(2.15 pm)
SIR BRIAN LANGSTAFF: Mr Bradley, you have five more minutes if you wish. That's the time which we are allotting you because we have a charity to come, and you have very generously offered the Inquiry a fuller statement of what you would have wished to say, but what you have to say will of course be circulated to all Core Participants for them to see too. So, although you are not here necessarily to cover it all, because of time it will be covered and they may comment on it if they wish, in due course. But, by all means, please come and finish.
MR BRADLEY: Many thanks, Sir Brian, I will use my best endeavours to limit myself to the five minutes concerned. I am going to return to the elephant in the room, the pharmaceutical companies. I will provide a full copy of my opening statement that includes details of the batch numbers, the dates upon which patients received the infected product and the fact that that product caused infections in the United Kingdom, to your Inquiry.
Arising from that particular situation -- which is extremely tragic and, as I indicated, in Canada was the subject matter subsequently of a matter of a criminal investigation -- the Society wishes to ascertain as to



whether the Inquiry intends to investigate the pharmaceutical companies to the utmost extent of its statutory powers. In that regard, there are powers that are available to this Inquiry that can be utilised in the United States and, more particularly, a federal judicial assistant statute, section 178.2, that allows an Inquiry -- or allows an Inquiry to seek documentation or what was termed in the United States "a foreign international tribunal".
That documentation is held in relation to pharmaceutical companies in multi-district litigation depositories.
Those litigation depositories resulted from claims that were advanced in the United States where as a result of those claims, copies of the discovery documentation was lodged in such depositories. On behalf of my clients, we seek to ascertain as to whether your Inquiry will seek access to such documentation available from the depositories, and available elsewhere, from work that has been undertaken by the Krever Inquiry and, indeed, the Royal Canadian Mounted Police.
I also wish to refer to the issue of Scotland. The Haemophilia Society has many members in Scotland and we wish to endorse and support the opening statement of



Haemophilia Scotland. I don't intend to go into that issue in any further detail here.
My clients, the Haemophilia Society, as I indicated are a charity, who have represented people with haemophilia for more than 68 years. As a practitioner, who for a large part of my career have looked after the interests of people with haemophilia, I have to say I am struck by the angst that exists within the UK community. We know what a jurisdiction, in which I have been involved on behalf of people who have haemophilia, and I have a working knowledge of Canada, the United States, Japan and New Zealand arising from contamination of blood and blood products has such a disharmonious situation existed.
I believe the significant passage of time that occurred, from the date of initial infection to the date of this Inquiry, where people were required to exist on subsistence-type payments has created such anxieties. I would hope, for the sake of the haemophilia community who I have had the privilege of representing, that those persons will be reconciled and that this public Inquiry and your work will assist in that purpose.
I note in my own jurisdiction that schemes for compensation have been provided. Life assurance mortgage protection, travel insurance and priority in



terms of healthcare benefits. That situation has allowed people to achieve some degree of closure.
In Ireland, people are entitled, like you, to assessment after compensation entitlements on a full liability basis, where individual assessment is provided by a specially established compensation tribunal pursuant to statute.
A further extension of that statute scheme occurred in 2006 and provided the mortgage protection life insurance and travel insurance. Priority healthcare exists. People have a card that allows them to get priority because the system injured them.
In contrast, in the United Kingdom, people in identical circumstances, who have suffered equal injustice, have been left to die in poverty, without dignity and without knowing why they were infected or dying. That is wrong. That needs to be addressed.
My clients say to government, and indeed to previous governments they have said it, "You ought to hang your head in shame for failing your own vulnerable citizens and our members in their greatest hour of need".
The Society believes that you have the power, Mr Chairperson, to make interim recommendations and it is now necessary for this Inquiry to make interim recommendations to alleviate basic financial hardship

and to commence the process of addressing compensation, and ensure the provision of healthcare entitlements. Nothing less is adequate. Delays are no longer tolerable. Thank you very much for your time.

SIR BRIAN LANGSTAFF: Thank you very much, Mr Bradley. We now have the opening statement by Samantha May on behalf of the Hepatitis C Trust.

Opening statement by SAMANTHA MAY

MS MAY: The Hepatitis C Trust is the only dedicated UK charity for people affected by Hepatitis C. The majority of us, myself included, have had Hepatitis C ourselves.

We were formed over 17 years ago because a group of patients, led by our former CEO, Charles Gore, were outraged at the lack of support, information and representation for people with Hep C and wanted to make it better for others.

Over the years, we have expanded beyond those core aims and now also provide a wide range of services and projects run by staff and volunteers, to raise awareness and to support vulnerable groups to get tested and treated, whilst always ensuring that Hep C stays firmly on the government's and policymaker's agenda; all of this contributing towards helping things to be better for everyone with this illness and getting the



undiagnosed diagnosed in whatever ways we can. This is in line with our ultimate goal of eliminating Hep C in the UK by 2030.

My role at the Trust for the best part of 15 years has been specifically to provide a national helpline for people infected and affected by Hepatitis C. We also provide information to the general public, employers, medics, drug services and more, and have taken more than 42,000 calls. Of those, around 4,000 contacts have been specifically from those who have been infected, affected or had concerns about blood and blood products.

We know that there are thousands of people no longer with us who should have been here to have their voice heard in this Inquiry and many more who are simply too ill to take part now that it is finally underway. And from what we have heard over the years, there are many more who have died who were never diagnosed and so therefore cannot be included.

I would like to take this opportunity to pay a personal tribute and give a voice to just one of them. Annie Walker from Norwich, who did so much to help me when I was first diagnosed back in 2002, just six months after she had been diagnosed herself -- although I didn't know that at the time, she already seemed like an old hand at it all. Knowing that I was not alone and



that I could talk freely to someone meant so much to me at the time.

Annie received infected blood aged 19 and later endured several difficult treatments over the years, but still had to undergo a liver transplant as a result of the liver damage that the Hep C had caused.

Unfortunately, she still went on to develop cancer after that and died in early 2016, aged 62. She did so much to support people and, despite her very difficult personal situation, had always campaigned long and hard specifically on infected blood issues and GP awareness right until the end.

But, despite her anger and frustration with it all, she managed all of that with intelligence, kindness and humour. It is a great shame that she was not here today to see the day of this Inquiry finally arrive, so she could have her say.

The last news she heard on the subject was the government's apology in March 2015. A close friend was with her at the time and said he will never forget the look of disappointment on her face. What she wanted was not an apology, but justice for everyone that had been affected.

Being diagnosed with any serious potentially life-threatening illness is devastating. What we have heard



from our callers is that it feels like life stops when they hear their diagnosis. Fears about how long they will have to live, how it will affect them and the people they care about, worries about transmission to others, tests, treatments, operations and possible death is overwhelming.

And the majority of those just diagnosed with Hep C will have no idea what it is or even if they do a little bit, they often get it confused with other illnesses. Unfortunately, often the person diagnosing them doesn't know much about it either. Most people are given no information or, possibly worse, misinformation. They are sometimes treated judgmentally, personal questions are asked about their lifestyle and how they could have got it and, although there are many ways that blood to blood transmission can occur, the suspicion will often be that it was due to intravenous drug use. This is of course a very high route of transmission, but it is not the only one.

And those infected with Hep C alone are often told -- wrongly, except in very particular circumstances -- that it is sexually transmitted and that there is an urgent need for their partner to be tested, and because that information is often relayed by a doctor, they believe it and that mistaken belief will

often greatly affect their personal relationships.

Then, most likely much later after their diagnosis, those who have received infected blood and blood products on the NHS will discover that in fact it could perhaps have been avoided entirely, or if it couldn't, that they should have at least found out about it a whole lot sooner, before the possibility of serious consequences from it arose.

When we talk to people and hear their stories we can take the time to ask pertinent questions. It is very often sad that, as they start to reflect, that over the years, often decades, they have perhaps only been only half the person they could have been and should have been because all those vague and often intermittent early symptoms they have been experiencing, feeling run down, digestive problems, brain fog, general aches and pains, low mood, depression, poor sleep, too much sleep, meant that they were misdiagnosed with a whole bunch of other things or labelled a hypochondriac. But they had actually been having that go on for so long they thought it was just simply just the way they were: busy, stressful lives; working too much; getting older; menopause; other health conditions.

But all that could have been avoided or at least made somewhat better if only they and their doctors had



known they were at risk of receiving infected blood and they had been offered a test decades ago.

Unfortunately for many, finding out too late left people with perhaps no option for treatment or lifestyle changes to slow down or prevent the devastating potential problems having Hepatitis C can cause, along with all the other illnesses it can make them more prone to developing.

And they could have had the chance to take steps to reduce the possibility, however small, of onward transmission.

As if all this isn't enough to deal with, some of them may then find out a few months later, after their initial diagnosis, after more tests, more waiting, more results and probably more confusing info, that aside from Hepatitis C, they have also developed cirrhosis or possibly even liver cancer.

And of course, there's not a single one of us who has lived with this illness who has not felt the absolute terror that they may have given it to someone else inadvertently during the time they were undiagnosed.

They may start to tell people about it, if indeed they're brave enough, as so many people feel so stigmatised they are simply too frightened to talk to



others. Then they realise that may be some people at least start to look at them a bit differently or stop seeing them so often, or don't let their kids come over to stay or eat at their house again. Dentists or medics may treat them differently. Their employer may overreact and panic about potential, but unfounded threats to the safety of their fellow staff or customers. They may get sacked or their contract is not renewed or they get put, totally unnecessarily, on to other duties.

Sometimes even their own family turns their back on them and takes their kids away with them, all due to ignorance about transmission.

At some point, hopefully -- but not always, as many people are unaware of this -- they find out that they are eligible to claim for financial assistance from the government that has been made available to help support them because of the effects of this illness and the older treatments for it. And so, they try to find the records to support their claim, an onerous task at a time when they are already feeling greatly affected by this illness. Many don't feel they can go ahead and claim for this reason, and we have also spoken to some who are simply too ashamed to even contemplate claiming.

But if they do go ahead, they're likely to find



they're not there. They have been routinely destroyed; they're incomplete; there's some before they received blood or blood products and some after, but not for them. Sorry, the hospital's closed, been burnt down, they're lost. Or maybe there weren't even notes there in the first place, or has something else happened to them?

Because it's usually taken 10, 20, 30, 40 or even more years to diagnose them, all of these things are much more likely to have happened, so then they find they are not actually going to be eligible for that help, anyway.

At the Trust, we do all that we can to properly inform, support, advocate and help everyone to navigate all these problems and many others. The Inquiry team has already started to hear personal stories from people across the UK in preparation for the start of this Inquiry. We have been hearing them continually week in and week out since we started.

As a Core Participant, we look forward to working closely with the Inquiry team to see how best we can support them and we'll make sure all the issues we have heard about from our callers are represented during the course of this Inquiry. They are typically people who are over 50, 60, 70 and even a few over 80s, many of

whom are just getting diagnosed now. And perhaps, naturally, they think it is something they must have caught relatively recently. But often, when we start to talk to them, it becomes obvious that the most likely cause of infection for many of them is receiving blood or blood products following accidents, during operations, childbirth or for specific health conditions many decades ago, going back to the late 60s.

At last, for all the groups represented in this Inquiry, it is an opportunity for all the evidence given by everyone affected to provide a road map to the answers for the many questions people have been campaigning about over the last three decades. Explanations of what happened, acknowledgement of what went wrong, accountability.

And we very much hope that it will provide some sort of justice, closure and healing by finally giving the proper and undivided attention and exploration that all of the questions that have been raised in the terms of reference by the people directly affected so rightly deserve.

And we would fully expect that the learning that comes from this Inquiry will help to inform and prevent any similar tragedy from occurring in the future.

And lastly, we very much hope during the Inquiry



that the public profile of this illness is raised and that anyone who has potentially been at risk from Hep C from the infected blood from the NHS before September 1991 goes and get gets tested, and also that a concerted effort is made to find them.

Because if all the people who have been at risk of Hep C can be identified quickly, with the new oral treatments that are available, that have a success rate of over 97 per cent, then they can be spared from these many and varied and problems that this illness causes. Most importantly, perhaps their lives can be saved.

Thank you.

SIR BRIAN LANGSTAFF: Thank you to The Hepatitis C Trust.

The next opening statement is from the Department of Health, Eleanor Grey Queen's Counsel. I ask you to listen to her with the same respect that you have shown to all other speakers.

Opening statement by ELEANOR GREY QC

MS GREY: Sir Brian, thank you for this opportunity to address this Inquiry, its Core Participants and all those affected by its important and sensitive work.

As you know, I represent the Department of Health and Social Care, as it is now called, and its predecessors over the years that your Inquiry will be examining.



Can I say on the department's behalf at the very beginning of these short remarks that we welcome this public Inquiry and that we are committed to cooperating with it and assisting it to the best of our ability to fulfil its terms of reference, every aspect of them.

The Prime Minister, when she first announced the establishment of an Inquiry, back in 2017, spoke of "an appalling tragedy which should never have happened". Your sponsoring minister, Mr Lidington, later stated:

"The infected blood scandal of the 1970s and 1980s is a tragedy that should never have happened."

Those are words from government ministers. However sincere they are, they cannot convey or comprehend the full knowledge and experience of those directly affected by the events that you are charged with investigating. But, on behalf of my clients, I do say that those words, the acceptance that this should not have happened, is an acceptance that things went wrong. Things happened that should not have happened and so, on behalf of my clients, I say, unreservedly, that we are sorry. We are sorry that this should be so, that this happened when it should not have done.

This is the beginning of a journey to uncover exactly what happened and why, but from those I represent it begins with an expression of sorrow and



regret.

Sir Brian, over the last two and a half days we have listened and we have heard the powerful and moving voices of some of those who have actually lived through tragedy, have experienced infection and its devastating effects upon their families and loved ones. The infected and the affected, to use the language of your counsel to the Inquiry.

Together with those in this hall, I and members of the team from the Department of Health and Social Care have heard individuals and their representatives speak of the truly horrendous wrongs that have "been visited upon us", to use the words of one of the Core Participants who spoke yesterday. We will continue to listen and to reflect upon those experiences, as you fulfil your promises to put the infected and the affected at the heart of this Inquiry.

We will convey back to those I represent the words, the emotions and the aspirations for this Inquiry of those who have been heard in this hearing room.

Now, we have heard many points, not only about what has happened, but about continuing or current steps that are needed and we will reflect upon them as your work continues.

The establishment of this Inquiry and the approval

by The Cabinet Office of its wide terms of reference represents a commitment. It is a commitment to ensuring that those infected and those affected are given full and truthful answers to questions that they have been asking for decades. It is a commitment to investigating and making findings upon issues of responsibility, individual responsibilities as well as organisational and systemic failures. It is a commitment to seeking to ensure that something similar never happens again. So, I should say this clearly: those I represent understand and will seek to support this Inquiry in achieving those objectives.

I will come back to that, but, first, can I just briefly return to the subject of who I represent. I mentioned the Department of Health and Social Care and its predecessor bodies. That includes, for present purposes, the representation of those organisations or bodies for which the department was responsible over the years, such as the Medicines and Healthcare Products Regulatory Agency, or MHRA, as well as individuals who worked for them.

Now, you, Sir, will appreciate the formulation I have just given is somewhat broad, perhaps even ill-defined at the moment. The breadth of the department's responsibilities has altered over the years



and that's reflected in the fact that the Welsh and Northern Ireland Governments have separate representation before you, for example, while some NHS bodies, regional health authorities for example, no longer exist.

What we wish to ensure is that there are no gaps in the coverage and reach of this Inquiry. In particular, we are committed to assisting you in ensuring that the Inquiry has full knowledge of and can exercise its statutory rights of access to all relevant repositories of documents and can gather further written and oral evidence from those who are able and available to assist you.

So, we will look at those who we represent and whether there are any gaps in coverage as the Inquiry progresses and take action as needed.

The Inquiry is, of course, independent of government, including of the Department of Health and Social Care. As Core Participants, we therefore stand on an equal footing with other Core Participants.

Sir Brian, it would be foolish of me to ignore or not to mention the fact that many of those who have suffered contamination with infected blood or blood products. Their affected families and friends do not trust the Department of Health or individuals who have



worked in it over the years. There have been eloquent statements about breaches of trust experienced as well as many reminders of what may at worst have been a cover-up or, at best, a lack of candour about past events.

There has been repeated mention of the destruction of documents, both government papers and medical records.

Now, standing here today, I do not seek to comment upon or to respond to those statements or to that legacy of distress and distrust. That will be a process over the months that follows these hearings as your Inquiry investigates these matters.

But two points, if I may, in response to the fears or the distrust which has been expressed of those whom I represent, and my two points are about the conduct of this Inquiry.

First, as I have already said, of course, you and your team are of course independent, with no links to any particular actors or interest groups in this long running tragedy and you will act, we know, with scrupulous impartiality in conducting your investigation into these matters.

You have already made that quite clear in your own opening address to its Core Participants and all those



who attended the Inquiry on Monday.

But, secondly, Sir, as I have stated, we are committed to assisting you to fulfilling the terms of reference in all their breadth, including, for example, your investigation of the issues of candour, openness and cover-up.

It will be the task of my legal team, as well as those who are supporting it behind the scenes, to ensure that our actions reflect that commitment. We wish to ensure that with time and with experience this commitment cannot be dismissed as mere empty words, but can be seen to be demonstrated in the engagement and in the learning of the Department of Health and Social Care, and its staff and its representatives in this Inquiry.

You and your team, Sir Brian, are entitled to look to us to fulfil that promise over the coming months.

Now, I am sure that at times this process will not be straightforward and there will be differences of perspectives and diverging views, strongly held views, between Core Participants. One of the roles of any Core Participant, and its legal team, if it has one, is to show the Inquiry how issues were perceived by those participants at the relevant time, in the light of the information which was known at the time, and that of

course includes enabling reflection on what could have been known with fuller Inquiry or what ought to have been known.

But perspectives about what was said or done in the past, or what is submitted about it now, are likely to differ, even to collide. But the important point here today, however, is the commitment of the team which I represent, together with our clients, to ensuring that the fullest possible picture is laid before you so that you can make findings upon it.

Now, this, we believe is necessary. It comes from our obligations to you as the Chair of a public Inquiry with full statutory powers, but just as important, it is also right. Right because it is the way to ensure that you can meet your terms of reference, right because it will enable you to give the infected and those affected the answers that they have been looking for, and right because there is an important public interest in the recommendations that you are empowered to make and in seeking to prevent future similar tragedies.

Now, Sir Brian, you will have heard it say, no doubt, even in the midst of appalling NHS treatment errors and mistakes, that the professionals involved did not intentionally seek to harm their patients. All but a very small minority, a tiny proportion of health



professionals are motivated by a desire to treat and to help.

Equally, although it may not be universally accepted, and speaking very generally, one of the motivations of those working for government, in government is public service.

Now, this Inquiry will put a mirror before many professional and government figures, and that mirror may reflect uncomfortable truths. With the assistance of Core Participants, we know that the Inquiry will explore the gap between those witnesses' aspirations or motivations and the reality of what happened to and what was experienced by the infected and the affected.

But I would ask for an appreciation of the fact that confronting, and acknowledging these gaps or realities, will be a difficult and painful experience for many witnesses. That is not a complaint. It is right and proper that it should take place, and nor am I seeking to make any comparison with the suffering of those affected or infected, which is on a different plain completely.

We would look to the Inquiry to create, by its conduct and its procedures, a space which enables learning and reflection by those it seeks to call to account.



Sir, I do not use the word "safe space", public inquiries are not safe or cosy places, and nor should they be, but a space to allow candid reflection.

I would hope that this objective of enabling learning and reflection through the conduct of this Inquiry will be shared by all Core Participants and that there will be cooperation in achieving this.

Now, over the summer, as you will know, we have been working on preliminary disclosure or information requests from the Inquiry, and to date we have delivered several thousand documents, but plainly that is a mere beginning.

We are committed to working with the Inquiry's own team and its representatives on the disclosure of documents, to ensure that there can be no questions or doubt about the completeness or the integrity of the documents supplied. We know that the Inquiry wants to see as fast a pace of delivery as is reasonably possible and that it wishes to see that the department keeps pace with the Inquiry's requests. The department is forming a dedicated team to deliver those commitments.

We look forward to working with you and your Inquiry team to deliver the disclosure that is required and to facilitating the participation by those from whom the Inquiry wishes to hear, whether by statements or in



person. This will require, of course as you would expect, a full review of documents held.

Recently you, Sir Brian, published a statement of intent upon the approach to disclosure and legal professional privilege, and you reminded bodies, such as those I represent, of the need to give careful consideration to the issue of waiving legal professional privilege in relation to past documents and events.

My clients will indeed do so, considering whether it is in the public interest to waive any such claims in the context of this vital Inquiry.

Sir, may I conclude by repeating the commitment of my clients, the Department of Health and Social Care, as well as the MHRA, to participating in your review as fully as possible so as to enable you to fulfil your terms of reference, both as rigorously and as expeditiously as possible.

We wish to work with the Inquiry to ensure that all those affected by its important work will conclude as a result of that work and your findings that justice has been secured.

Thank you very much.

SIR BRIAN LANGSTAFF: We will take tea after the next two presentations and before Mr Cory-Wright QC gives his address to you.

The next statement is from Alphy Maginness on behalf of organisations in Northern Ireland.

Opening statement by ALPHY MAGINNESS

MR MAGINNESS: Thank you, Chairman. Good afternoon, Sir Brian, good afternoon, ladies and gentlemen.

I can confirm I represent four bodies from Northern Ireland, the Department of Health in Northern Ireland, the Regional Health and Social Care Board, the Northern Ireland Blood Transfusion Service and the Belfast Health and Social Care Trust.

On behalf of those four bodies, I can say we welcome the establishment of this Inquiry and its extensive terms of reference. We, too, are conscious of the tragedies and the life changing impacts that have resulted from the use of contaminated blood and blood products. The people who have been infected or otherwise affected are entitled to know all those facts that can be established and to have the truth as soon as it can be delivered.

We hope that the Inquiry will be able to proceed expeditiously to its conclusion, appreciating of course that it must be afforded sufficient time to consider fully and thoroughly the vast volume of evidence that it will receive.

Three of these four bodies are Core Participants to



this Inquiry, and I wish to explain briefly the function and role of each.

Firstly, the Department of Health has overall responsibility for the provision of health and social care in Northern Ireland. All health and social care bodies are accountable to the department. The permanent secretary of the department is also the chief executive of health and social care in Northern Ireland.

The Regional Health and Social Care Board was established in April 2009 by the Northern Ireland Health and Social Care Reform Act, also of 2009. It is the successor of the Eastern Health and Social Services Board, which had operated from its establishment in 1972. That Eastern Board had management responsibility for the Blood Transfusion Service in Northern Ireland, from 1972 until April 1994. It was also responsible for haematology services within the local management area.

The Northern Ireland Blood Transfusion Service was established as a special agency in April 1994. As its title suggests, it has been responsible since then for the collection, testing and distribution to hospital blood banks of blood and blood products for the region.

The Inquiry will have received the agency's response to the rule 9 request, on 21 September, last Friday, confirming that work has commenced to locate, retrieve



and catalogue information for the Inquiry. Additional staffing has also been in put in place to complete this work.

The Belfast Health and Social Care Trust has applied for Core Participant status. It was established in April 2007 following a restructuring of health and social care in Northern Ireland. It retains responsibility for the Northern Ireland Haemophilia Centre at Belfast City Hospital and the Children's Haematology Unit at the Royal Belfast Hospital for Sick Children. It also has responsibility for the regional hepatology service and the HIV service for those affected secondary to transfusion of blood and its components.

The trust has also been in correspondence with the Inquiry and confirmed its commitment to supporting the Inquiry in an open and transparent manner.

Sir Brian, I can also confirm that each organisation is endeavouring to identify and collate relevant documents and records for the benefit of the Inquiry.

I can also reassure you that the relevant documents and records will be preserved for the duration of the Inquiry and, indeed, at your request, Sir Brian, the permanent secretary has written to all health and social care organisations reminding them of their requirement



to preserve documents and to waive any fees that may normally be charged for access to medical records in the case of infected and affected people who request such access for the purpose of providing evidence to this Inquiry.

One cannot fail, Sir, to be moved by the stories of courage, fortitude, dignity and perseverance that we have heard over the last few days from those infected or affected.

The Core Participants in Northern Ireland are fully aware of the terms of reference for the Inquiry, which are extensive and cover a lengthy period, in particular since 1970.

I can confirm to you, Sir, the Inquiry can expect the full cooperation of those Core Participants and we look forward to further engagement with the Inquiry and the Inquiry team.

That concludes the opening comments from the Northern Ireland Core Participants.

SIR BRIAN LANGSTAFF: There is an opening statement from the Welsh Health Service to be read by junior counsel to the Inquiry Katie Scott.

Opening statement from VAUGHAN GETHING (read)

MS SCOTT: My name is Katie Scott, I am one of the junior counsel to the Inquiry and I have a written statement by

Vaughan Gething, the Cabinet Secretary for Health and Social Services from the Welsh Government.

Having met and spent time with the individuals and families of those affected in Wales, their strength of feeling in favour of a UK wide public Inquiry into the circumstances surrounding their treatment with contaminated blood became apparent. The families seek closure and clarity about what has happened to them.

I am pleased that their call for such action has been listened to and that the Inquiry is now starting.

Sir Brian Langstaff has listened to the views from Wales, either through the consultation responses or in person, by meeting those affected, their families, Haemophilia Wales and our cross-party group at the Welsh Assembly. I am content with the proposed terms of reference for the Inquiry as these reflect the thoughts and wishes of people directly affected and the wider stakeholders that I and my officials have previously met.

I also support Sir Brian's proposal to establish expert groups to assist the Inquiry in gathering its evidence.

My officials will continue to support the Inquiry team as this important work gathers pace, to ensure that the voices of those affected in Wales are heard, and



that the survivors and their families feel assured that the Inquiry will take account of their evidence and provide answers to their questions and concerns. I look forward to receiving regular updates from the Inquiry team.

SIR BRIAN LANGSTAFF: As promised, there will now be a 20 minute break.

(3.05 pm)

(A short break)

(3.25 pm)

SIR BRIAN LANGSTAFF: The opening statement on behalf of NHS blood and transport Charles Cory-Wright Queen's Counsel.

Opening statement by CHARLIE CORY-WRIGHT

MR CORY-WRIGHT: Thank you, Sir Brian, and good afternoon, and good afternoon to those infected, those affected, to other Core Participants, and others here and interested in this Inquiry.

My name is Charlie Cory-Wright. I am representing the NHS blood and transplant.

I am a barrister instructed by Weightmans solicitors. At the moment, I am the only barrister instructed. That may change if it turns out that it is more cost effective to instruct anyone more junior as well.

I will explain more, in a moment, about NHS Blood



and Transplant and its place within the NHS.

NHS Blood and Transplant is an unwieldy and dangerous name and staff in the organisation generally refer to it as NHSBT. I am aware that initials can sometimes be annoying and confusing and sound like jargon, particularly when lots are being used, but I hope that using that shorter form today is sensible.

I am going to use the word "we" both for accuracy and for economy when describing NHSBT and its team for the Inquiry.

I should explain, first, what I propose to do in these 15 minutes. People are entitled to know about NHSBT, what it is and our role here, so I am going to do the following: I am going to make a few important preliminary remarks about this Inquiry and about NHSBT's approach to it.

Secondly, I'm going to say a little about NHS BT's history. That is important given the historical scope of this Inquiry and, thirdly, I am going to describe in a little more detail NHSBT's hopes for the Inquiry and what it aims to help achieve for everyone concerned.

It goes, we hope, without saying that NHSBT fully supports the Inquiry and all of its terms of reference. Our primary concern is for those who were given infected blood or infected blood products, and for their families



and others who have been affected by this. We do know that we can never truly understand the impact this has had on the infected, their families and loved ones. However, we do of course know that impact has been devastating. One only has to have paid attention to what has been said over the last three days to be aware of that.

We understand that our job is to provide the Inquiry team with all the help that we can in fulfilling its terms of reference. We will do whatever we can to assist the Inquiry in order that answers can be provided to the questions asked by those infected and those affected.

We will be open, constructive and honest. Our motivation is to get to the truth for those infected and affected to the best of our abilities. In that sense, we share -- we hope -- the same approach as the Inquiry itself.

Indeed, we understand that this Inquiry is above all things a search after truth, the unvarnished truth about all of the many disquieting things that we have been hearing about over the last three days. We do get it. That if the Inquiry is able to do that job properly, then that is likely to include the uncovering of facts that are seriously unpalatable.

Whatever those truths may be, we want to say, loud and clear at the outset, that we too are very sorry for what happened to all those infected, all those affected, all who are victims.

We also understand that actions speak louder than words. We hope that we are demonstrating that in our cooperation with the Inquiry, both thus far and as it continues, as well as in terms of the safety measures we now apply in screening protocols and the like, which I will outline in a moment.

We do understand and embrace the need for the Inquiry to apply current clinical science, and current standards and norms, to its scrutiny of what went wrong. It is only by doing that the lessons that need to be learnt will be clear.

Finally in this introductory section, I hope I can help by mentioning this morning's invitation by Steven Snowden QC, who raised Bishop James Jones's six point charter for public bodies and invited those here involved to sign up to that charter.

That question having been raised, NHSBT has considered the charter and its six points. We do not see those six points as any different to the commitment that we were already making to the Inquiry and, in those circumstances, NHSBT confirms its intention to be guided



by and to strive to follow those principles.

I should explain who has been here this week from NHSBT. On Monday, at the commemoration and opening of the Inquiry there were Dr Gail Miflin, NHSBT medical and research director, and Roy Griffins, one of our longest standing non-executive directors. Yesterday, there were Millie Banerjee, the Chair of NHSBT, and Sally Johnson, our interim chief executive and Dr Miflin, again.

Today, there are Dr Sheila MacLennan, a very senior consultant at NHSBT, who is also the Chair of the Joint United Kingdom Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee, a mouthful, which I will shall refer to further down the line as JPAC, and Professor David Roberts, who is also a longstanding senior consultant and associate medical director at NHSBT.

So, what is NHSBT?

Well, it is, as you have heard, one of the four blood services, each dealing with a different part of the UK, involved as Core Participants in this Inquiry. It is, as such, an NHS body involved in the provision of blood to others for the treatment by clinicians of patients who require that. NHSBT is an independent, formally described as an executive arm's length body of



the Department of Health and Social Care, technically constituted as a special health authority. That all sounds quite complex, but essentially we are not a government department and we are not part of one.

We do work closely with the UK Government and the Department of Health and Social Care, and are accountable through our chief executive to them and, ultimately, to the Secretary of State. I should add that NHSBT is not to be equated with the NHS as a whole or indeed to be treated as some way representing the NHS as a whole. NHSBT's role as described just now clearly justifies its status as a Core Participant in this Inquiry.

But if other NHS bodies ought to be involved, no doubt they will be. We all heard on Monday that the Inquiry is considering involving other such bodies and that is obviously a developing picture.

Its history briefly. NHSBT was established in 2005 when the National Blood Authority and UK Transplant merged with the responsibility to provide a blood and transplantation service to the NHS. We initially provided a blood service to England and to North Wales but that changed to England alone in May 2016 when the All Wales Blood Service was formed.

Providing a blood service includes the recruitment



of blood donors and collection testing and manufacturing of blood components which we then deliver to hospitals in the NHS. We have always been responsible for organ donation and transplantation services to the whole of the UK. We also manage the donation, storage and transplantation of tissues and stem cells.

Of particular relevance are our responsibilities to encourage people to donate organs, blood and tissue, to optimise the safety and supply of blood, organs, stem cells and tissue, to help raise the quality effectiveness and clinical outcomes of blood and transplant services, to provide expert evidence to other NHS organisations and the four UK health departments, to commission and conduct research and development, to improve outcomes for patients and to implement relevant EU statutory frameworks and guidance.

Now, as I have already said, the history of the organisation is important given the historical scope of the Inquiry. Although NHSBT itself has only existed since 2005, there have obviously been a number of predecessor bodies, many of which no longer exist. The precise family tree is complicated and we are going to provide the diagram to the Inquiry showing the family tree so that all can see clearly how this works, but for present purposes we hope it is enough to say that we

recognise that we will be speaking for and providing documentation in place of those defunct predecessor bodies in regard to the Inquiry.

To this end, we'll provide information to the Inquiry relating to the National Blood Authority which was formed in 93, itself formed by a combination of earlier bodies with equivalent responsibilities.

I have referred to JPAC already. That is the professional advisory committee that deals with this. It is not a legal entity in itself. It now lies under the governance of NHSBT and we will be ensuring that its documents too and those relating to its predecessor bodies are made available to the Inquiry.

Our role in the Inquiry. We have already had a good and cooperative dialogue with the Inquiry team about such obvious and highly important matters as the location and disclosure of relevant documentation, a very significant exercise for all concerned.

We have suggested cooperation between us and the Inquiry team in the task of searching, both by computer and manually, the extensive archive now available. We are planning an event for Core Participants including those infected and those affected to demonstrate how blood services have changed beyond recognition since the 1970s and 80s, both in our policy making, particularly



around who is allowed to donate, of which more in a moment, but also in the technology and processes used for testing and manufacturing blood components.

We also invited the Inquiry team to visit any part of our organisation to show how modern blood testing and manufacturing is now performed. We are glad to hear the Inquiry is keen to take us up on this invitation.

I'd like to say something now about NHSBT's relationship with the public. The first thing to say is that we are of course extremely grateful to all those who become blood donors and we thank them for their continued support and commitment to our blood service. The NHS could not run, as it currently does, without them. They are everyday heroes in what they do to save and improve other people's lives.

Next a number of things about the need to maintain the trust of all members of the public in the blood services we provide. We recognise how important this is. We would hope that all of this would be obvious but sometimes it is important to say things expressly even if they should be clear implicitly. Any one of us here today may have been or may be in the future a recipient of a blood component. Transfusion of a human substance can never by its very nature be entirely risk free and to receive one you must be unwell or sufficiently in



need of a transfusion for the benefits of the procedure to outweigh any inherent risks.

For precisely that reason we must do all we can to ensure that we recognise properly the value and importance of individual's lives, health and wellbeing and that of their loved ones, and effectively to reassure all concerned that this is so.

We repeat our commitment to do all we can to make the blood components that we deliver to hospitals today as safe as we reasonably can. More on that in a moment.

We also recognise that we are part of the NHS and that we do this within the system as a whole. We wish to reassure the Inquiry and the wider public that modern safety standards are rigorous and our blood supply is one of the safest in the world. Again, more on that in a moment.

In terms of reassurance as to the current position, it is important in the circumstances that I say something about these current practices and procedures. Safety is at the forefront of everything we do. These are not just words. Our actions are prompted and directed by the guidelines and the testing that are in place to protect both donors and patients and we are subject to regular inspections by independent regulators. Our safety policy is formulated by two



separate advisory committees: JPAC, already referred to, and the Advisory Committee on the Safety of Blood, Tissues and Organs.

All blood donations are routinely tested for Hepatitis B, Hepatitis C, Hepatitis E, human immunodeficiency virus, syphilis, and for the first time donors, human T-lymphotropic, before they are released into the supply chain. If any blood donation tests positive for infection, it is not released into the blood supply chain and therefore cannot be issued to a patient. The donor is also given appropriate support and advice.

Also, every donor completes an extensive donor health check questionnaire before each donation. This is designed to detect donors who have a recognisable risk of infection who can then be excluded or subject to further testing. Those considered at risk are considered asked to defer donation until it is safe for them to do so. For example, if a donor has travelled to an area where malaria is present, they asked not to donate for four months even though they have remained well throughout, due to the risk of passing on an undiagnosed malarial infection.

If someone has had their ears pierced, even though the risk of getting Hepatitis B from such is very small,

they are also asked not to donate for four months. These are very low risks indeed but demonstrate the lengths we go to to protect recipients of blood today.

We have also, with the other UK blood services, established a UK wide haemophilia vigilance system called SHOT, Serious Hazards of Transfusion. This is a blood supply surveillance scheme where all hospitals in the UK report as a condition of their registration any recognised or unexpected reactions to blood products to this body.

This operates through a group of internal and external experts who work with professional independents and make recommendations to hospitals and blood services. It allows us to understand how changes we have made may have impacted on patients and also allows us to pick up early signs of any unexpected impending problems.

Whilst we hope that the rigour of our current systems offers some reassurance going forward, we are constantly vigilant to any possible threat to the safety of the blood supply. Most importantly, we also appreciate that this does not at all address the historic issues that have brought us here and we fully understand and believe in the need to answer questions and provide explanations to those whose lives have been



devastated, from whom and on whose behalf we have heard so powerfully.

In conclusion, we hope that all of this provides some assurance to the Inquiry and to those infected and those affected and to the wider public as to NHSBT's desire and determination to assist the Inquiry process as fully as possible.

We are acutely aware of the particular importance that this Inquiry is able to submit its report quickly in order to benefit as many people as possible.

We reiterate, our absolute commitment to honesty, openness and transparency and to assisting the Inquiry in every way we can.

We have provided the Inquiry team with initial evidence and disclosed a large amount of information to it. As we have already said, we have also met with them to discuss arrangements for them to inspect a considerable number of documents and undertake searches for what they consider relevant to the Inquiry. We have confirmed to them that they will have access to search and examine any of the documents that we hold. We will continue to work closely with the team to ensure that all requests for information are properly dealt with in a timely manner. We will also be working closely with the Inquiry and the Department of Health



and Social Care to ensure that any documents from our predecessor organisations that have not already been identified are made available.

Those whose lives have been so tragically affected have waited a very long time for an investigation that satisfies their concerns. It has come too late for some and to say that that must be a matter of huge regret for all does not remotely do justice to the situation. However, we have an opportunity here to help provide answers to those who so unquestionably deserve them. We intend to take it.

SIR BRIAN LANGSTAFF: Thank you, Mr Cory-Wright.

Simon Bowie QC appears to make the opening statement on behalf of the Scottish National Blood Transfusion Service.

Opening statement by Simon Bowie QC

MR BOWIE: Good afternoon, ladies and gentlemen, Mr Chairman, Sir. My name is Simon Bowie and I represent the Scottish National Blood Transfusion Service or SNBTS. I am instructed by the Scottish Health Service Central Legal Office.

At the outset I and SNBTS would like to offer our deepest sympathy to all those who have been affected by the subject matter of this Inquiry, something which has been spoken about so eloquently by so many over the past



few days.

In this statement I am going to say a few words about the following: first, who SNBTS is and what it does; secondly, its relationship with the other UK blood services; thirdly, its views specifically about the terms of reference, and fourthly, and perhaps most importantly, its attitude towards this Inquiry generally. And I'll deal with the last of these first.

SNBTS is pleased to be here as a Core Participant at the very outset of this significant Inquiry. It recognises that the issues which will be addressed during the Inquiry are of great importance to those people who have been infected and affected but also to organisations like SNBTS within the NHS, and of course to the general public as a whole.

SNBTS recognises that as a Core Participant it has a contribution to make to the work of this Inquiry. In that regard, it has sought to engage positively with the various requests made to it by the Inquiry team. It has been able to respond promptly when asked to produce, for example, the large amount of documentation which it holds.

Going forward, I can assure the Inquiry team and the Chairman, Sir, that SNBTS will continue to adopt this attitude. It knows how important it is to the work of

the Inquiry and to it securing its objectives that organisations like SNBTS fully engage with the process.

In the coming months and years SNBTS hopes to make a material contribution to the work of the Inquiry and looks forward to assisting the Chairman and Inquiry team in whatever ways it can.

Likewise, I know that the Scottish Health Boards have the same attitude and will do likewise.

SNBTS was also a Core Participant in the Penrose Inquiry and fully engaged with it over a number of years. Having that involvement, it is believed that SNBTS is well qualified to assist in the work of this Inquiry.

What does SNBTS do and what is its relationship with the other UK blood services? The Scottish National Blood Transfusion Service sits within NHS National Services Scotland and is part of NHS Scotland. It is the specialist provider of blood, tissues and cells in Scotland. As an organisation it is quite separate and distinct from its counterparts in England, Wales and Northern Ireland, being set up and run within a peculiarly Scottish political, legal and social framework. It does, however, collaborate closely with the other UK blood services in, for example, ensuring the development and maintenance of guidelines and



standards.

As well as ensuring the supply of blood, SNBTS also supplies human tissues and cells such as bone, heart valves and tendons, all of which are vital for the numerous operations carried out every day across Scotland. Its core purpose is to ensure that NHS Scotland has adequate blood supplies to meet the transfusion needs of all patients in Scotland.

In that regard it is critical that it maintains public confidence in the nation's blood supply. SNBTS believes that this Inquiry will be important to that end.

Finally, SNBTS relies on its relationship with the public because it is only with the willingness of the public to donate that SNBTS can do the work it does. The organisation carries out all of these functions by working in close partnership with communities, donors, hospitals and healthcare professionals. It seeks to ensure that it can supply donated blood, tissues and cells for use in the treatment of all patients. Its aim is to deliver a transfusion service for the benefit of all patients in Scotland. In all of this its goal is to treat with care and respect all those who are affected by its work.

Lastly, some comments in relation to the terms of



reference. In relation to the terms of reference, it would respectfully appear to SNBTS that all of the issues identified are of significant public importance and would not for its part seek to prioritise any issue or issues in particular over others. SNBTS will assist in all relevant matters and looks forward to working with the Chairman, the Inquiry team and all of the other participants in the coming months. Thank you very much.

SIR BRIAN LANGSTAFF: The opening statement on behalf of the Welsh Blood Service by Debra Powell QC.

Opening statement by DEBRA POWELL QC

MS POWELL: Thank you, Sir, and good afternoon to you and to everyone here.

I represent the Welsh Blood Service with Miss Susanna Rickard. The Welsh Blood Service is not a freestanding entity of itself. It is a division of Velindre University NHS Trust. Legal & Risk Services of NHS Wales Shared Services Partnership are the appointed legal representatives for Velindre. Although Velindre University NHS Trust is the statutory body, I shall refer throughout and for the sake of ease to the Welsh Blood Service.

It is right that I start by saying that the Welsh Blood Service recognises the huge importance of the work that the Inquiry is to undertake. The fact that so many



patients in the past were infected with terrible diseases as a result of receiving infected blood and infected blood products that were intended to help them was, as you, Sir, said in your opening remarks, a catastrophe.

We are acutely aware that the lives of the victims and of their families have been utterly devastated and in many cases lost and we are very sorry for what happened and for what they, for what you, have suffered.

We agree wholeheartedly with what has been said by so many of the speakers so far, that the victims and their families are entitled to answers to the questions that they have been asking for so long. We fully support the Inquiry and its terms of reference and are committed to assisting the Inquiry honestly and openly to enable answers to be given to those important questions. And to respond to Mr Snowden QC this morning, yes, and to be clear, our objective is to assist the search for truth.

We have established a dedicated team to work on the needs of the Inquiry generally. But perhaps the most significant aspect of the assistance that we can provide to the Inquiry, certainly at this stage, is in finding and providing access to documents. We have begun the work of providing you with information and

documentation, Sir, in accordance with requests made by your Inquiry team and further work is being undertaken in locating documents that may be relevant to your work.

Although there have been other more limited inquiries into the administration of infected blood and infected blood products to patients in the UK, the Welsh Blood Service were not asked to participate in or to provide evidence or documentation to those Inquiries and so much of the material that is now sought to be provided to your Inquiry by the Welsh Blood Service is being sought for the first time.

Inevitably, given the substantial period of time with which the Inquiry is concerned, and the organisational changes in the provision of blood services in Wales throughout that time and since, the process of finding the documents is not a straightforward one. But strenuous efforts have been and will continue to be made to make all potentially relevant documentation available to your Inquiry team and we wish to stress, as others have done, that it will be for the Inquiry team to determine which of those documents are relevant. That will not be a task we will be undertaking.

I am going to say just a little about the evolution of blood services in Wales over the relevant period.



In 1946, the national Blood Transfusion Service was formally established in England and Wales with a number of regional transfusion centres, including Cardiff. In 1948, it came under the control of the then new National Health Service. Blood services in North Wales, though, were provided from the Liverpool regional transfusion centre, whilst the South Wales regional transfusion centre at Cardiff covered mid South and West Wales.

In 1994, the blood services of England came under the control of the newly created National Blood Authority, but the South Wales regional transfusion centre did not become part of the NBA and was under the control of the Welsh office.

The Welsh Blood Service evolved from the South Wales Regional Transfusion Service in Cardiff, at the time of Welsh devolution in 1997. It became a division of the Velindre NHS Trust, as it then was, in 1999, and at that time it still covered mid, South and West Wales with blood collection and distribution in North Wales managed from Liverpool, still, under NHS Blood and Transplant in accordance with the longstanding arrangements.

In May 2016, for the first time, the Welsh Blood Service became an all Wales service when it became responsible for North Wales.

Today, the Welsh Blood Service collects voluntary



non-remunerated blood donations from the general public. It processes and tests those donations, and distributes them to hospitals for patient care. It provides medical consultant support to hospital blood transfusion committees and clinical advice is given to hospitals as required. It is authorised and licensed by the medicines and healthcare products regulatory agency, which audits the service at regular defined periods.

The safety of the blood supply chain is of paramount importance to the Welsh Blood Service and it takes the most rigorous steps in ensuring that it is safe for donors to donate blood and safe for patients to receive those blood products when they need them.

We want to take this opportunity to reassure the public, whose help and support is so fundamental to the maintenance of the blood supplies that underpin the NHS today, that vital lessons have already been learned about maintaining the safety of the blood supply chain; that blood services today are worlds away from the blood services of the past.

But that in no way detracts from the importance of discovering how and why this treatment disaster happened and you can be assured, Sir, that in the difficult task ahead, you and your Inquiry team will have the full cooperation of the Welsh Blood Service. Thank you.



SIR BRIAN LANGSTAFF: Counsel to the Inquiry.

Reply by counsel to the Inquiry, JENNI RICHARDS QC.

MS RICHARDS: Can I start by expressing our gratitude for all the contributions we have heard over the last two days. You have given the Inquiry much food for thought and I hope you will understand that we will want to reflect on much of what has been said. In particular, you have told us about the issues that are of the most importance to you. That is going to be of considerable value to us in compiling the draft list of issues, prioritising lines of investigation and planning the hearings, and we offer a heartfelt thank you for that.

Some of you have also raised important procedural points. Again, we want to reflect on those, not least because there are still some further written submissions to come and it is important that we consider everything that's been said.

There are, however, a handful of points which I can deal with now.

Firstly, I need to correct something Mr O'Neill said. He referred to there being, in Scotland, "ongoing police investigations". That isn't the case and it isn't what I said, and I have clarified that with Mr O'Neill and he is happy that I correct the position.

The two police investigations in Scotland, to which

I referred on Monday, are not ongoing. They are investigations that were closed a few years ago, but the documents relating to them have very recently been disclosed to the Inquiry, by Police Scotland, and will now be assessed by the Inquiry for relevance, cataloguing, indexing and onward disclosure to Core Participants.

Secondly, I want to return to the issue of the participation or non-participation of the Scottish Government. The Scottish Government spokesman was reported by the BBC yesterday to have said this, and I quote:

"We are in the process of discussing a number of issues with The Cabinet Office, such as the Inquiry's terms of reference, in order to enable the Scottish Government and NHS Scotland bodies to participate fully in the Inquiry. As we have already set out, we expect to become Core Participants to the Inquiry once these issues are resolved."

End of quote. You may be forgiven for thinking there are a couple of minor issues to be ironed out as the sole impediments to the Scottish Government's participation in this Inquiry.

In fact, what we understand the issues to be are twofold. Firstly, the Scottish Government has asked the



Cabinet Office to confirm that reconsideration of areas considered by Lord Penrose will be kept to a minimum.

Secondly, the Scottish Government has asked that the Inquiry or the Cabinet Office meet the staffing, legal and travel costs of the Scottish Government and the NHS in Scotland of participating in the Inquiry.

Can I deal with each of those in turn? I repeat what I said on Monday: the terms of reference have been set and they cover Scotland. We will, as we said on Monday, avoid unnecessary duplication with Penrose and we are very grateful to the assistance of Mr O'Neill and his team in helping us identify noncontroversial matters from the Penrose report that can be utilised.

But it is for the Chair to interpret and fulfil the terms of reference. It is not a matter for the Scottish Government or the Cabinet Office. We intend to be and are independent of government, and if the Scottish Government considers that the Cabinet Office can tell you, Sir, what to do, it is wrong.

If the Scottish Government has submissions to make about what can or should, or cannot or should not be revisited from Penrose, then the appropriate means for it to do so is to become a Core Participant and make submissions on that issue openly, as all of you have taken the trouble to do over the last few days.



As for the request for funding, the Inquiry is not in a position to and will not be funding the Scottish Government's costs, nor those of the NHS in Scotland.

Can I deal, then, with some other matters, a handful of matters that have arisen. As I said, much of what has been said is material that we want to go away and think about.

Expert groups. There was some reference to them as expert panels. They are expert groups, and that's not mere semantics because "panel" is a term of art under the Inquiries Act.

The experts, who will after hearing your suggestions become members of the expert groups, will not be decision-makers. They will have the status of expert witnesses providing independent evidence to the Inquiry, and that's important because, as witnesses, their evidence will be disclosed to Core Participants and published on the Inquiry's website. It will not be evidence given to the Chair behind closed doors.

Mr O'Neill raised a couple of queries which I hope I can answer in relation to experts. First, he asked this: if there is consensus amongst the experts, but Core Participants do not think their views are well-founded, will there be an opportunity for the experts' views to be challenged?



The answer to that is: yes, in two ways. Core Participants will first will able to propose questions in writing to the experts once they have seen their reports. If the answers to those questions don't address the concerns, and if the issues are of significance to the Inquiry and its terms reference, then the likely course will be one or more of the members of the expert group will be called to give expert evidence and to be questioned.

The second point Mr O'Neill raised in his written submissions was to lay down the concern that you were unaware of whether the intention was that expert groups would be involved after the evidential stage in the process and the extent to which they might influence your final report, Sir.

Again, I hope I can clarify the position. The experts will not be giving private advice to the Chair at the report writing stage or any other stage.

It is conceivable, of course, that the expert groups might have views to offer that might be highly relevant to the question of recommendations if, as the Chair hopes the Inquiry will be in a position to do, it makes recommendations in due course.

But, if so, that expert evidence about recommendations will again be public and shared.

The fourth point I wanted to deal with is Mr Lock's and indeed the concern of some others about Maxwellisation or the use of Salmon Letters. That is the process which provides for people who are to be criticised in a report to respond prior to publication. Two concerns have been raised by Core Participants in this regard.

Firstly, that it can lead to significant delays before the final report is published and, secondly, that it lacks transparency. Can I say we entirely understand those concerns. I can, I think, provide some reassurance on the question of delay. Our intention is that significant criticisms will already have been aired in the course of the investigation process and the hearings, and so witnesses and organisations will have had an opportunity to respond.

The consequence of that is that if we have to go down the Maxwellisation or warning letters route at all, it should not lead to significant delay because people or bodies should not need very long to respond to a criticism that's already been fully aired and explored.

The second concern about lack of openness is not as easily addressed for this reason: Mr Lock I think invited the Inquiry to effectively jettison the entire



process of Maxwellisation and, again, we completely understand why he says that. But there are certain requirements in the Inquiry Rules and you will appreciate, and indeed no doubt expect no less, that the Inquiry must act in accordance with the law and must act fairly.

If, having heard all the evidence and read all the evidence the Chair proposes in due course to make critical judgments or findings about individuals or organisations, as indeed he is being asked to do by so many Core Participants, he would not, I am sure, want any individual or organisation or organ of government to be able to say: we're entitled to reject those criticisms or those recommendations because the Inquiry adopted a process that was unlawful or unfair.

It is vital that the legitimacy of the ultimate conclusions and recommendations reached by the Chair is not undermined.

Mr Lock very sensibly suggested that the Inquiry consider this issue further and set out the ground rules at an early stage, and that is a very good suggestion. It is exactly what we'll do. We are going to look very carefully at what has been said. We are going to look very carefully at the requirements of the Inquiry rules in that regard and we will set out, at an early stage



and certainly long before we get to the oral hearings next year, the approach that the Inquiry will take to that process.

Fifthly, a point raised by Mr Williams QC about witness statements. He asked whether witness statements will be in the witness's own words and, if necessary, in the witness's own language, and the short answer to that is yes.

The Inquiry gets witness statements by doing something called issuing a rule 9 request. Again, that's a requirement of the rules, addressed to the witnesses is a series of questions that the Inquiry wants the witness to answer. But how those questions are answered and, indeed, in what language those questions are answered is a matter for the witness. If the witness wants to use strong terms, that is a matter for the witness.

A further point that was made, I think by Mr Stein QC, was that the Inquiry should be considering what was known prior to 1970. We agree and that is the approach we have been taking thus far and the approach that we will continue to take.

There were some very helpful practical suggestions about a timeline or a chronology, and we accept that a shared or common understanding of key dates and key



events will be important, and we are going to give further consideration to the best way of achieving that, practically.

Mr Stein also raised a question about document ownership and whether there would be a clear record of who provides the copy of a document to the Inquiry. The answer to that, again, is yes, both in terms of the Inquiry's own document management system and in terms of the Relativity database, to which Core Participants will have access.

My penultimate point in response to some submissions made indeed by all Core Participants, but I have in mind particularly some submissions made by Mr Snowden this morning. Particular lines of Inquiry were suggested as regards documentation, and mention was made of seeking files from the Treasury and the Foreign Office. Those are extremely helpful suggestions. We will be taking those forward and, to make matters absolutely clear, we ask for unredacted copies of documents to be provided to us and we will scrutinise any claim for legal professional privilege or public interest immunity with rigour.

I have also committed -- having spoken to Mr Snowden and to his junior -- that the Inquiry will take up the extremely troubling issue he raised about destruction of

medical records and charging for medical records. That should not happen and the Inquiry team will address questions to the relevant trust as a matter of urgency.

All the other points that have been raised, as I say, we will take away and reflect.

The final observation that I want to make is this: what came across with very great clarity and power, particularly, if I may say so, from the opening statements made by individual unrepresented Core Participants, is that although this Inquiry is looking back over decades, and that indeed is one of the great challenges for the Inquiry, this isn't an Inquiry into matters of history, but into matters which continue to this day to have a profound effect on people's lives.

We are acutely conscious of the enormous responsibility that rests on the Inquiry's shoulders and we will do our best to fulfil that responsibility.

Thank you.

Concluding remarks by SIR BRIAN LANGSTAFF

SIR BRIAN LANGSTAFF: I have only a few words to say to follow that. The first two words are "thank you". Thank you in particular for what was described by one of our contributors earlier on today as "the spirit in which the Inquiry has begun", because the one thing which has been palpable I think, I suspect to all of



us -- certainly, it is the way that I have felt it -- is the spirit of enthusiasm, cooperation, togetherness and a faith that this Inquiry will get the answers that you deserve. I intend to do my very best to make sure that it does.

Thank you very much. Can I just say you are largely -- not entirely, but largely Core Participants and the Inquiry cannot work as it should without the full participation of all its Core Participants. One of the encouraging things about today was not only your desire to participate, which is clear, but the promises that we have had from the Department of Health, the Blood Transfusion Services -- if I can describe them like that across each of the three countries -- to help as Core Participants. It is a pity that the Scottish Government has not yet joined them, though I would hope that in due course -- I hope in quick course -- it will.

The reflection of the mammoth nature of the task which we are undertaking has been the sheer number of those of you who have managed to come today despite all the difficulties of that, and I don't underestimate them.

I welcome that willingness and I thank you for it.

You have given me, as indeed Jenni Richards has said, many things to think about. Well, that was the



purpose of the last three days and it has achieved that purpose, and we must now go, having listened -- the other part of listening is thinking about what's been said and that's what we propose to do. We will engage fully with those who are represented with your representatives on all the issues, including vexed issues, like having witness statements prepared in time and so on, and indeed we can start those discussions this evening, should that be necessary.

But can I add two further things, and they are both really about visibility. These three days have made this scandal visible, really visible in a way that I was told, when we consulted on the terms of reference, you felt it had not been before. Now, we have the press and the media to thank for that. It has become visible and visible to many who had not perhaps understood that they were not on their own. Some of you have said to me in the course of these three days that you hadn't really understood that there were others in your position until you came to this gathering, and that, perhaps, has been one of the great advantages of everyone coming together, properly together, for the last three days.

But what it means is that there may be others who are watching on TV or reading the paper or looking at social media, who had not, until these last three days,



understood that they were people who shared what you share. I do appeal to them, and I would ask those who can, in the media, to help with this, to remind everyone who wishes to come forward: it is not too late. Every witness statement is important. If we are to get to the truth, it is a collaborative effort from all parties and that may include those whose voices have not yet surfaced.

If for any reason there are people who feel that they may have suffered the effects of transfusion or contaminated blood products in the past, but have not yet put their hands up or have not felt able to, can I invite them to do so. Their rights to privacy will be respected insofar as we possibly can. You will know from your experience that is so, and it will be so.

But the second consequence of the visibility of these three days is that you may think that the Inquiry will be invisible for the next six or seven months. A number of you have said, "It is so nice to see that the Inquiry's started", it did actually start on 2 July, when the terms of reference were agreed by Parliament.

By saying, "It is so nice to be here at the start of the Inquiry", misses the fact that for those months, very nearly three months since 2 July, the Inquiry has actually been hard at work and you have seen how hard at

work it has been from the disclosure that we have sought, seeking documents, getting documents which some people have never seen before, and considering how best to bring you together to hear what your priorities were and to hear how we could improve the procedures of the Inquiry. We are open always to listen to better ways of doing that, whoever wishes to advise us of them.

What it means is that for those couple of months or so you have not really felt that the Inquiry was going on, and it has been, and it will do for the next six or seven months. It may seem to you that, as memories of this fade, that it was empty promise.

Let me give you an assurance that tomorrow morning, before 9 o'clock, I shall be hard at work, as my Inquiry team have been since 2 July, a larger team than it was then, but it needs to be, and we shall stay hard at work until the job is done.

We do not so much start as continue our search for the truth. Thank you.

(4.30 pm)