Witness Name: Sandra Falconer
Statement No WITN7295001
Exhibits: WITN7295002
Dated: 2 December 2022

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF SANDRA FALCONER

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

I, Sandra Falconer, will say as follows: -

Section 1: Introduction

Q1. Please set out your name, address, date of birth and any professional qualifications relevant to the duties you discharged while working in the Health Planning and Quality Division of the Scottish Health Department.

1. Sandra Falconer, GRO-C Date of Birth GRO-C 1954. I do not have any professional qualifications relevant to the duties I discharged while working in the Scottish Health Department.

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

2. Employment history

Dates	Grade/role	Department
3 August 1970 - June 1971	Clerical Assistant Supporting the maintenance and distribution of publications for HM ships.	Ministry of Defence(N) Flag Officer Scotland and Northern Ireland Confidential Book Office
June 1971 – February 1989	Clerical Officer with some spells of temporary promotion to Executive Officer Various positions including purchasing, stock control, accounts, explosive safety licensing.	Ministry of Defence(N) Royal Naval Armament Depot Crombie
February 1989 – 2 December 1990	Executive Officer Checking and approval of student grant applications.	Students Awards Agency
5 December 1990 – August 1998	Executive Officer (with some spells of temporary promotion to Higher Executive Officer). The Branch had responsibility for sponsorship of divisions within the Common Services Agency including the Scottish Blood Transfusion Service (SNBTS), Scottish Ambulance	Scottish Executive Health Department Management Executive

	Service (SAS), Supplies Division and Central Legal Office (CLO). I provided support in these areas as required. This included researching and drafting responses to official and ministerial correspondence. (I moved from the Blood Policy division as part of a reorganisation in early 1998 returning on promotion in August 1998.)	
August 1998 – May 2005	Higher Executive Officer Responsibility included development of guidance for the NHS in relation to the Disability Discrimination Act, policy on rehabilitation services (wheelchair, prosthetic and orthotic services), Medical devices and SNBTS. This included investigating and providing first drafts of responses to official and ministerial correspondence,	Health Department

	ministerial briefing and PQs in relation to these areas.	
May 2005 – April 2007	Higher Executive Officer (B2) Assistant Secretary to the Mobility and Access Committee Scotland (MACS)	External Secondment Opportunity
April 2007 – March 2010	B2 Policy responsibility for NHS Complaints, Advocacy, NHS Volunteering, Health Rights Information Service.	Scottish Government Health Department Patient Focus and Public Involvement
March 2010 – February 2014 February 2014 – February 2017 Partial retirement working 2 Days a week	B3 Involvement in the development of areas of the Patient Rights Act 2011 including the Charter of Patient Rights and Responsibilities Feedback and complaints regulation and the establishment of the Patient Advice and Support Service. I also provided Secretariat support for No-Fault Compensation Review Group announced in 2009.	Patient Support and Participation

	This included assisting in the drafting of the group's report, and subsequent consultations relating to it.	

Q3. Please set out your membership, past or present, of any other committees, associations, parties, societies or groups relevant to the Inquiry's Terms of Reference, including the dates of your membership and the nature of your involvement.

3.

3.1 I provided secretariat support for the No Fault Compensation Group announced by Nicola Sturgeon in 2009. The Group's report was published in February 2011 and research reports and costings followed.[1]

3.2 A consultation on draft proposals for a 'No-blame' redress Scheme in Scotland for harm resulting from clinical treatment ran from 23 March 2016 to 12 August 2016. [2]

3.3 Unfortunately, I broke my hip and required a full hip replacement at the end of February 2016. I developed a blood clot on my lung following surgery and as a result did not return to work until mid-June 2016. A full-time member of staff had assumed responsibility for the work. I did draft the report of the responses to the consultation on my return but I don't know whether this was published or if the work was progressed further. I retired in February 2017 but with leave my last day in the office was mid-December 2016.

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1 (https://www.webarchive.org.uk/wayback/archive/20150218125380e /http://www.gov.scot/Topics/Health/Policy/no-Fault-Compensation

2 (https://www.gov.scot/publications/blame-redress-scheme) U

Q4. The Inquiry is aware that you provided a statement to the Penrose Inquiry in 2011 (PRSE0001966). Does your statement remain true and accurate to the best of your knowledge? If there are matters contained in the statement that you do not consider to be true and accurate, please explain what they are and why they are no longer true and accurate.

4. My statement to the Penrose Inquiry remains true and accurate to the best of my knowledge. I note the reference to Point 35 on the schedule of documents. In this regard I would suggest that SNBTS were best placed to advise on their readiness and ability to introduce testing at an earlier date and to offer views on whether it was appropriate to use a second generation kit which was still being evaluated. I have also looked at the Penrose Inquiry findings and in particular the comments at Item 31.530. I note that there is no recognition here of the pressures on the blood transfusion centres at that time as a result of the Gulf Crisis. These pressures are highlighted within the Report at Items 31.265, 31.266 and 31.297.

Q5. Please confirm whether you have provided evidence to, or have been involved in, any other inquiries, investigations or criminal or civil litigation in relation to human immunodeficiency virus ("HIV") and/or hepatitis B virus ("HBV") and/or hepatitis C virus ("HCV") infections and/or variant Creutzfeldt-Jakob disease ("vCJD") in blood and/or blood products, other than the Penrose Inquiry. Please provide details of your involvement and copies of any statements or reports which you provided.

5. I can confirm that I have not provided evidence to, or been involved in, any other inquiries, investigations or criminal or civil litigation in relation to HIV and/or HBV and/or HCV infections and/or vCJD in blood and/or blood products, other than the Penrose Inquiry.

Section 2: vCJD

Q6.The Inquiry understands that Scotland's first notification exercise took place in November 2002, where the Scottish Parliament and Chief Medical Officer for Scotland agreed that haemophilia patients in Scotland should be informed of their exposure to affected batches of factor concentrate [BHCT0004027; SCGV0000078_027]. What role did you (and to your knowledge others in your team) have in the decisions made by the Scottish Health Department to notify those who had received blood components or blood products from a donor identified as suffering from

SCGV0000095_188, SCGV0000096_145, SCGV0000098_166, HSOC0011109, HSOC0011095, SCGV0001056_029, SBTS0003136_123, SCGV0000193_092, SCGV0000040_194, SCGV0000098_047 DHSC0004555_177, DHSC0004735_026, NCRU0000143_175, SCGV0001056_006, SCGV0001056_007, SCGV0001056_017, SCGV0001057_069, SCGV0001061_072, DHNI0000043_025 and SCGV0001057_076 may assist in answering this question.

6. The papers provided show that the UK-wide notification strategy was developed by the Microbiological Safety of Blood and Tissues (MSBT) expert group in parallel with guidance from the vCJD incident panel on reporting, investigation and contacting patients. Dr Keel provided the link between the Health Department and the MSBT and is therefore best placed to provide detailed comment on the process, complexities, considerations and risk assessments involved. Dr Keel and Professor Franklin (SNBTS) were both members of the vCJD incident panel. The list of publications/guidance (Exhibit WITN7295002) referred to Question 11 below shows that this area was led by Public Health colleagues and that most of the guidance, informed by the work of the expert groups, was developed and issued by the CMO's division. I do not recall being involved in or influencing any specific part of the guidance but do recall liaising with colleagues in Public Health for advice/updates and we will have been involved in the development of the guidance relating to the blood transfusion service and in keeping Ministers informed of the position.

Q6A. In your draft, you state at paragraph 6 that whilst you were not involved in influencing any specific part of the guidance, you liaised with colleagues in Public Health for advice/updates and in the development of the guidance relating to the blood transfusion service. Please answer the following:

a. What guidance relating to the blood transfusion service did you develop? Please provide the title and if possible, the final guidance circulated.

b. What was your contribution to this guidance?

c. Who worked on this guidance with you (individuals and/or organisations) and what was their contribution?

d. What updates and/or advice did you receive from Public Health in relation to vCJD

6A a,b & c Guidance specifically related to the Blood transfusion Service was contained in a Health Department Letter HDL(2003)19 entitled "1.Better Blood Transfusion Programme; 2. availability of imported fresh frozen plasma from Scottish National Blood Transfusion ServicWITe; and 3. SNBTS information leaflets on blood products" (Exhibit WITN3530052). The information contained within the HDL will in the main have been provided by SNBTS, and agreed/cleared by Dr Keel/CMO's division. I don't remember exactly but my involvement is likely to have been restricted to putting the information together under the covering sheet in the appropriate format for clearance and issue as an HDL.

d. Exhibit WITN7295002 provides details of guidance issued by the CMO and Public Health Division colleagues in relation to vCJD between 1998 and 2015. Advice sought from the CMO's division and Public Health Division colleagues will have been in relation to progress in the development and provision of guidance, contributions to briefing, correspondence and questions.

Q7. What other arrangements were put in place by the Scottish Health Department to ensure that those who were being notified of their 'at risk of vCJD' status, were provided with appropriate information and support when receiving their

diagnosis. You may be assisted by SCGV0001056_029; SBTS0003200_130; SCGV0000095_026; SCGV0000078_027; LOTH0000082_017; SCGV0000098_073.

7. The Scottish Centre for Infection and Environmental Health (SCIEH) supported by the Health Protection Agency (HPA) developed a detailed plan and timetable for the identification, notification and management (which included emotional support and/or information on where to access support) of patients who received implicated products.

Q8. In SNBTS meeting minutes dated 16 January 2001 [SCGV0000095_026], you agreed to provide Professor Franklin with details of a care package being offered to those infected with vCJD. Please provide details of what this package offered, including details of eligibility and how it was received.

8. The reference was presumably to the scheme announced in October 2000. Details of the care package, eligibility and support being offered to those infected with vCJD are available at: [3]

Q9. Please explain, to the best of your recollection, why it took until the end of 2003 and into 2004 to inform recipients of blood transfusions and blood products of their possible exposure to vCJD [SCGV0000193_092; SCGV0000098_047].

9. The papers provided show there was a delay in providing detailed guidance but also that it was considered the responsibility of the attending doctor to inform patients and that this responsibility overruled any guidance. Please also see my answer to Question 6.

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1. [3] http://www.vcjdtrust.co.uk/the-compensation-scheme/.

Q9A **In your answer to a question asking why you believe it took to the end of 2003 to 2004 to inform recipients of blood transfusion and blood products of their possible exposure to vCJD, you state in paragraph 9 that there was a delay in providing detailed guidance and that it was the responsibility of attending doctors to inform patients. Please answer the following**

a. Please provide further detail on the decision that it was the responsibility of attending doctors to inform patients. Was this an official policy? Who implemented this policy, including which regions it was implemented in? Please provide any documents which may support the implementation of this policy.

b. Please provide details of the guidance you mention in this answer. What was the title of the guidance? How and to whom was it circulated? If possible, please provide a copy of this guidance

9.A

a. The information in relation to the responsibility of the attending Doctor was taken from document SBTS0003200_130. Please see pages 26 and 27 of the paper (under Banner Committee heading) and also page 28. The comments were made by Dr Keel who would be best placed to provide further information in relation to this position. Dr Keel's letter of 29 October 2002 (GGCL0000152_004) to Professor Lowe and Haemophilia Directors Group also reflects this position as does the CMO letter CMO/2004/13 available online[4].
b. I do not have and have been unable to find the guidance in relation to informing and counselling of patients which I believe will have been issued by the CMO's Division. I did, however, find the Framework

[4] https://www.scot.nhs.uk/sehd/cmo/CMO(2004)13.pdf

document developed by the CJD incident panel which has been archived and is now available online[5].

Q10. On 8th January 2003, you were contacted by Charles Lister, head of blood policy at the Department of Health, to provide a response to a parliamentary question concerning a Scottish blood donor subsequently found to have vCJD [DHSC6701278].

a. Under the heading, 'Rebuttal lines to take', the fourth bullet point states that SNBTS informed the SEHD of this incident in March 2001; the seventh bullet point states that Scottish Haemophilia Directors notified haemophilia patients on 26th November. The Inquiry understands this to be 2002. What steps did the SEHD take on receipt of this information? Why did you understand it had taken so long to inform patients of their potential exposure to vCJD? You may find DHNI0000049_017, GGCL0000152_001, GGCL0000152_004, LOTH0000630_211 GGCL0000151, SCGV0000096_145 and SCGV0001061_005.

10. The papers provided also show that the incident reported by SNBTS in March 2001 was referred to the CJD incident panel for advice and guidance. SCGV0001061_005 shows this on CJD incident panel meeting on 26 March 2001. The entry on page 26 of SBTS0003200_130 states that Drs were informed on 11/1/2002 and that the decision to inform patients was considered to be for the attending Doctor. It also notes that letters were

5 https://webarchive.nationalarchives.gov.uk/ukgwa/20121103003432/http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/CreutzfeldtJakobDisease/CJDIncidentsPanel/

issued by Haemophilia Directors on 26/11/2002. The Drs and the HDs had been awaiting guidance from the Banner Committee (a sub-committee of the vCJD incident panel). Although I don't know the specifics of why it took so long to provide guidance I would suggest the complexity of the issue and the risk assessment played a major part in the delay. Please also see my answer to question 6.

Q11. The Inquiry seeks to understand what actions the SEHD and other organisations such as the SNBTS took to mitigate the risk of transmission of vCJD through the use of contaminated surgical instruments.

Please provide an outline of any proposals or guidance, whether accepted or not, that were made in an effort to protect patients from the risk of vCJD transmission through the use of surgical instruments, particularly in regards to de-contamination. You may find the documents SCGV0001048_081; SCGV0001064_049; NHBT0011244_002 useful.

12. Details of the guidance issued in the form of Management Executive Letters (MELs), Health Department Letters(HDLs) and CMO guidance between 1998 and 2015 are given in the attached screenshot of the list of documents available on the SEHD website (Exhibit WITN7295002). Please see my answer to question 6.

Q12. The Inquiry understands that you contributed to a study titled "Mapping the prevalence of sickle cell and beta thalassaemia in England: estimated and validating ethnic-specific rates". Aside from this study, did you or your team contribute to any proposals, discussions, studies etc., to ensure the safety of blood in partial exchange transfusions given to patients with sickle cell disease? You may find NHBT0011245_001 useful.

13.1 I did not contribute to the study mentioned. The co-author S Falconer was from Imperial College at St Marys Hospital, London. From the information given I am unable to advise whether anyone from the Health Department contributed to any proposals, discussions, studies etc.to ensure the safety of blood given to patients with sickle cell disease. I note, however, that the paper NHBT0011245_001 appears to relate to a proposed UK wide study and SNBTS/Scotland may well have been involved in this.

12.2 Indemnity was provided by the Health department for various clinical trials undertaken by SNBTS (e.g. SCGV0000095_188 item 3 and SCGV0000095_026 item 3 refer) but I do not remember whether any of the SNBTS trials specifically related to patients with sickle cell disease. Records of the trials for which indemnity was provided by the Department should be on file or available from SNBTS.

Q13. Please tell us anything further regarding vCJD which you consider to be relevant to the Inquiry's terms of reference, particularly in relation to candour and transparency.

14. The documents provided show that the delay in the provision of guidance caused concern for SNBTS and the Haemophilia Directors particularly in relation to candour and transparency. Please also see my answer to question 6.

Section 3: HCV Litigation

Q14. Document SCGV0000243_094 comprises a submission from Bob Stock to the Minister and Deputy Minister of Health and Community Care dated June 2001 whereby you are copied in. Please provide your views on the following:

a. Why would a public announcement on 27th June provide "useful media camouflage"? Why was this considered to be advantageous?

b. In reference to paragraph 6 of the submission, why was a "low key" announcement proposed?

c. Why was it considered to be advantageous for the public announcement to take place

15. It was routine practice to liaise with the Press office on suitable dates for announcements/publications etc. and I would assume that is what happened in relation to this announcement. Bob Stock would be best placed to provide advice on the submission and its content.

Q15. What part did you play in the decision that was ultimately made, that the Executive would only settle those issued cases brought under the Consumer Protection Act that were directly analogous to the cases that succeeded pursuant to the Burton judgment. You may find SCGV0000191_031, HSOC0011961, SCGV0000243_098, HSOC0011961, SCGV0000096_086 and SCGV0000192_189 helpful.

16. I did not play a part in the decision that was ultimately made in relation to the cases brought under the Consumer Protection Act. My understanding is that the decision was based on advice from legal Counsel.

Q16. What was your understanding of the reasons why the Executive did not (following the Burton judgment) agree to make payments to:

(i) those who had been infected with HCV by blood or blood products between 1 March 1988 and 1 September 1991 but who had not issued proceedings within 10 years;

(ii) those who had been infected with HCV by blood or blood products prior to 1 March 1988.

17. I did not play a part in the decision that was ultimately made in relation to the cases brought under the Consumer Protection Act. My understanding is that the decision was based on advice from legal Counsel.

Q17. What did you understand to be the reason why it was considered necessary to align policy decisions on compensation with all the UK administrations? You may find SCGV0000247_065 of assistance.

18. I assume that Ms Deacon wished to see a consistent approach across the UK but I have no personal recollection of this being discussed.

Section 4: The Irish Tribunal

Q18. On 7th March 2000, representatives of SNBTS were invited to give expert evidence at the Lindsay Tribunal into HCV and HIV infection via contaminated blood (the 'Irish Tribunal'). Please explain why the Scottish Executive and those advising were reluctant to allow the representatives to participate? The following documents may assist in assist in answering this question: SCGV0000194_030, SCGV00 00194_036, SCGV0000194_035, SCGV0000194_034 and SCGV0000194_028.

Q19. In your submission to the Minister for Health and Community Care Susan Deacon, dated 9th May 2000, you refer to "the possible dangers of SNBTS becoming involved in areas we would not wish them to" [SCGV0000194_034, para 5]. Please elaborate on what was meant by this.

Q20. Please explain why the chosen response was to provide evidence in affidavit form. Please outline what evidence may

have prejudiced any further Scottish Hep C litigation? [SCGV0000194_032 and SCGV0000194_023].

19. 19 & 20. The concerns stemmed from the fact that there was litigation in Scotland and SNBTS were unsure whether it would be appropriate for issues raised in this to be discussed during the Irish Tribunal. I think the concern stemmed more from a protocol point of view given that as part of the complaints procedure at that time the guidance was that 'if someone instigated legal proceedings then the complaints procedure should immediately stop' and that all papers relating to the matter should be passed to the relevant person appointed to deal with such matters. (The complaints guidance, which was issued with MEL 1999(49) is relevant but unfortunately not attached to version of the MEL now available on the SEHD website [6]

    The initial request was for two representatives to attend and SNBTS had also previously raised concerns about the time commitment involved. This concern was repeated and noted in the minutes of the SNBTS General issues meeting held on 13 February 2001 (SCGV0000095_188). I am not sure there was any great reluctance to allow SNBTS' participation and the minute of the meeting on 13 February 2001 (SCGV0000095_188) does confirm that the Minister and SNBTS subsequently confirmed they were content for Dr Peter Foster (SNBTS) to attend the Tribunal. The Tribunal report confirms he attended in person.

Section 5: Internal Review

Q21. Please describe your involvement in the investigation and preparation of the Scottish Executive report ('the Report') published in October 2000 titled 'Hepatitis C and Heat Treatment of Blood Products for Haemophiliacs in the Mid 1980s'. Please include a description of:

[6] (https://www.sehd.scot.nhs.uk/mels1999_49.pdf)

(a) your role, if any, in determining the scope of the report's investigation;

21.1(a) I did not have a role in determining the scope of the report's investigation. My understanding is that this was based on the discussions at the meeting Ms Deacon had with the Haemophilia Society on the 14 Sept. The follow up letter to the Haemophilia Society SCGV0000170_011 appears to confirm this.

(b) the extent and source of the documentation made available to those who carried out the investigation;

21.2(b) I did identify and request relevant files on the heat treatment of blood products from storage to assist in the investigation. (I would note that the files held by the Department would not necessarily contain details of information given to patients by their Drs). I did receive and examine the written submissions from individuals to identify the various issues being raised.

(c) any instructions you may have received from Ministers with regard to the scope and methodology of investigation.

21.3(c) See my response to 21a (Please note that the schedule shows document DHSC0006801_084 as dated 01/01/1999 but it is a follow up to Ms Deacon's meeting with the Haemophilia Society on 14/09/1999. The schedule also shows SCGV0000170.152 dated 23/09/1999 as an email from Karen Jackson to me but it addressed to Michael Palmer and appears to be a response to DHSC0006801_084 dated 17/09/1999).

Q21A. In your draft, you provide at paragraphs 21.1(a) - 21.3(c) your answers to subquestions 21(a), 21(b) and 21(c). Please answer the main body of Question 21, namely: "...describe your involvement in the investigation and preparation of the Scottish Executive report ('the Report') published in

October 2000 titled 'Hepatitis C and Heat Treatment of Blood Products for Haemophiliacs in the Mid 1980s'.

36A. I was not involved in the investigation or preparation of the Report published in October 2000 other than to provide the support indicated in my answers to 21a, 21(b), 21(c), 24 to 31.

Q22 The Inquiry understands that you and other members of the Scottish Executive Health and Community Care Department involved in writing the report met with clinicians on 1 September 1999 [PRSE0000976]. Please explain the purpose of this meeting.

22. The note of the meeting (PRSE0000978) shows that Dr Keel explained the purpose of the meeting was to clarify the validated information that would be needed for a briefing meeting with the Minister on 9 September ahead of her planned meeting with the Haemophilia Society on 14 September.

Q23 The Inquiry has seen a memo dated 8 September 1999 to the Minister which has as an appendix which sets out the preliminary conclusion drawn by the investigators [SCGV0000043_047]. Did you have any concerns that preliminary conclusions had been drawn so early on in the investigation process, and before there had been either a meeting with the Haemophilia Society, or detailed consideration of their allegations?

23. I note that the appendix to the memo SCGV0000043_047 dated 8 September talks about initial impressions following preliminary investigation ahead of the meeting with the Haemophilia Society rather than a preliminary conclusion drawn by the investigators. They were therefore not fixed and there was scope for them to change.

Q24 **The Inquiry understands that those involved in the investigation and in writing the report did not meet with the patients who were making the allegations about their treatment that were being investigated. Please explain the rationale for this decision and set out how it was that you thought that their allegations could be investigated without such a meeting.**

Q25 **Please set out the steps that you or to your knowledge others involved in the investigation took, to:**

a. Probe and test the evidence you received from clinicians and the SNBTS about the matters being investigated in the report.
b. Probe and evaluate the evidence you received from patients about the matters being investigated in the report.

Q26 **On 14th January 2000 you attended a progress meeting and subsequently drafted the note shown in SCGV0000170_078.**

a. Why was it considered necessary to keep the DH(E) informed of the process (paragraph 3)?
b. Please describe, to the best of your recollection, how the remit outlined in paragraph 4 was arrived at. In particular, why was a window of 1985 to 1987 selected for review?

Q27. **What consideration was given during the internal review to the fact that the Haemophilia Centre Directors had indicated that they were concerned about possible litigation [SCGV0000171_077]? Did this impact on the way in which their evidence was viewed by the investigators?**

Q28. **What impact did the advice that you received from the solicitors that documents and photos etc may be later**

produced in court litigation, have on the investigation? SCGV0000170_079

Q29 Was the internal review conducted to silence calls for a full public inquiry? Please explain your answer. Document SCGV0000170_071 may be of assistance.

Q30. Please explain why there was a delay in publishing the report and its findings (You may wish to refer to documents HSOC0020454, HSOC0020387_012, SCGV0000172_059, SCGV0000172_047, SCGV0000172_039, SCGV0000172_025, SCGV0000172_026 and SCGV0000173_122).

Q31 Why did you understand it to have been suggested that the Report could be released "under the cover of all the interest re: fuel protests" (SCGV0000172_039)?

24 -31 (Answer to questions 24. to 31). Christine Dora led on the investigation and writing of the report and is therefore best placed to answer these questions. Ms Dora worked part time (I can't remember her working pattern) and in her absence on annual leave and non-working days I was asked to draft briefing notes, answer queries etc. I did this based on the information available to me and by consulting others as appropriate and clearing information with Dr Keel and other senior colleagues. Most of the requests occurred towards the end of the process and I did get involved in the arrangements for the web publication of the report. I have no recollection of any suggestion that the review was conducted to silence calls for a public inquiry. Please also see my answer to Question 36.

Q32 What was Professor Mike Greaves' role in the report? [SCGV0000174_078, SCGV0000172_049 (p.4), SCGV0000172_054, SCGV0000174_027, SCGV0000175_039 (p.5)].

Q33 Did you have any role in the decision to commission his involvement? If so,

a. What was your role? What was your understanding of the reasons for his involvement?

b. What was the purpose of his involvement?

c. Was Professor Greaves considered to be independent of SEHD? If so, on what basis?

32. and 33. I do not recall having had a specific role in the decision to commission the involvement of Professor Greaves. The papers show I did obtain a copy of his biography.

Q34 Following publication of the Report on 24th October 2000, concerns were raised by the Haemophilia Society and campaigners that it was too limited in scope and that conclusions were reached without taking into account the evidence provided by those infected [HSOC0011980, HSOC0012017, SCGV0000180_084, HSOC0011976 and SCGV0000173_031]. Please describe what immediate action the SEHD took in response to these criticisms.

Q35 Please explain your understanding as to why the report itself was undertaken by the Scottish Executive rather than an external independent body. Was any consideration given to the idea that the report should be completed by an independent body? you may find PRSE0001404 and MACK0002371_002 of assistance.

34. and 35. Please see my answer to questions 23 to 31.

Q36 Ms Deacon gave evidence to the inquiry on 29 July 2022, in which she stated that she considered this report to be the first step in a process of trying to shine light on what had

happened. Was this a view shared by you, or to your knowledge, by others?

36. I believed it was a genuine exercise to clarify and explain the circumstances.

Q36A In your draft, you state at paragraph 36, 'I believed it was a genuine exercise to clarify and explain the circumstances.' Please expand upon your answer to Question 36, namely whether you shared the view of Ms Deacon that the report published on 24 October 2000 was the 'first step in a process of trying to shine light on what had happened'.

36A. Paragraph 4 of Michael Palmer's briefing document SCGV0000043_047 of 8 September 1999 states previous examination of the Society's case had been conducted in 1996 and 1998. This would suggest the internal review was not the first step. Michael Palmer may have further details of what was involved in the previous examinations. Ms Dora, who conducted the internal review may be best placed to give a view on whether it was considered, at that time, to be the first step in a process to shine a light on what had happened

Section 6: Calls for a public inquiry

Q37 On 5 April 2002, you were copied in to an email sent by Bob Stock to the health ministers [SCGV0000175_018] which outlined parliamentary pressures that the Department of Health England were facing to hold a public inquiry. The email states that consideration for a 'lesser status enquiry' (sic) was being given (internal or independent external). In what way did parliamentary pressures in Westminster impact on the Scottish Executive's response to calls for a public inquiry (document ARCH0001907 is provided for background);

37. I am not sure that the pressures on the Department of Health impacted on the Scottish Executive's decision not to hold a public inquiry but rather that it was based on an understanding of the position in Scotland. SCGV0000175_018 shows that the Health and Community Care Committee had rejected a petition calling for a public inquiry and the outcome of the Ross Committee work was awaited.

Q38 The campaign for a public inquiry gathered pace in Autumn 2003 [HSOC0015032_005, HSOC0029317 and SCGV0001116_087]. Bob Stock prepared the note shown in SCGV0000043_015, which was later modified by you SCGV0000044_043.

a. Please outline what investigation, analysis or enquiries were undertaken for your department to remain "yet to be convinced that anyone acted wrongly in the light of the facts that were available to them at the time".

b. On what basis was it decided that: (i) a public inquiry would "achieve little" in addressing the situation of affected people; (ii) it was unlikely that lessons could be learned? Document SCGV0000262_206 may assist you in answering these questions.

c. Please explain why the threshold for holding an inquiry was said to be "either a deliberate intention on the part of officials or NHS staff to act in a way that was recognised as not being in the interests of patients, or they acted irresponsibly in a way that was against patients' interests"? Where was this threshold for establishing an inquiry obtained from?

d. To what extent was consideration given to the fact that such evidence may only be obtained in the course of an inquiry?

38. The modification to the Brix note SCGV0000043_015 undertaken by me reflected the updated position e.g. the conclusion of the investigation by Association

of Chief Police Officers in Scotland (ACPOS) and subsequent correspondence from the Haemophilia Society. Bob Stock may be best placed to provide additional comment on the initial BRIX note and the discussion that took place with others to agree the position adopted. I note, however, in relation to question 38a item 2.2 of document SCGV0000098_166 does record investigation, enquiries and analysis involving SNBTS and Sols office. Please see my answer to Question 42.

Q39 On or around 8th October 2003, Minister of Health Malcolm Chisholm and Bob Stock attended a meeting with Philip Dolan of the Scottish Haemophilia Forum also attended by Frank Maguire of Thompsons solicitors [SCGV0000262_120 and HSOC0029318].

a. Did you attend this meeting? If so, please outline, to the best of your recollection, what discussions took place in respect of calls for a public inquiry. Why was the meeting considered 'gruelling'?
b. Did you share Bob Stock's view that there was 'no logical basis' for holding a public inquiry [SCGV0000262_119]?

39. I do not think I attended this meeting or at least have no recollection of being in attendance and am therefore unable to comment on the discussions that took place. Bob Stock would be best placed to provide advice on this.

Q40 Document SCGV0000098_166 contains minutes drafted by you of a meeting you attended with members of SNBTS on 11 November 2003. Did you agree with Bob Stock's view at paragraph 2.2, that it was fundamental that any inquiry should only proceed on the basis that it would provide new information. Why was it considered unlikely that an inquiry would find anything new?

40. I believe Bob Stock based this comment on the evidence available to him and also the findings of the recent investigation, enquiries and analysis undertaken in

response to the motions in the Scottish Parliament by Brian Adam MSP and Christine Grahame MSP calling for a Public Inquiry. Please see my answer to Question 42.

Q41. Documents MACK0000600, SCGV0000193_190, SCGV0000193_092 and SCGV0000193_080 are letters from you to campaigners seeking a public inquiry. Please outline where you sourced the factual information contained in your responses, in particular, whether it was sourced from established 'lines'? In reference to the sentence "he [Malcolm Chisholm] has stated that he is prepared to consider any new evidence which may emerge", what, in your opinion, would have constituted new evidence?

41. The responses to the campaigners will have reflected the Department's position at that time. It did also involve a review of the findings of the Irish Tribunal in order to provide an extract of the findings to clarify the different situation in Ireland. I believe that the position adopted in the Brix note SCGV000043_015 will have been developed following investigation, enquiries and analysis involving SNBTS and Sols office and I am not sure there is anything I can usefully add to this.

Q42 On 24th March 2005, the Health and Community Care Committee invited the then Minister of Health Andy Kerr to attend their next meeting to discuss the issue of a public inquiry. You emailed a draft response letter and written evidence shown in SCGV0000263_097. Please outline what investigation, analysis or enquiries were undertaken to compile this written evidence. To what extent were established lines used?

42. The briefing provided in SCGV0000263_097 would be based on my understanding of the Department's position and would have been drafted following discussion with and contributions from the various divisions and senior colleagues. I don't have anything further I can usefully add to the information contained in the briefing note.

Q43 To what extent did financial implications, both in terms of the cost of a public inquiry and the potential for compensation to victims, influence the department's advice to Ministers on holding a public inquiry?

Q44 To what extent, if any, did the establishment and findings of inquiries in other countries, such as Canada, France and Ireland, influence your advice to Ministers on holding a public inquiry.

43 and 44. I believe that the advice was based on the situation in Scotland and the evidence available at that time rather than the cost and findings of inquiries in other countries. See my answer to question 42.

Q45 This Inquiry has heard evidence from campaigners and former Secretary of State for Health, Lord Norman Fowler [INQY1000144 and INQY1000145] that the Government should have established a UK-wide public inquiry before now. Please set out your present view on this.

45. I would have thought that if the conditions/reasons for establishing the Penrose Inquiry were also applicable/relevant to other parts of the UK then perhaps it would have been appropriate for a UK wide inquiry at that time.

Section 7: Work done on financial products

Q46 What actions did you, and to your knowledge others in the department, take to investigate access to financial products (including mortgages and insurance) for those infected with HCV via blood and blood products.

46. In response to a Health and Community Care Committee report a meeting was set up with Financial Institutions on 9 December 2002 to discuss

how mortgage and insurance services might be improved for people suffering from Hepatitis C.

Q47 What was the outcome of those investigations? You may find SCGV0000254_019, SCGV0000254_054, SCGV0000193_147, SCGV0000254_078 and DHSC5541441 of assistance.

47. The Minutes of the meeting DHSC5541441 record that the meeting had been useful although Mr Dolan had some concerns that discrimination would continue. Contact details for the representatives from the ABI and CML were shared and they confirmed they would be happy to discuss any further questions Mr Dolan and the Hep C Forum might wish to discuss with them at a later date. SCGV000254_019 and SCGV0000193_147 follow up on subsequent concerns raised by Mr Dolan. SCGV0000193_147 shows ABI consultation document on best practice on HIV was shared with interested parties.

Section 8: Steps taken to assist people in finding their medical records

Q48 Please set out the role you played in assisting people in obtaining their medical records, and circumstances in which this arose. You may find SCGV0000195_007, SCGV0000195_096 and SCGV0000195_087 of assistance.

48. The documents provided show that Malcolm Chisholm had offered assistance for those having difficulty obtaining their medical records and that this offer was repeated on 28 May. My contact details were provided and the notes and correspondence show that four people contacted the department and that I made enquiries on their behalf and that the issues were resolved.

Section 9: Other

Q49 Please provide any further comment that you wish to provide about matters of relevance to the Inquiry's Terms of Reference.

49. The Inquiry may already have the relevant files with this information but would mention that while researching/reviewing old files for information to assist in the drafting of responses to correspondence I did come across:
- a communication from DH(E) asking whether Scotland wanted to be included in a contract for the supply of products from the US. Scotland declined; and
- an old newspaper article which featured an MP talking about the need for the development of a home treatment product for people with haemophilia.
Sorry I don't recall the dates of these documents.

Statement of Truth

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

Signed ___GRO-C_____

Dated ___2/12/2022_____

Table of exhibits:

Date	Notes/ Description	Exhibit number
2003	Health Department Letter (HDL)	WITN3530052
Undated	Screen shots showing advice issued between 1998 and 2005	WITN7295002