Witness Name: Mr Robert Stock
Statement No: WITN7078002
Exhibits: See Exhibit Table
Dated: 21.07.2022

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 27 June 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.

Section 2: Skipton Fund

1. **The Inquiry seeks to understand the role you took in designing and setting up the Skipton Fund. In particular:**
   a. What role did you have in advising the Minister of the terms of the scheme.
   b. What role did you have in negotiating with the other three nations about the terms of the scheme?

A1. In most respects, the UK compensation scheme – later to be named the Skipton Fund – mirrored the scheme that had already been approved by the Scottish Executive. My overall role was to act as a facilitator in integrating it into the final UK scheme and to assist the Department of Health in establishing the UK scheme.

a) My duties also included keeping the Health Minister and SEHD management updated on any important developments and to seek advice from them regarding any development that deviated significantly from the parameters of the Scottish scheme that they had already endorsed.

b) Department of Health took the lead in coordinating the setting up of the UK scheme – including coordinating the contributions of all the devolved administrations. I didn't therefore have one-to-one negotiations with either the Welsh or Northern Ireland administrations. My role was that of an 'informed participant'. Based on the experience I had gained working up the Scottish scheme, I tried to provide positive contributions that would be helpful to the other three administrations in defining and establishing the UK scheme (document SCGV0000258_108 – where I set out my ideas on a possible communication strategy – provides an example of this).

2. **Why was the decision taken to provide lump sum payments rather than ongoing payments under the scheme? What role did you have in this decision?**

A2. I am afraid I do not have any specific memories about the debate around ongoing payments. However, it is apparent that document SCGV0000251_043 expresses the Scottish Executive's *"initial preference for a scheme that would make ongoing payments to surviving patients — triggered by progression to a stage of disease that could easily be linked to the concepts of need and suffering"* – going on to argue in favour of such payments because – *"such payments would be less likely to be perceived as compensation, and therefore as being a new departure from the principle that the "NHS does not pay compensation when there is no legal liability*".

I think that this Scottish Executive view, expressed in December 2002, was abandoned soon after. The Ross Report (2003) in particular made no mention of ongoing payments. I am fairly sure that none of the organisations representing potential claimants were asking for it either and I am not aware of it being the norm for other schemes set up to make payments to people suffering from health issues.

3. **Why were the lump sum payments set at the level they were, rather than at the level recommended by the Ross Report or awarded in the Republic of Ireland? What role did you have in this decision?**

A3. The reasons the lump sum payments were set at the level they were rather than those recommended in the Ross Report are outlined in detail in the answers I gave to questions 10 and 12 in my first statement. But, in summary, the definitive issue was that the payments recommended in the Ross Report exceeded the level which SEHD considered could reasonably be diverted from the budget available for normal patient care services. Decision making on that basis was not unique to this situation – the need to balance the needs of one group of patients against those of another is something health services have to do routinely. It is, for instance, enshrined in the concept of the QALY (quality-adjusted life year) that is routinely used by the National Institute of Clinical Excellence to decide whether outlay on expensive treatments can be justified after taking into account the effect that outlay would have on the provision of other services.

The reasons the lump sum payments were set at the level they were rather than those awarded in the Republic of Ireland was that the circumstances in Ireland were not comparable with those that formed the background to the Scottish or UK schemes. In Ireland, a judicial inquiry had concluded that the contamination of the Irish blood supply was due to "wrongful practices" on the part of the Irish Blood Transfusion Board.

My role – as regards the Scottish scheme that acted as a template for the UK scheme – was to present the appropriate facts to SEHD management and the Health Minister in a clear fashion with recommendations on options on how to proceed. With regard to Ireland, I did have a telephone conversation with an official of the Irish health service to ensure that my understanding of their situation was correct.

4. **What was the rationale for setting the trigger for the second payment as cirrhosis or liver cancer? What role did you have in that decision? Why was the trigger adopted by the Ross Committee not used? What role did you have in this decision?**

A4. I am afraid I don't have any recollection of dealing with the arguments for and against different trigger point definitions. However, the argument for the second payment trigger point of the Scottish scheme being preferable to the Recommendation B trigger point in the Ross Report (development of chronic HCV) is fairly clearly laid out in DHSC5322232. That was that there was concern in the Scottish Executive that using the phrase "*people who develop chronic Hepatitis C*" could result in paying compensation to claimants who had any level of HCV infection – rather than just those who had experienced "*serious harm*" (which was the threshold that Scottish Ministers considered appropriate).

The discussions on what might actually comprise serious harm in the context of HCV infection, on the issue of detecting that serious harm and on the effect of the latter on the former, would have predominantly been of a medical nature. Therefore, I think it is likely that I would have been involved in these mainly as an observer. My role would primarily have been to help ensure that the outcomes of those discussions were taken into account in the eventual Skipton Fund scheme.

5. What role did you have in a. the initial decision taken, that those who received monies from the scheme would be required to waive their rights to bring a claim against the Government for damages arising out of their hepatitis C infection, and b. the decision to remove the waiver as a condition of receiving financial assistance?

A5. I am afraid I do not remember anything about the "waiver" issue. However, the exchange of messages contained in document SCGV0000257_004 seems to make clear the following:

a) The initial decision (to require those who received monies from the scheme to waive their rights to institute legal proceedings against the NHS or Ministers) was included as a direct request of OSSE (Office of the Solicitor of the Scottish Executive) – who apparently felt this was a normal requirement to impose for any such scheme.

b) The later decision to remove the waiver requirement was a direct response to the antipathy of the Health Minister (Malcolm Chisholm) to the idea.

In both cases my role would have been to ensure the advice I had been given was duly incorporated into relevant documentation that affected the scheme.

6. Why were the estates of those who died before the announcement of the scheme in August 2003 precluded from applying for financial assistance from the scheme? What role did you play in this decision?

A6. As I outlined in my answer to question 10 of my first statement, the Ross Report extended liability beyond that covered by previous schemes (in particular Macfarlane) by including a number of novel features. Inclusion of payments to the estates of those who died was one of those features. There was concern that acceptance of those features would result in the overall outlay on the scheme being much larger than would have been the case under previous schemes and that it would create a precedent that could result in a similar feature being built into future schemes. In both cases this would divert funds from normal patient care.

My role was to provide briefing for SEHD management and the Heath Minister that laid out these issues clearly and provided recommendations on the options available.

7. Why were those who cleared hepatitis C naturally, (natural clearers), excluded from the scheme? What role did you play in that decision?

A7. I am afraid I do not remember anything about this issue at all.

8. What role did you have in the design of the procedural requirements of the scheme? In particular, what role did you play in determining the evidence that would be required to meet the criteria to receive financial assistance from the scheme?

A8. As a representative of one of the four administrations involved in setting up the UK scheme, I will clearly have been involved in making input to the design of the procedural requirements but I am afraid I have no memory of it. As far as I can recall, the Scottish scheme had not progressed to the stage of looking at procedural requirements by the time it was subsumed into the UK scheme. As a result, I would not have brought any readymade material to negotiations and would purely have been making input based on

my experience in holding policy roles and passing on helpful comments I might have received from within SEHD.

9. The Inquiry heard oral evidence from Charles Lister on 8 June 2022 that it was his understanding that there were likely to be gaps in medical records such that it would be unlikely for there to be any direct evidence linking a person's hepatitis C infection with their treatment by blood or blood products. As to this:
a. What was your expectation in this regard, and what was that based upon?
b. What if any consideration was given to the fact that many applicants were likely to have difficulty providing evidence from their medical records of their treatment with blood and blood products, when determining the eligibility criteria?

A9. I am afraid that I have no recollection at all about this issue.

10. The Inquiry understands from a minute you wrote on 6 August 2003 that Wales and Northern Ireland had not been 'party to developments' about the HCV compensation scheme. Why was this? When were they first consulted and informed of 'developments'?

A10. I was not aware of any general standing instruction within the Scottish Executive that recommended or mandated consultation with the Welsh and Northern Ireland administrations and I did not, as a result, engage in such consultation as regards any of the health issues within my branch's portfolio. In contrast, there definitely was a standing instruction to consult with the Westminster administration when appropriate. This was in the early years of devolution and I think things had not bedded down on these sorts of procedures at that stage. I suspect that the fact that England was treated differently reflects the fact that, prior to devolution, all civil servants in Scotland reported to the Scottish Office.

When I wrote in paragraph 3 of the 6 August 2003 minute *(The UK government).....invited discussions....to explore the potential for similar schemes elsewhere in the UK* I think I was indicating that John Reid was proposing that his administration take the lead in involving the devolved administrations. [This seems to be confirmed by what I wrote in paragraph 3 of the 11 December 2003 briefing note for the Health Minister (SCGV0001084_061)].

As far as I can recall this would have been the first time the Welsh and Northern Ireland administrations would have been involved.

11. What steps were taken by the Scottish Executive to draw the existence of the Skipton Fund to the attention of those infected with HCV via blood and blood products?

A11. I note that in document SCGV0000258_108 (31 March 2004) I laid out my initial thinking on a possible communications strategy for the Skipton Fund. I am afraid that I have no memory of what happened after that.

12. The Inquiry understands that by the time you left your post, the Skipton Appeals Panel had still not been set up. What was the reason for the delay?

A12. I am afraid that I do not remember anything about the Appeals Panel issue.

Section 3: Other

I do not have any other evidence to offer to the Inquiry regarding the establishment and initial operation of the Skipton Fund.

Statement of Truth

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

Signed _____ __ _____

Dated _____21.07.2022_____

Table of exhibits:

Date	Notes/ Description	Exhibit number
31/03/2004	Email from Bob Stock to David Reay; Gerry Dorrian; Richard Gutowski; Sue Paterson cc Sandra Falconer; Aileen Keel re: Skipton Fund - Outstanding Issues [Communications strategy] to be discussed at meeting. Suggestions include: Press release to announce 'doors open' for Skipton Fund (SF); CMO letter to clinicians and a different one for GPs; Distribution of posters; Full information on the SF website with links to patient organisation websites; need for two different types of appeal: second payment and basic eligibility	SCGV0000258_108
18/12/2002	Fax from Bob Stock, Scottish Executive, to Simon Stockwell, Scottish Office, re: ex gratia payment scheme for 'hepatitis C from blood' patients	SCGV0000251_043
01/08/2003	Email chain between Bob Stock, David Reay and Richard Gutowski, re: HEP C and attaching documents.	DHSC5322232
30/03/2004	Email from RG "Bob" Stock to Sandra Falconer. Re : Hepatitis C Herald Story	SCGV0000257_004
11/12/2003	Policy, 'Hepatitis C From Blood' Ex Gratia Scheme - Details of Proposed Parameters and Administration, written by Bob Stock.	SCGV0001084_061