial correspondence. I was required to bring key issues to the attention of Ministers using the format prescribed by the Scottish Executive and following set rules for consultation and content – I was required to present the issues clearly and concisely with clear, unambiguous recommendations/conclusions. Where appropriate I would conduct negotiations with other UK administrations. Subject to the necessary consultation, I had a fair degree of autonomy but was required to keep SEHD management and Ministers fully informed and to act in line with the expressed views of Ministers and SEHD policy.

Generally speaking, I would draft ministerial submissions and PQ responses myself whilst ministerial correspondence would be shared with my assistant, Sandra Falconer. These activities frequently involved consultation with other parts of the Scottish Executive – including Solicitor's Office, SEHD Finance Team and the Chief Medical Officer. Occasionally consultation might include external bodies.

I took over as Head of Branch immediately on joining SEHD. At that time, I had extensive experience in a civil service policy role but I had no specialist medical knowledge or experience of how NHSScotland operated or how it interfaced with SEHD. I was very reliant on Dr. Keel and her team to advise me in those respects.

3. I have not held membership, past or present, of any other committees, associations, parties, societies or groups relevant to the Inquiry's Terms of Reference.
   I appeared before the Health and Community Care Committee on several occasions to answer questions about the various subjects that were included in my Branch's portfolio and on many occasions I was asked to provide briefing for the Scottish Executive Health Minister in relation to issues and enquiries raised by the committee.
4. I have not been involved in any other enquires concerning HIV/HBV/HCV/vCJD in blood and/or blood products other than the Scottish Executive's Expert Group that produced

the Ross Report.

Section 2: The Ross Report 5-14

5. I was asked to prepare a proposal for the establishment of an Expert Group to advise on whether, generally, the NHS in Scotland should depart from its previous stance of not paying compensation where there was no legal requirement to do so – with special reference to the situation of people who had contracted HIV or HCV by blood or blood products administered by the NHS as part of their treatment. The proposal included full background information on the abovementioned HIV/HCV situation and on other compensation systems that already existed. Once this proposal was discussed and approval was given for the establishment of such a group, I oversaw the process of getting it set up, defining its terms of reference, agreeing the composition of its membership and arranging for the provision of a competent Higher Executive Officer from the Health Department to act as its secretariat.
6. I do not remember the details of how this was done. Malcolm Chisholm was particularly keen that Lord Ross should chair the Group – based on his performance on the Royal Society of Edinburgh mediation review group. Several other members of this group were also eventually chosen as members of the Expert Group. We selected Phillip Dolan (Haemophilia Society – a key organisation in the infected blood context) and Frank Maguire (Senior Partner, Thompsons solicitors – who was regularly writing to the Department on behalf of people infected through blood/blood products) on the basis that they were obvious choices. I also approached a number of other organisations who represented people suffering from HIV or HCV to see if they were interested in serving on the Group. The inclusion of GRO-A of Capital C was a result of my enquiries. Dr. Keel may be able to provide additional information as to how members with relevant medical expertise were selected.
7. I will have had some role in bringing together ideas for the terms of reference from a variety of sources but do not remember in detail what the extent of my own involvement was.
8. My function on the Expert Group was as a special advisor. I also oversaw the secretariat that SEHD had provided. I would have attended all the meetings and assisted the group in providing any information that the Health Department held that would have assisted their deliberations (subject to the usual reasonable restrictions that applied in such situations) and would have acted as an interface between the group and the Health Minister.

   I don't remember who was involved in the actual drafting of the Ross Report. It seems

likely that the secretariat (Moira Milligen) will have produced it in conjunction with Lord Ross.

9. I felt that the Group had deviated from their terms of reference by omitting to take into account the caveats contained in the Notes to the Terms of Reference (regarding the possibility of inhibition of innovation and creativity, being consistent with efficient health service provision and representing a fair deal for ALL patients). I felt that many Group members – including Lord Ross – had to some extent focused on the plight of people harmed by blood and blood products without considering all the other factors they were expected to take into account.
10. I provided briefing for Malcolm Chisholm advising that the aspect of the Expert Group's final report that dealt with a compensation scheme for those infected with HCV via blood products etc. had failed to take into account achieving the abovementioned balance and would likely incur costs which would exceed the amount considered to be affordable without impacting current health service provision and would involve making payments to groups of people who would not, by analogy, have been covered in any previous similar scheme. Also, that implementation of their payment proposals would raise the prospect of creating a precedent with the potential to adversely affect health service provision in the future. This was because the payments proposed would be made in circumstances where payments had not previously been made in any UK health service compensation scheme.

    The background to this situation was that, prior to the establishment of the Macfarlane Trust, the norm throughout the UK had been for compensation to be paid only if a person had suffered harm for which the health service was legally liable. Macfarlane extended that scope to provide compensation in a no-fault situation. It seemed likely that, in consequence, other groups of people harmed by health service treatment would expect to be treated in the same way – irrespective of whether their situation was analogous to the people covered by Macfarlane.

    The compensation scheme proposed in the Ross report extended eligibility beyond Macfarlane in a number of significant ways. In particular, the proposed eligibility criteria would have included – those who had contracted the virus but were symptomless i.e. could be said not to have been harmed by it; those who had recovered from the virus and were now free of harmful effects; those who became infected with the virus following health service treatment but where it had not been possible to establish whether the infection was as a direct result of that treatment (rather than via some other infection route) and those who experienced "anxiety, stress and social disadvantage" (as opposed to serious deterioration in physical condition). It also proposed payments to dependents or executors of those who had died due to contracting the virus and those who had died

from other causes (but who would have been eligible under the scheme if they had still been alive).

The consequence of these significant extensions to the eligibility criteria was that the Health Department would have to pay out considerably more than would have been the case under the "old norm" or under terms similar to Macfarlane and this additional outlay would have to be diverted from normal patient care services. There was also the real prospect that people who had been harmed by other types of health service treatment (either then or in the future) would expect the new criteria to apply to their situation – with long term implications for the health budget.

Taking these factors into consideration I submitted a proposal to the Health Minister for an alternative payment scheme that did not suffer from these drawbacks.

11. My duties included providing advice to both Malcolm Chisholm and the Expert Group. Therefore, I was routinely involved in discussions with Malcolm Chisholm and Lord Ross – although I don't recall being involved in any discussions that involved both of them at the same time.
12. The Scottish Executive did not accept the recommendation in the Ross Report that dealt with a compensation scheme for those infected with HCV via blood products etc. because of the financial and precedent implications stated in my answer to question 10. As far as I can recall the other recommendations were accepted – at least in principle.
    a) I am not aware of Alan Milburn being involved at all in the decision by the Scottish Executive to reject the recommendation that dealt with a compensation scheme for those infected with HCV via blood products etc.
    b) The cost of the scheme was one of the factors contributing to rejection of the that particular recommendation as outlined in my answer to question 10.
13. Statistical information was used to estimate how many of the people who had been infected with HCV by blood and blood products were likely to be able to claim under the terms of the proposed scheme. These numbers were then used to work out what size of award could be offered to different categories of eligible claimants without exceeding the funds considered affordable without prejudicing other health service provision.

Section 3: vCJD

15. I have examined the documents provided to me by the Inquiry that relate to "vCJD in Blood" and they clearly show that I did have involvement with this issue. However, I am afraid that, even after looking at these, I can remember very little about it apart from the fact that it was a very complex issue and there were difficult decisions to be made – particularly in relation to balancing the (probably small) risks to patients with the need to

maintain an adequate blood supply to the NHS in Scotland.

My branch's responsibilities covered a wide range of health services in addition to "blood issues" including orthotics, podiatry, wheelchair use, pensions for injured service personnel and audiology. When I took over the branch, blood issues was the only one of these that was consuming a significant work load. However, this had changed by the time vCJD in blood had emerged as an important issue. RNID had mounted a high-profile campaign for digital hearing aids to be provided on the NHS. Initially, a lot of my time was taken up responding to this campaign and then, when Scottish Ministers decided that this should actually take place, I was tasked with overseeing the roll out of digital hearing aid provision across Scotland. This was a big piece of work that eventually necessitated the department recruiting a reasonably high-ranking individual to my team (and reporting to me) to act as project manager for the programme.

I am afraid that my involvement in two very high-profile pieces of work at the same time appears to have affected my ability to recall events and information from that period.

16. Please see my answer to question 15.
17. Please see my answer to question 15.
18. Please see my answer to question 15. I have no view on the effectiveness of this measure (most of this happened just before I retired and document DHSC0020877_015 supplied for my reference concerns events after I retired).

    It is likely Dr. Keel will be better placed to give an opinion on the effectiveness of the measure.
19. Please see my answer to question 15.

I have examined document SCGV0001056_039 and have no detailed recollection of the issues discussed in it. However, it is apparent from the draft text for Mr. Reid's written statement, contained in Annex B, that the Health Protection Agency (on behalf of the CJD Incidents Panel) had advised the Department of Health in June 2004 on *which patients needed to be assessed and subsequently contacted* and on *managing the possible risk to public health of those patients.*

I do not know why the Health Protection Agency did not start the assessment and notification processes until September or whether they, or the Department of Health, passed the advice of the CJD Incidents Panel to SEHD in June. Dr. Keel may be able to advise on this.

I think the reason that the decision to make the announcement in September was initiated by the Department of Health (rather than by SEHD) may have been that both the

Health Protection Agency and the CJD Incidents Panel were UK (rather than Scottish) organisations.

20. The set of circumstances described occurred before I joined the Scottish Executive and I am afraid that I do not recall anything about it.

21. The statement that I "*led the work looking at the communication of risk across health care*", isn't correct. I didn't have that role or responsibility and I don't know why this misunderstanding has arisen. I have indicated in my answer to question 15 the health topics that fell within the remit of my branch as regards planning and quality issues. In relation to these I reported the Head of Health, Planning and Quality Division who, in turn, reported to the Head of the Health Department.

    As regards vCJD, my branch's responsibilities were limited to overseeing the assessment and management of any risk of vCJD being transmitted via blood transfusion or via blood products. At the time in question, it was unknown whether the persons who had developed vCJD following a blood transfusion had done so as a result of the transfusion or from some other cause e.g. eating meat products from cattle infected with bovine spongiform encephalopathy. The possibility of vCJD being transmitted by the blood transfusion route therefore remained a theoretical one. Application of the precautionary principle would have indicated that this theoretical risk should be prevented by SNBTS not taking blood donations from people who might have been exposed to the disease. To minimise the risk as much as possible would have included barring people from donating blood if they had received a blood transfusion in the UK anytime during a considerable period of years previously. It was thought likely that this would result in a significant loss of blood donations and could jeopardise the ability of the Health Service to treat serious (and in some cases life-threatening) conditions.

    So, the decision as to what course of action to take involved balancing the theoretical risk of vCJD transmission against the definite risks associated with not having enough blood available for essential health service activities.

    I am afraid that I do not remember what the exact concern was about communication between SNBTS and SEHD.

22. I do not have anything further to add regarding vCJD.

    Lack of Candour: vCJD

23. I do not remember this particular exchange and I haven't had sight of the 'letter to Clinical Directors' to which it refers.

    For any potentially serious health service issue, it may be appropriate to take a precautionary approach. But to declare or imply that there was a definite risk when there was no definitive test available at the time runs the risk of misleading the public and

causing unnecessary alarm and could give the impression that a definite risk was acknowledged when that wasn't actually the case.

24. At the time I joined the Scottish Executive I gained the impression that, where there was a common policy to announce, synchronisation of the announcement across administrations was standard practice – the rationale being that, otherwise, all administrations other than the first to make the announcement would be inconvenienced by receiving a flood of enquiries from journalists and parliamentarians querying why they hadn't made a similar announcement and, when they subsequently did make such an announcement, being unfairly accused of only doing so to follow suit.

    I am afraid that I do not remember why the roll-out of notification to potentially infected persons was synchronised.

Section 4: Litigation and settlements

25. a),b), It was the HD Press Office who decided that 27 June was best for "media camouflage". In including this in my submission I was merely reiterating the phraseology as it had come to me from them. I do not now know what that the "media camouflage" was or why they felt such camouflage" was desirable but I surmise that it is very likely that they felt there would be an adverse reaction from campaigning groups to the fact that the scope of the compensation being offered was less than they had expected.

    c) The choice of a date when Susan Deacon was on leave and parliament was in recess was made by herself. I didn't have a level of communication with her that made it likely that she would have shared her motivation with me.

    d) I believe I was involved in the finalisation of the paper but am uncertain whether I was involved in its drafting as I had only been employed by the Scottish Executive for a short period when I wrote the covering email.

26. I have looked at documents SCGV0001100_042 and SCGV0000244_116 and I have no specific recollection of this litigation or my involvement with the Scottish Executive Solicitor's Office in this matter. However, my understanding that SNBTS, as part of the Common Services Agency, rather than a "core department", would have been considered an "arm's length" service. With such services (whilst it is appropriate for Ministers to set their strategic direction) the norm was that they should deal with their own support functions such as legal representation, publicity, marketing etc. Litigation, in particular, would normally be handled by the Central Legal Office. My reading of SCGV0001100_042 and SCGV0000244_116 is that Colin Troupe (for the Solicitor's Office) was making reference to the "arm's length" status of SNBTS and had some reluctance at the prospect of being involved beyond what was normal in this situation.

27. As far as I can recall the settlement being proposed by Susan Deacon in this announcement was more limited in scope than many campaigners (including the

Haemophilia Society) wanted – so it was anticipated that there might be an outcry about this.

Section 5: Internal review

28. This report was published seven months prior to my employment with the Scottish Executive. I had no involvement with its preparation whatsoever.
29. I cannot remember why I did not attend this meeting but this could have been because of a number of reasons. I may have been on leave, I may have been attending or chairing another meeting concerned with the roll out of digital hearing aids, I may have been ill or in hospital for surgical removal of my prostate or attending as an outpatient in connection with another medical problem I had at that time.

    However, the fact that I did not attend this meeting does not mean that it was being afforded insufficient priority. Andrew McLeod, as Head of Health Planning and Quality Division, was my line manager and he would have been completely conversant with the "blood issues" portfolio. Sandra Falconer – my extremely competent right-hand person on blood issues – had been intimately involved with it for a considerable time before I joined the Scottish Executive and took over as Head of Branch from my predecessor, Christine Dora, and she would have known the 'subject' inside out.
30. As I have previously mentioned, I had no involvement in the preparation of this report and so have no first-hand insight in to whether Shona Robison questions are pertinent or not. Please also see my answer to question 31 b) below.

Section 6: Calls for a public inquiry

31.

a) I am afraid I do not remember whether the "SE Investigation" referred to in the first bullet point of page 18 is a reference to the October 2000 report. I am afraid I cannot remember who the "prominent independent expert" was. It is possible that Dr. Keel may remember.

b) In the context of it being the "October 2000 report", I cannot recall having any concerns about the reliability of the report at the time. I believe my predecessor, Christine Dora, oversaw its production – in consultation with others. I did not have any particular experience or expertise that would have put me in a position to think that the exercise was not carried out in a completely professional manner. Later, as recorded in (SCGV0000262_206_1), I did discover that some Scottish Haemophilia Directors continued to purchase potentially more risky commercial clotting factor after they could have obtained PFC product free of charge – but this was not within the

remit of the October 2000 report and seemed to me to be the actions of particular individuals rather than part of an organisational pattern.

c) I am afraid that I do not remember how the Philip Dolan rumour came to my attention and I do not know if efforts were made to explore the accuracy of his accusations. It is possible that Dr. Keel may be able to provide background to this issue.

32. a),b)The situation regarding the desirability/feasibility of holding a public enquiry in Scotland was complex. This was because, at the time that patients were infected with HIV/HCV by blood or blood products, blood transfusion services in Scotland were largely independent of those in the rest of the UK whereas that was not the case for haemophilia clinicians.

My branch had responsibility for overseeing SNBTS operations and I felt there was a reasonable body of evidence that, despite some faults (notably in relation to the lookback exercise), they had acted timeously to ensure the blood donations they used were not from a high-risk source – in contrast to their English counterparts.

My branch did <u>not</u> have responsibility for haemophilia clinicians across the UK and, in including their actions in the general 'line' that there was need for a public enquiry and that the health service was now much more risk-averse, I would have relied on advice from elsewhere in the Health Department – which would most likely have been channelled to me via Dr. Keel. I was not inclined to challenge this as my own impression (gained from sight of historical correspondence and message exchanges with a few haemophilia clinicians) was that most of them had acted in good faith on the evidence that was available to them at the time and there was no generic malpractice. I felt that, if there were a few clinicians who had not acted correctly, then this would be better pursued as a professional malpractice issue rather than via a public enquiry.

c) I am afraid I do not know who made the editing comments.

I certainly don't think there was any pressure to provide Ministers with anything other than truthful and balanced information and, similarly, there was no pressure to present matters in "the best possible light". These submissions were completely internal to the Scottish Executive and there would have been no logic in providing Ministers with anything other than a complete picture so that they could make a fully informed opinion of their own which they then could subsequently present to "the world" without fear of some factor emerging that they were unaware of.

33.

a) The underlying issue associated with the Medicines Control Agency and reserved powers is explained in my message to Jan Marshall of 9/10/2003

(contained within SCGV0000262_119) which states "*The situation is that it would, presumably (subject to your advice), be possible for Scottish Ministers to establish an enquiry into the conduct of relevant parts of the health service in the 1970s and 1980s (as regards the decisions made in terms of prescribing certain blood products) but inevitably such an enquiry would run into the buffers when it came to address the fact that these products were licensed by Medicines Control Agency (…recently subsumed in the Medicines and Healthcare products Regulatory Agency [MHRA])*" …(because) "*The Medicines and Healthcare products Regulatory Agency [MHRA]) … function remains with the UK government as a reserved matter*.

I do not remember making the comment about "playing the reserved card" but it would appear that I was cautioning against using the above defence as a reason for not pursuing a public enquiry. Please see my answer to question 33 (e) below.

b) I am afraid I do not recall this particular meeting or why I described it as being "gruelling". I attended many meetings with Philip and I had a good personal relationship with him. However, in the context of meetings, he was habitually quite confrontational and frequently he would refuse to address the topic for which the meeting had been convened but insist on pursuing his own agenda.

c) I am afraid I do not know who Patrick Layden was (or what his role was) and can make no guess as to what the "political sensitivities" were that he was referring to.

d) Please see my answer to question 33 (a) above and 33 e) below.

e) This is a reference to the matters covered in my answer to a) above. I am discussing the pros and cons of two valid arguments relating to whether there was a case for holding a public inquiry in Scotland – namely "the lack of (expert) consensus on the risks associated with Hepatitis C (at the time) versus the argument that the blood products at the heart of the issue were licensed by the Medicines Control Agency (now the MHRA and outwith the jurisdiction of the devolved Scottish administration. I think it is likely that I felt that, despite "*MHRA jurisdiction*" being a legitimate legal argument, it would likely be perceived as 'hiding behind the letter of the law' and was a weaker argument than "*lack of expert consensus*" – which aligned with the much stronger, and morally compelling, argument that NHS staff acted "in good faith in the light of the evidence available to then at the time".

f) I would have obtained the information for each component of the table from a variety of sources and I am afraid that I cannot now remember the detail of those sources.

34. In making the comment that "that it was fundamental that any inquiry should only proceed on the basis that it would provide new information" I was stating the Health Department view that funds and resources intended for the care of current patients should not be diverted into supporting any exercise that would ultimately prove to be futile. I would-have made this comment in the context of holding an inquiry in Scotland.

As regards holding an inquiry into the conduct of SNBTS, the Health Department view reflected the opinion that it was unlikely any significant new information would be revealed that would justify the resource 'cost' involved. And, as regards holding an inquiry into other relevant issues, it reflected the opinion that nothing useful would be revealed because the Scottish Executive did not have appropriate devolved powers that would enable the inquiry to demand access to crucial information held by the Department of Health (as I understand proved subsequently to be the case when the Penrose Inquiry was held).

When (in document SCGV0000098_166) I said I thought "that it was unlikely an inquiry would find anything new", I think it is likely that I was referring to the situation I have described above and the issues I have outlined in my answer to question 32 a) and b).

35. I believe that what I am implying here is that a distinction needed to be made between officials or NHS staff who acted in the way described and those who had acted in good faith in the light of evidence available at the time. A public inquiry in Scotland might have been merited if it was believed that the former situation had existed whereas it would not have been merited in the latter situation. This might have been the threshold for holding an enquiry in Scotland, although I cannot discount the possibility that it might not have been the only factor.
36. I can only answer this in general terms. Communication did take place with health officials at the Department of Health England but this was no more or less than would ordinarily be the case in circumstances where different administrations are simultaneously dealing with an identical or similar issue. This would have included exchange of relevant information and the synchronisation of announcements when appropriate (as I have outlined in my answer to Question 24). But it would not have altered any decision by the Scottish Administration to independently pursue a different course of action from other administrations if it felt that was the right thing to do and it was within the devolved powers available to it.
37. I do not believe that the decision not to hold a public inquiry in Scotland was influenced in any way by the need to align with the position in Westminster and I consider the accusations contained in HSOC0028473 to be completely unfounded.
38. Both the cost implications and the resource implications of a public inquiry in Scotland were always a major consideration in the advice I provided to Ministers – for the reason

that such outlay would adversely impact on the ability of the Scottish health service to provide adequate care for patients and this could only be justified if such an inquiry was likely to provide a meaningful outcome.

39. On several occasions the advice that I provided for the Ministers contained information on the inquiries in other countries – so they were always aware of these inquiries. However, the particular circumstances giving rise to inquiries in those countries was markedly different to the circumstances in Scotland so they were not presented as being influential but just as background.

40) If I understand it correctly, the opinion expressed by Norman Fowler relates to holding a UK-wide public inquiry. The devolved powers available to Scottish Ministers did not empower them to initiate such an inquiry so it was never part of my remit to consider one. As regards my own "present view" I find it difficult to separate the question of whether an inquiry in Scotland should have been held earlier from the question of whether it should have been held at all.

Although it was not my opinion at the time I first started dealing with this issue, by the time I retired I had come round to the opinion that the general arguments against ex-gratia payment schemes were flawed. I came to the conclusion (and that is my view now) that the real answer was for there to be an all-embracing no-fault compensation scheme that could be applied to any situation where patients were harmed by NHS treatment. Crucially this should be funded by central government, rather than from Health service budgets, (as this and other "infected blood" inquiries have been) so that compensation can be provided to people in need without disadvantaging other patients and without unnecessarily stigmatising health service staff who were involved in the provision of a particular treatment and who had acted in good faith in providing it.

40 a) I am almost certain that I drafted document SCGV0001080_040 although, without sight of the covering email, I cannot state it as a fact.

This paper was no different than those that preceded it in that the desirability of holding a public inquiry in Scotland was always "in the frame" but to be considered in the wider context of a cost- benefit appraisal where the cost would be measured in terms of the impact on the Health Department's budget and resources, and the benefit measured in terms of the likelihood of such an inquiry revealing new information that would ensure the improvement of health service practice in the future in a way that was proportionate to the aforementioned 'cost'.

Section 7: Other

41) I was instrumental in putting forward a proposal to Ministers for the Effective use of Blood Project but I had no involvement in the detail of the project.
I do not know how successful the project was – Dr. Keel is likely to be better placed than I to comment on that.

42) I do not have any further comment that I wish to provide about matters of relevance to the Inquiry's Terms of Reference.

Statement of Truth

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

Signed GRO-C

Dated 30 June 2022

Table of exhibits:

Date	Notes/ Description	Exhibit number