

<p>1 (2.15 pm) 2 SIR BRIAN LANGSTAFF: Mr Bradley, you have five more minutes 3 if you wish. That's the time which we are allotting you 4 because we have a charity to come, and you have very 5 generously offered the Inquiry a fuller statement of 6 what you would have wished to say, but what you have to 7 say will of course be circulated to all Core 8 Participants for them to see too. So, although you are 9 not here necessarily to cover it all, because of time it 10 will be covered and they may comment on it if they wish, 11 in due course. But, by all means, please come and 12 finish. 13 MR BRADLEY: Many thanks, Sir Brian, I will use my best 14 endeavours to limit myself to the five minutes 15 concerned. I am going to return to the elephant in the 16 room, the pharmaceutical companies. I will provide 17 a full copy of my opening statement that includes 18 details of the batch numbers, the dates upon which 19 patients received the infected product and the fact that 20 that product caused infections in the United Kingdom, to 21 your Inquiry. 22 Arising from that particular situation -- which is 23 extremely tragic and, as I indicated, in Canada was the 24 subject matter subsequently of a matter of a criminal 25 investigation -- the Society wishes to ascertain as to</p> <p style="text-align: center;">Page 1</p>	<p>1 Haemophilia Scotland. I don't intend to go into that 2 issue in any further detail here. 3 My clients, the Haemophilia Society, as I indicated 4 are a charity, who have represented people with 5 haemophilia for more than 68 years. As a practitioner, 6 who for a large part of my career have looked after the 7 interests of people with haemophilia, I have to say I am 8 struck by the angst that exists within the UK community. 9 We know what a jurisdiction, in which I have been 10 involved on behalf of people who have haemophilia, and 11 I have a working knowledge of Canada, the United States, 12 Japan and New Zealand arising from contamination of 13 blood and blood products has such a disharmonious 14 situation existed. 15 I believe the significant passage of time that 16 occurred, from the date of initial infection to the date 17 of this Inquiry, where people were required to exist on 18 subsistence-type payments has created such anxieties. 19 I would hope, for the sake of the haemophilia community 20 who I have had the privilege of representing, that those 21 persons will be reconciled and that this public Inquiry 22 and your work will assist in that purpose. 23 I note in my own jurisdiction that schemes for 24 compensation have been provided. Life assurance 25 mortgage protection, travel insurance and priority in</p> <p style="text-align: center;">Page 3</p>
<p>1 whether the Inquiry intends to investigate the 2 pharmaceutical companies to the utmost extent of its 3 statutory powers. In that regard, there are powers that 4 are available to this Inquiry that can be utilised in 5 the United States and, more particularly, a federal 6 judicial assistant statute, section 178.2, that allows 7 an Inquiry -- or allows an Inquiry to seek documentation 8 or what was termed in the United States "a foreign 9 international tribunal". 10 That documentation is held in relation to 11 pharmaceutical companies in multi-district litigation 12 depositories. 13 Those litigation depositories resulted from claims 14 that were advanced in the United States where as 15 a result of those claims, copies of the discovery 16 documentation was lodged in such depositories. On 17 behalf of my clients, we seek to ascertain as to whether 18 your Inquiry will seek access to such documentation 19 available from the depositories, and available 20 elsewhere, from work that has been undertaken by the 21 Krever Inquiry and, indeed, the Royal Canadian Mounted 22 Police. 23 I also wish to refer to the issue of Scotland. The 24 Haemophilia Society has many members in Scotland and we 25 wish to endorse and support the opening statement of</p> <p style="text-align: center;">Page 2</p>	<p>1 terms of healthcare benefits. That situation has 2 allowed people to achieve some degree of closure. 3 In Ireland, people are entitled, like you, to 4 assessment after compensation entitlements on a full 5 liability basis, where individual assessment is provided 6 by a specially established compensation tribunal 7 pursuant to statute. 8 A further extension of that statute scheme occurred 9 in 2006 and provided the mortgage protection life 10 insurance and travel insurance. Priority healthcare 11 exists. People have a card that allows them to get 12 priority because the system injured them. 13 In contrast, in the United Kingdom, people in 14 identical circumstances, who have suffered equal 15 injustice, have been left to die in poverty, without 16 dignity and without knowing why they were infected or 17 dying. That is wrong. That needs to be addressed. 18 My clients say to government, and indeed to previous 19 governments they have said it, "You ought to hang your 20 head in shame for failing your own vulnerable citizens 21 and our members in their greatest hour of need". 22 The Society believes that you have the power, 23 Mr Chairperson, to make interim recommendations and it 24 is now necessary for this Inquiry to make interim 25 recommendations to alleviate basic financial hardship</p> <p style="text-align: center;">Page 4</p>

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<p>1 and to commence the process of addressing compensation, 2 and ensure the provision of healthcare entitlements. 3 Nothing less is adequate. Delays are no longer 4 tolerable. Thank you very much for your time. 5 SIR BRIAN LANGSTAFF: Thank you very much, Mr Bradley. We 6 now have the opening statement by Samantha May on behalf 7 of the Hepatitis C Trust. 8 Opening statement by SAMANTHA MAY 9 MS MAY: The Hepatitis C Trust is the only dedicated UK 10 charity for people affected by Hepatitis C. The 11 majority of us, myself included, have had Hepatitis C 12 ourselves. 13 We were formed over 17 years ago because a group of 14 patients, led by our former CEO, Charles Gore, were 15 outraged at the lack of support, information and 16 representation for people with Hep C and wanted to make 17 it better for others. 18 Over the years, we have expanded beyond those core 19 aims and now also provide a wide range of services and 20 projects run by staff and volunteers, to raise awareness 21 and to support vulnerable groups to get tested and 22 treated, whilst always ensuring that Hep C stays firmly 23 on the government's and policymaker's agenda; all of 24 this contributing towards helping things to be better 25 for everyone with this illness and getting the</p> <p style="text-align: center;">Page 5</p>	<p>1 that I could talk freely to someone meant so much to me 2 at the time. 3 Annie received infected blood aged 19 and later 4 endured several difficult treatments over the years, but 5 still had to undergo a liver transplant as a result of 6 the liver damage that the Hep C had caused. 7 Unfortunately, she still went on to develop cancer 8 after that and died in early 2016, aged 62. She did so 9 much to support people and, despite her very difficult 10 personal situation, had always campaigned long and hard 11 specifically on infected blood issues and GP awareness 12 right until the end. 13 But, despite her anger and frustration with it all, 14 she managed all of that with intelligence, kindness and 15 humour. It is a great shame that she was not here today 16 to see the day of this Inquiry finally arrive, so she 17 could have her say. 18 The last news she heard on the subject was the 19 government's apology in March 2015. A close friend was 20 with her at the time and said he will never forget the 21 look of disappointment on her face. What she wanted was 22 not an apology, but justice for everyone that had been 23 affected. 24 Being diagnosed with any serious potentially life- 25 threatening illness is devastating. What we have heard</p> <p style="text-align: center;">Page 7</p>
<p>1 undiagnosed diagnosed in whatever ways we can. This is 2 in line with our ultimate goal of eliminating Hep C in 3 the UK by 2030. 4 My role at the Trust for the best part of 15 years 5 has been specifically to provide a national helpline for 6 people infected and affected by Hepatitis C. We also 7 provide information to the general public, employers, 8 medics, drug services and more, and have taken more than 9 42,000 calls. Of those, around 4,000 contacts have been 10 specifically from those who have been infected, affected 11 or had concerns about blood and blood products. 12 We know that there are thousands of people no longer 13 with us who should have been here to have their voice 14 heard in this Inquiry and many more who are simply too 15 ill to take part now that it is finally underway. And 16 from what we have heard over the years, there are many 17 more who have died who were never diagnosed and so 18 therefore cannot be included. 19 I would like to take this opportunity to pay 20 a personal tribute and give a voice to just one of them. 21 Annie Walker from Norwich, who did so much to help me 22 when I was first diagnosed back in 2002, just six months 23 after she had been diagnosed herself -- although 24 I didn't know that at the time, she already seemed like 25 an old hand at it all. Knowing that I was not alone and</p> <p style="text-align: center;">Page 6</p>	<p>1 from our callers is that it feels like life stops when 2 they hear their diagnosis. Fears about how long they 3 will have to live, how it will affect them and the 4 people they care about, worries about transmission to 5 others, tests, treatments, operations and possible death 6 is overwhelming. 7 And the majority of those just diagnosed with Hep C 8 will have no idea what it is or even if they do a little 9 bit, they often get it confused with other illnesses. 10 Unfortunately, often the person diagnosing them doesn't 11 know much about it either. Most people are given no 12 information or, possibly worse, misinformation. They 13 are sometimes treated judgmentally, personal questions 14 are asked about their lifestyle and how they could have 15 got it and, although there are many ways that blood to 16 blood transmission can occur, the suspicion will often 17 be that it was due to intravenous drug use. This is of 18 course a very high route of transmission, but it is not 19 the only one. 20 And those infected with Hep C alone are often 21 told -- wrongly, except in very particular 22 circumstances -- that it is sexually transmitted and 23 that there is an urgent need for their partner to be 24 tested, and because that information is often relayed by 25 a doctor, they believe it and that mistaken belief will</p> <p style="text-align: center;">Page 8</p>

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<p>1 often greatly affect their personal relationships. 2 Then, most likely much later after their diagnosis, 3 those who have received infected blood and blood 4 products on the NHS will discover that in fact it could 5 perhaps have been avoided entirely, or if it couldn't, 6 that they should have at least found out about it 7 a whole lot sooner, before the possibility of serious 8 consequences from it arose. 9 When we talk to people and hear their stories we can 10 take the time to ask pertinent questions. It is very 11 often sad that, as they start to reflect, that over the 12 years, often decades, they have perhaps only been only 13 half the person they could have been and should have 14 been because all those vague and often intermittent 15 early symptoms they have been experiencing, feeling run 16 down, digestive problems, brain fog, general aches and 17 pains, low mood, depression, poor sleep, too much sleep, 18 meant that they were misdiagnosed with a whole bunch of 19 other things or labelled a hypochondriac. But they had 20 actually been having that go on for so long they thought 21 it was just simply just the way they were: busy, 22 stressful lives; working too much; getting older; 23 menopause; other health conditions. 24 But all that could have been avoided or at least 25 made somewhat better if only they and their doctors had</p> <p style="text-align: center;">Page 9</p>	<p>1 others. Then they realise that may be some people at 2 least start to look at them a bit differently or stop 3 seeing them so often, or don't let their kids come over 4 to stay or eat at their house again. Dentists or medics 5 may treat them differently. Their employer may 6 overreact and panic about potential, but unfounded 7 threats to the safety of their fellow staff or 8 customers. They may get sacked or their contract is not 9 renewed or they get put, totally unnecessarily, on to 10 other duties. 11 Sometimes even their own family turns their back on 12 them and takes their kids away with them, all due to 13 ignorance about transmission. 14 At some point, hopefully -- but not always, as many 15 people are unaware of this -- they find out that they 16 are eligible to claim for financial assistance from the 17 government that has been made available to help support 18 them because of the effects of this illness and the 19 older treatments for it. And so, they try to find the 20 records to support their claim, an onerous task at 21 a time when they are already feeling greatly affected by 22 this illness. Many don't feel they can go ahead and 23 claim for this reason, and we have also spoken to some 24 who are simply too ashamed to even contemplate claiming. 25 But if they do go ahead, they're likely to find</p> <p style="text-align: center;">Page 11</p>
<p>1 known they were at risk of receiving infected blood and 2 they had been offered a test decades ago. 3 Unfortunately for many, finding out too late left 4 people with perhaps no option for treatment or lifestyle 5 changes to slow down or prevent the devastating 6 potential problems having Hepatitis C can cause, along 7 with all the other illnesses it can make them more prone 8 to developing. 9 And they could have had the chance to take steps to 10 reduce the possibility, however small, of onward 11 transmission. 12 As if all this isn't enough to deal with, some of 13 them may then find out a few months later, after their 14 initial diagnosis, after more tests, more waiting, more 15 results and probably more confusing info, that aside 16 from Hepatitis C, they have also developed cirrhosis or 17 possibly even liver cancer. 18 And of course, there's not a single one of us who 19 has lived with this illness who has not felt the 20 absolute terror that they may have given it to someone 21 else inadvertently during the time they were 22 undiagnosed. 23 They may start to tell people about it, if indeed 24 they're brave enough, as so many people feel so 25 stigmatised they are simply too frightened to talk to</p> <p style="text-align: center;">Page 10</p>	<p>1 they're not there. They have been routinely destroyed; 2 they're incomplete; there's some before they received 3 blood or blood products and some after, but not for 4 them. Sorry, the hospital's closed, been burnt down, 5 they're lost. Or maybe there weren't even notes there 6 in the first place, or has something else happened to 7 them? 8 Because it's usually taken 10, 20, 30, 40 or even 9 more years to diagnose them, all of these things are 10 much more likely to have happened, so then they find 11 they are not actually going to be eligible for that 12 help, anyway. 13 At the Trust, we do all that we can to properly 14 inform, support, advocate and help everyone to navigate 15 all these problems and many others. The Inquiry team 16 has already started to hear personal stories from people 17 across the UK in preparation for the start of this 18 Inquiry. We have been hearing them continually week in 19 and week out since we started. 20 As a Core Participant, we look forward to working 21 closely with the Inquiry team to see how best we can 22 support them and we'll make sure all the issues we have 23 heard about from our callers are represented during the 24 course of this Inquiry. They are typically people who 25 are over 50, 60, 70 and even a few over 80s, many of</p> <p style="text-align: center;">Page 12</p>

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<p>1 whom are just getting diagnosed now. And perhaps, 2 naturally, they think it is something they must have 3 caught relatively recently. But often, when we start to 4 talk to them, it becomes obvious that the most likely 5 cause of infection for many of them is receiving blood 6 or blood products following accidents, during 7 operations, childbirth or for specific health conditions 8 many decades ago, going back to the late 60s. 9 At last, for all the groups represented in this 10 Inquiry, it is an opportunity for all the evidence given 11 by everyone affected to provide a road map to the 12 answers for the many questions people have been 13 campaigning about over the last three decades. 14 Explanations of what happened, acknowledgement of what 15 went wrong, accountability. 16 And we very much hope that it will provide some sort 17 of justice, closure and healing by finally giving the 18 proper and undivided attention and exploration that all 19 of the questions that have been raised in the terms of 20 reference by the people directly affected so rightly 21 deserve. 22 And we would fully expect that the learning that 23 comes from this Inquiry will help to inform and prevent 24 any similar tragedy from occurring in the future. 25 And lastly, we very much hope during the Inquiry</p> <p style="text-align: center;">Page 13</p>	<p>1 Can I say on the department's behalf at the very 2 beginning of these short remarks that we welcome this 3 public Inquiry and that we are committed to cooperating 4 with it and assisting it to the best of our ability to 5 fulfil its terms of reference, every aspect of them. 6 The Prime Minister, when she first announced the 7 establishment of an Inquiry, back in 2017, spoke of "an 8 appalling tragedy which should never have happened". 9 Your sponsoring minister, Mr Lidington, later stated: 10 "The infected blood scandal of the 1970s and 1980s 11 is a tragedy that should never have happened." 12 Those are words from government ministers. However 13 sincere they are, they cannot convey or comprehend the 14 full knowledge and experience of those directly affected 15 by the events that you are charged with investigating. 16 But, on behalf of my clients, I do say that those words, 17 the acceptance that this should not have happened, is an 18 acceptance that things went wrong. Things happened that 19 should not have happened and so, on behalf of my 20 clients, I say, unreservedly, that we are sorry. We are 21 sorry that this should be so, that this happened when it 22 should not have done. 23 This is the beginning of a journey to uncover 24 exactly what happened and why, but from those 25 I represent it begins with an expression of sorrow and</p> <p style="text-align: center;">Page 15</p>
<p>1 that the public profile of this illness is raised and 2 that anyone who has potentially been at risk from Hep C 3 from the infected blood from the NHS 4 before September 1991 goes and get gets tested, and also 5 that a concerted effort is made to find them. 6 Because if all the people who have been at risk of 7 Hep C can be identified quickly, with the new oral 8 treatments that are available, that have a success rate 9 of over 97 per cent, then they can be spared from these 10 many and varied and problems that this illness causes. 11 Most importantly, perhaps their lives can be saved. 12 Thank you. 13 SIR BRIAN LANGSTAFF: Thank you to The Hepatitis C Trust. 14 The next opening statement is from the Department of 15 Health, Eleanor Grey Queen's Counsel. I ask you to 16 listen to her with the same respect that you have shown 17 to all other speakers. 18 Opening statement by ELEANOR GREY QC 19 MS GREY: Sir Brian, thank you for this opportunity to 20 address this Inquiry, its Core Participants and all 21 those affected by its important and sensitive work. 22 As you know, I represent the Department of Health 23 and Social Care, as it is now called, and its 24 predecessors over the years that your Inquiry will be 25 examining.</p> <p style="text-align: center;">Page 14</p>	<p>1 regret. 2 Sir Brian, over the last two and a half days we have 3 listened and we have heard the powerful and moving 4 voices of some of those who have actually lived through 5 tragedy, have experienced infection and its devastating 6 effects upon their families and loved ones. The 7 infected and the affected, to use the language of your 8 counsel to the Inquiry. 9 Together with those in this hall, I and members of 10 the team from the Department of Health and Social Care 11 have heard individuals and their representatives speak 12 of the truly horrendous wrongs that have "been visited 13 upon us", to use the words of one of the Core 14 Participants who spoke yesterday. We will continue to 15 listen and to reflect upon those experiences, as you 16 fulfil your promises to put the infected and the 17 affected at the heart of this Inquiry. 18 We will convey back to those I represent the words, 19 the emotions and the aspirations for this Inquiry of 20 those who have been heard in this hearing room. 21 Now, we have heard many points, not only about what 22 has happened, but about continuing or current steps that 23 are needed and we will reflect upon them as your work 24 continues. 25 The establishment of this Inquiry and the approval</p> <p style="text-align: center;">Page 16</p>

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<p>1 by The Cabinet Office of its wide terms of reference 2 represents a commitment. It is a commitment to ensuring 3 that those infected and those affected are given full 4 and truthful answers to questions that they have been 5 asking for decades. It is a commitment to investigating 6 and making findings upon issues of responsibility, 7 individual responsibilities as well as organisational 8 and systemic failures. It is a commitment to seeking to 9 ensure that something similar never happens again. So, 10 I should say this clearly: those I represent understand 11 and will seek to support this Inquiry in achieving those 12 objectives.</p> <p>13 I will come back to that, but, first, can I just 14 briefly return to the subject of who I represent. 15 I mentioned the Department of Health and Social Care and 16 its predecessor bodies. That includes, for present 17 purposes, the representation of those organisations or 18 bodies for which the department was responsible over the 19 years, such as the Medicines and Healthcare Products 20 Regulatory Agency, or MHRA, as well as individuals who 21 worked for them.</p> <p>22 Now, you, Sir, will appreciate the formulation 23 I have just given is somewhat broad, perhaps even 24 ill-defined at the moment. The breadth of the 25 department's responsibilities has altered over the years</p> <p style="text-align: center;">Page 17</p>	<p>1 worked in it over the years. There have been eloquent 2 statements about breaches of trust experienced as well 3 as many reminders of what may at worst have been 4 a cover-up or, at best, a lack of candour about past 5 events.</p> <p>6 There has been repeated mention of the destruction 7 of documents, both government papers and medical 8 records.</p> <p>9 Now, standing here today, I do not seek to comment 10 upon or to respond to those statements or to that legacy 11 of distress and distrust. That will be a process over 12 the months that follows these hearings as your Inquiry 13 investigates these matters.</p> <p>14 But two points, if I may, in response to the fears 15 or the distrust which has been expressed of those whom 16 I represent, and my two points are about the conduct of 17 this Inquiry.</p> <p>18 First, as I have already said, of course, you and 19 your team are of course independent, with no links to 20 any particular actors or interest groups in this long 21 running tragedy and you will act, we know, with 22 scrupulous impartiality in conducting your investigation 23 into these matters.</p> <p>24 You have already made that quite clear in your own 25 opening address to its Core Participants and all those</p> <p style="text-align: center;">Page 19</p>
<p>1 and that's reflected in the fact that the Welsh and 2 Northern Ireland Governments have separate 3 representation before you, for example, while some NHS 4 bodies, regional health authorities for example, no 5 longer exist.</p> <p>6 What we wish to ensure is that there are no gaps in 7 the coverage and reach of this Inquiry. In particular, 8 we are committed to assisting you in ensuring that the 9 Inquiry has full knowledge of and can exercise its 10 statutory rights of access to all relevant repositories 11 of documents and can gather further written and oral 12 evidence from those who are able and available to assist 13 you.</p> <p>14 So, we will look at those who we represent and 15 whether there are any gaps in coverage as the Inquiry 16 progresses and take action as needed.</p> <p>17 The Inquiry is, of course, independent of 18 government, including of the Department of Health and 19 Social Care. As Core Participants, we therefore stand 20 on an equal footing with other Core Participants.</p> <p>21 Sir Brian, it would be foolish of me to ignore or 22 not to mention the fact that many of those who have 23 suffered contamination with infected blood or blood 24 products. Their affected families and friends do not 25 trust the Department of Health or individuals who have</p> <p style="text-align: center;">Page 18</p>	<p>1 who attended the Inquiry on Monday.</p> <p>2 But, secondly, Sir, as I have stated, we are 3 committed to assisting you to fulfilling the terms of 4 reference in all their breadth, including, for example, 5 your investigation of the issues of candour, openness 6 and cover-up.</p> <p>7 It will be the task of my legal team, as well as 8 those who are supporting it behind the scenes, to ensure 9 that our actions reflect that commitment. We wish to 10 ensure that with time and with experience this 11 commitment cannot be dismissed as mere empty words, but 12 can be seen to be demonstrated in the engagement and in 13 the learning of the Department of Health and Social 14 Care, and its staff and its representatives in this 15 Inquiry.</p> <p>16 You and your team, Sir Brian, are entitled to look 17 to us to fulfil that promise over the coming months.</p> <p>18 Now, I am sure that at times this process will not 19 be straightforward and there will be differences of 20 perspectives and diverging views, strongly held views, 21 between Core Participants. One of the roles of any Core 22 Participant, and its legal team, if it has one, is to 23 show the Inquiry how issues were perceived by those 24 participants at the relevant time, in the light of the 25 information which was known at the time, and that of</p> <p style="text-align: center;">Page 20</p>

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<p>1 course includes enabling reflection on what could have 2 been known with fuller Inquiry or what ought to have 3 been known. 4 But perspectives about what was said or done in the 5 past, or what is submitted about it now, are likely to 6 differ, even to collide. But the important point here 7 today, however, is the commitment of the team which 8 I represent, together with our clients, to ensuring that 9 the fullest possible picture is laid before you so that 10 you can make findings upon it. 11 Now, this, we believe is necessary. It comes from 12 our obligations to you as the Chair of a public Inquiry 13 with full statutory powers, but just as important, it is 14 also right. Right because it is the way to ensure that 15 you can meet your terms of reference, right because it 16 will enable you to give the infected and those affected 17 the answers that they have been looking for, and right 18 because there is an important public interest in the 19 recommendations that you are empowered to make and in 20 seeking to prevent future similar tragedies. 21 Now, Sir Brian, you will have heard it say, no 22 doubt, even in the midst of appalling NHS treatment 23 errors and mistakes, that the professionals involved did 24 not intentionally seek to harm their patients. All but 25 a very small minority, a tiny proportion of health</p> <p style="text-align: center;">Page 21</p>	<p>1 Sir, I do not use the word "safe space", public 2 inquiries are not safe or cosy places, and nor should 3 they be, but a space to allow candid reflection. 4 I would hope that this objective of enabling 5 learning and reflection through the conduct of this 6 Inquiry will be shared by all Core Participants and that 7 there will be cooperation in achieving this. 8 Now, over the summer, as you will know, we have been 9 working on preliminary disclosure or information 10 requests from the Inquiry, and to date we have delivered 11 several thousand documents, but plainly that is a mere 12 beginning. 13 We are committed to working with the Inquiry's own 14 team and its representatives on the disclosure of 15 documents, to ensure that there can be no questions or 16 doubt about the completeness or the integrity of the 17 documents supplied. We know that the Inquiry wants to 18 see as fast a pace of delivery as is reasonably possible 19 and that it wishes to see that the department keeps pace 20 with the Inquiry's requests. The department is forming 21 a dedicated team to deliver those commitments. 22 We look forward to working with you and your Inquiry 23 team to deliver the disclosure that is required and to 24 facilitating the participation by those from whom the 25 Inquiry wishes to hear, whether by statements or in</p> <p style="text-align: center;">Page 23</p>
<p>1 professionals are motivated by a desire to treat and to 2 help. 3 Equally, although it may not be universally 4 accepted, and speaking very generally, one of the 5 motivations of those working for government, in 6 government is public service. 7 Now, this Inquiry will put a mirror before many 8 professional and government figures, and that mirror may 9 reflect uncomfortable truths. With the assistance of 10 Core Participants, we know that the Inquiry will explore 11 the gap between those witnesses' aspirations or 12 motivations and the reality of what happened to and what 13 was experienced by the infected and the affected. 14 But I would ask for an appreciation of the fact that 15 confronting, and acknowledging these gaps or realities, 16 will be a difficult and painful experience for many 17 witnesses. That is not a complaint. It is right and 18 proper that it should take place, and nor am I seeking 19 to make any comparison with the suffering of those 20 affected or infected, which is on a different plain 21 completely. 22 We would look to the Inquiry to create, by its 23 conduct and its procedures, a space which enables 24 learning and reflection by those it seeks to call to 25 account.</p> <p style="text-align: center;">Page 22</p>	<p>1 person. This will require, of course as you would 2 expect, a full review of documents held. 3 Recently you, Sir Brian, published a statement of 4 intent upon the approach to disclosure and legal 5 professional privilege, and you reminded bodies, such as 6 those I represent, of the need to give careful 7 consideration to the issue of waiving legal professional 8 privilege in relation to past documents and events. 9 My clients will indeed do so, considering whether it 10 is in the public interest to waive any such claims in 11 the context of this vital Inquiry. 12 Sir, may I conclude by repeating the commitment of 13 my clients, the Department of Health and Social Care, as 14 well as the MHRA, to participating in your review as 15 fully as possible so as to enable you to fulfil your 16 terms of reference, both as rigorously and as 17 expeditiously as possible. 18 We wish to work with the Inquiry to ensure that all 19 those affected by its important work will conclude as 20 a result of that work and your findings that justice has 21 been secured. 22 Thank you very much. 23 SIR BRIAN LANGSTAFF: We will take tea after the next two 24 presentations and before Mr Cory-Wright QC gives his 25 address to you.</p> <p style="text-align: center;">Page 24</p>

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<p>1 The next statement is from Alphy Maginness on behalf 2 of organisations in Northern Ireland. 3 Opening statement by ALPHY MAGINNESS 4 MR MAGINNESS: Thank you, Chairman. Good afternoon, 5 Sir Brian, good afternoon, ladies and gentlemen. 6 I can confirm I represent four bodies from 7 Northern Ireland, the Department of Health in 8 Northern Ireland, the Regional Health and Social Care 9 Board, the Northern Ireland Blood Transfusion Service 10 and the Belfast Health and Social Care Trust. 11 On behalf of those four bodies, I can say we welcome 12 the establishment of this Inquiry and its extensive 13 terms of reference. We, too, are conscious of the 14 tragedies and the life changing impacts that have 15 resulted from the use of contaminated blood and blood 16 products. The people who have been infected or 17 otherwise affected are entitled to know all those facts 18 that can be established and to have the truth as soon as 19 it can be delivered. 20 We hope that the Inquiry will be able to proceed 21 expeditiously to its conclusion, appreciating of course 22 that it must be afforded sufficient time to consider 23 fully and thoroughly the vast volume of evidence that it 24 will receive. 25 Three of these four bodies are Core Participants to</p> <p style="text-align: center;">Page 25</p>	<p>1 and catalogue information for the Inquiry. Additional 2 staffing has also been in put in place to complete this 3 work. 4 The Belfast Health and Social Care Trust has applied 5 for Core Participant status. It was established 6 in April 2007 following a restructuring of health and 7 social care in Northern Ireland. It retains 8 responsibility for the Northern Ireland Haemophilia 9 Centre at Belfast City Hospital and the Children's 10 Haematology Unit at the Royal Belfast Hospital for Sick 11 Children. It also has responsibility for the regional 12 hepatology service and the HIV service for those 13 affected secondary to transfusion of blood and its 14 components. 15 The trust has also been in correspondence with the 16 Inquiry and confirmed its commitment to supporting the 17 Inquiry in an open and transparent manner. 18 Sir Brian, I can also confirm that each organisation 19 is endeavouring to identify and collate relevant 20 documents and records for the benefit of the Inquiry. 21 I can also reassure you that the relevant documents 22 and records will be preserved for the duration of the 23 Inquiry and, indeed, at your request, Sir Brian, the 24 permanent secretary has written to all health and social 25 care organisations reminding them of their requirement</p> <p style="text-align: center;">Page 27</p>
<p>1 this Inquiry, and I wish to explain briefly the function 2 and role of each. 3 Firstly, the Department of Health has overall 4 responsibility for the provision of health and social 5 care in Northern Ireland. All health and social care 6 bodies are accountable to the department. The permanent 7 secretary of the department is also the chief executive 8 of health and social care in Northern Ireland. 9 The Regional Health and Social Care Board was 10 established in April 2009 by the Northern Ireland Health 11 and Social Care Reform Act, also of 2009. It is the 12 successor of the Eastern Health and Social Services 13 Board, which had operated from its establishment in 14 1972. That Eastern Board had management responsibility 15 for the Blood Transfusion Service in Northern Ireland, 16 from 1972 until April 1994. It was also responsible for 17 haematology services within the local management area. 18 The Northern Ireland Blood Transfusion Service was 19 established as a special agency in April 1994. As its 20 title suggests, it has been responsible since then for 21 the collection, testing and distribution to hospital 22 blood banks of blood and blood products for the region. 23 The Inquiry will have received the agency's response 24 to the rule 9 request, on 21 September, last Friday, 25 confirming that work has commenced to locate, retrieve</p> <p style="text-align: center;">Page 26</p>	<p>1 to preserve documents and to waive any fees that may 2 normally be charged for access to medical records in the 3 case of infected and affected people who request such 4 access for the purpose of providing evidence to this 5 Inquiry. 6 One cannot fail, Sir, to be moved by the stories of 7 courage, fortitude, dignity and perseverance that we 8 have heard over the last few days from those infected or 9 affected. 10 The Core Participants in Northern Ireland are fully 11 aware of the terms of reference for the Inquiry, which 12 are extensive and cover a lengthy period, in particular 13 since 1970. 14 I can confirm to you, Sir, the Inquiry can expect 15 the full cooperation of those Core Participants and we 16 look forward to further engagement with the Inquiry and 17 the Inquiry team. 18 That concludes the opening comments from the 19 Northern Ireland Core Participants. 20 SIR BRIAN LANGSTAFF: There is an opening statement from the 21 Welsh Health Service to be read by junior counsel to the 22 Inquiry Katie Scott. 23 Opening statement from VAUGHAN GETHING (read) 24 MS SCOTT: My name is Katie Scott, I am one of the junior 25 counsel to the Inquiry and I have a written statement by</p> <p style="text-align: center;">Page 28</p>

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<p>1 Vaughan Gething, the Cabinet Secretary for Health and 2 Social Services from the Welsh Government. 3 Having met and spent time with the individuals and 4 families of those affected in Wales, their strength of 5 feeling in favour of a UK wide public Inquiry into the 6 circumstances surrounding their treatment with 7 contaminated blood became apparent. The families seek 8 closure and clarity about what has happened to them. 9 I am pleased that their call for such action has 10 been listened to and that the Inquiry is now starting. 11 Sir Brian Langstaff has listened to the views from 12 Wales, either through the consultation responses or in 13 person, by meeting those affected, their families, 14 Haemophilia Wales and our cross-party group at the Welsh 15 Assembly. I am content with the proposed terms of 16 reference for the Inquiry as these reflect the thoughts 17 and wishes of people directly affected and the wider 18 stakeholders that I and my officials have previously 19 met. 20 I also support Sir Brian's proposal to establish 21 expert groups to assist the Inquiry in gathering its 22 evidence. 23 My officials will continue to support the Inquiry 24 team as this important work gathers pace, to ensure that 25 the voices of those affected in Wales are heard, and</p> <p style="text-align: center;">Page 29</p>	<p>1 and Transplant and its place within the NHS. 2 NHS Blood and Transplant is an unwieldy and 3 dangerous name and staff in the organisation generally 4 refer to it as NHSBT. I am aware that initials can 5 sometimes be annoying and confusing and sound like 6 jargon, particularly when lots are being used, but I 7 hope that using that shorter form today is sensible. 8 I am going to use the word "we" both for accuracy 9 and for economy when describing NHSBT and its team for 10 the Inquiry. 11 I should explain, first, what I propose to do in 12 these 15 minutes. People are entitled to know about 13 NHSBT, what it is and our role here, so I am going to do 14 the following: I am going to make a few important 15 preliminary remarks about this Inquiry and about NHSBT's 16 approach to it. 17 Secondly, I'm going to say a little about NHS BT's 18 history. That is important given the historical scope 19 of this Inquiry and, thirdly, I am going to describe in 20 a little more detail NHSBT's hopes for the Inquiry and 21 what it aims to help achieve for everyone concerned. 22 It goes, we hope, without saying that NHSBT fully 23 supports the Inquiry and all of its terms of reference. 24 Our primary concern is for those who were given infected 25 blood or infected blood products, and for their families</p> <p style="text-align: center;">Page 31</p>
<p>1 that the survivors and their families feel assured that 2 the Inquiry will take account of their evidence and 3 provide answers to their questions and concerns. I look 4 forward to receiving regular updates from the Inquiry 5 team. 6 SIR BRIAN LANGSTAFF: As promised, there will now be 7 a 20 minute break. 8 (3.05 pm) 9 (A short break) 10 (3.25 pm) 11 SIR BRIAN LANGSTAFF: The opening statement on behalf of NHS 12 blood and transport Charles Cory-Wright Queen's Counsel. 13 Opening statement by CHARLIE CORY-WRIGHT 14 MR CORY-WRIGHT: Thank you, Sir Brian, and good afternoon, 15 and good afternoon to those infected, those affected, to 16 other Core Participants, and others here and interested 17 in this Inquiry. 18 My name is Charlie Cory-Wright. I am representing 19 the NHS blood and transplant. 20 I am a barrister instructed by Weightmans 21 solicitors. At the moment, I am the only barrister 22 instructed. That may change if it turns out that it is 23 more cost effective to instruct anyone more junior as 24 well. 25 I will explain more, in a moment, about NHS Blood</p> <p style="text-align: center;">Page 30</p>	<p>1 and others who have been affected by this. We do know 2 that we can never truly understand the impact this has 3 had on the infected, their families and loved ones. 4 However, we do of course know that impact has been 5 devastating. One only has to have paid attention to 6 what has been said over the last three days to be aware 7 of that. 8 We understand that our job is to provide the Inquiry 9 team with all the help that we can in fulfilling its 10 terms of reference. We will do whatever we can to 11 assist the Inquiry in order that answers can be provided 12 to the questions asked by those infected and those 13 affected. 14 We will be open, constructive and honest. Our 15 motivation is to get to the truth for those infected and 16 affected to the best of our abilities. In that sense, 17 we share -- we hope -- the same approach as the Inquiry 18 itself. 19 Indeed, we understand that this Inquiry is above all 20 things a search after truth, the unvarnished truth about 21 all of the many disquieting things that we have been 22 hearing about over the last three days. We do get it. 23 That if the Inquiry is able to do that job properly, 24 then that is likely to include the uncovering of facts 25 that are seriously unpalatable.</p> <p style="text-align: center;">Page 32</p>

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<p>1 Whatever those truths may be, we want to say, loud 2 and clear at the outset, that we too are very sorry for 3 what happened to all those infected, all those affected, 4 all who are victims.</p> <p>5 We also understand that actions speak louder than 6 words. We hope that we are demonstrating that in our 7 cooperation with the Inquiry, both thus far and as it 8 continues, as well as in terms of the safety measures we 9 now apply in screening protocols and the like, which 10 I will outline in a moment.</p> <p>11 We do understand and embrace the need for the 12 Inquiry to apply current clinical science, and current 13 standards and norms, to its scrutiny of what went wrong. 14 It is only by doing that the lessons that need to be 15 learnt will be clear.</p> <p>16 Finally in this introductory section, I hope I can 17 help by mentioning this morning's invitation by 18 Steven Snowden QC, who raised Bishop James Jones's six 19 point charter for public bodies and invited those here 20 involved to sign up to that charter.</p> <p>21 That question having been raised, NHSBT has 22 considered the charter and its six points. We do not 23 see those six points as any different to the commitment 24 that we were already making to the Inquiry and, in those 25 circumstances, NHSBT confirms its intention to be guided</p> <p style="text-align: center;">Page 33</p>	<p>1 the Department of Health and Social Care, technically 2 constituted as a special health authority. That all 3 sounds quite complex, but essentially we are not 4 a government department and we are not part of one.</p> <p>5 We do work closely with the UK Government and the 6 Department of Health and Social Care, and are 7 accountable through our chief executive to them and, 8 ultimately, to the Secretary of State. I should add 9 that NHSBT is not to be equated with the NHS as a whole 10 or indeed to be treated as some way representing the NHS 11 as a whole. NHSBT's role as described just now clearly 12 justifies its status as a Core Participant in this 13 Inquiry.</p> <p>14 But if other NHS bodies ought to be involved, no 15 doubt they will be. We all heard on Monday that the 16 Inquiry is considering involving other such bodies and 17 that is obviously a developing picture.</p> <p>18 Its history briefly. NHSBT was established in 2005 19 when the National Blood Authority and UK Transplant 20 merged with the responsibility to provide a blood and 21 transplantation service to the NHS. We initially 22 provided a blood service to England and to North Wales 23 but that changed to England alone in May 2016 when the 24 All Wales Blood Service was formed.</p> <p>25 Providing a blood service includes the recruitment</p> <p style="text-align: center;">Page 35</p>
<p>1 by and to strive to follow those principles.</p> <p>2 I should explain who has been here this week from 3 NHSBT. On Monday, at the commemoration and opening of 4 the Inquiry there were Dr Gail Mifflin, NHSBT medical and 5 research director, and Roy Griffins, one of our longest 6 standing non-executive directors. Yesterday, there were 7 Millie Banerjee, the Chair of NHSBT, and Sally Johnson, 8 our interim chief executive and Dr Mifflin, again.</p> <p>9 Today, there are Dr Sheila MacLennan, a very senior 10 consultant at NHSBT, who is also the Chair of the Joint 11 United Kingdom Blood Transfusion and Tissue 12 Transplantation Services Professional Advisory 13 Committee, a mouthful, which I will shall refer to 14 further down the line as JPAC, and 15 Professor David Roberts, who is also a longstanding 16 senior consultant and associate medical director at 17 NHSBT.</p> <p>18 So, what is NHSBT?</p> <p>19 Well, it is, as you have heard, one of the four 20 blood services, each dealing with a different part of 21 the UK, involved as Core Participants in this Inquiry. 22 It is, as such, an NHS body involved in the provision of 23 blood to others for the treatment by clinicians of 24 patients who require that. NHSBT is an independent, 25 formally described as an executive arm's length body of</p> <p style="text-align: center;">Page 34</p>	<p>1 of blood donors and collection testing and manufacturing 2 of blood components which we then deliver to hospitals 3 in the NHS. We have always been responsible for organ 4 donation and transplantation services to the whole of 5 the UK. We also manage the donation, storage and 6 transplantation of tissues and stem cells.</p> <p>7 Of particular relevance are our responsibilities to 8 encourage people to donate organs, blood and tissue, to 9 optimise the safety and supply of blood, organs, stem 10 cells and tissue, to help raise the quality 11 effectiveness and clinical outcomes of blood and 12 transplant services, to provide expert evidence to other 13 NHS organisations and the four UK health departments, to 14 commission and conduct research and development, to 15 improve outcomes for patients and to implement relevant 16 EU statutory frameworks and guidance.</p> <p>17 Now, as I have already said, the history of the 18 organisation is important given the historical scope of 19 the Inquiry. Although NHSBT itself has only existed 20 since 2005, there have obviously been a number of 21 predecessor bodies, many of which no longer exist. The 22 precise family tree is complicated and we are going to 23 provide the diagram to the Inquiry showing the family 24 tree so that all can see clearly how this works, but for 25 present purposes we hope it is enough to say that we</p> <p style="text-align: center;">Page 36</p>

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<p>1 recognise that we will be speaking for and providing 2 documentation in place of those defunct predecessor 3 bodies in regard to the Inquiry. 4 To this end, we'll provide information to the 5 Inquiry relating to the National Blood Authority which 6 was formed in 93, itself formed by a combination of 7 earlier bodies with equivalent responsibilities. 8 I have referred to JPAC already. That is the 9 professional advisory committee that deals with this. 10 It is not a legal entity in itself. It now lies under 11 the governance of NHSBT and we will be ensuring that its 12 documents too and those relating to its predecessor 13 bodies are made available to the Inquiry. 14 Our role in the Inquiry. We have already had a good 15 and cooperative dialogue with the Inquiry team about 16 such obvious and highly important matters as the 17 location and disclosure of relevant documentation, 18 a very significant exercise for all concerned. 19 We have suggested cooperation between us and the 20 Inquiry team in the task of searching, both by computer 21 and manually, the extensive archive now available. We 22 are planning an event for Core Participants including 23 those infected and those affected to demonstrate how 24 blood services have changed beyond recognition since the 25 1970s and 80s, both in our policy making, particularly</p> <p style="text-align: center;">Page 37</p>	<p>1 need of a transfusion for the benefits of the procedure 2 to outweigh any inherent risks. 3 For precisely that reason we must do all we can to 4 ensure that we recognise properly the value and 5 importance of individual's lives, health and wellbeing 6 and that of their loved ones, and effectively to 7 reassure all concerned that this is so. 8 We repeat our commitment to do all we can to make 9 the blood components that we deliver to hospitals today 10 as safe as we reasonably can. More on that in a moment. 11 We also recognise that we are part of the NHS and 12 that we do this within the system as a whole. We wish 13 to reassure the Inquiry and the wider public that modern 14 safety standards are rigorous and our blood supply is 15 one of the safest in the world. Again, more on that in 16 a moment. 17 In terms of reassurance as to the current position, 18 it is important in the circumstances that I say 19 something about these current practices and procedures. 20 Safety is at the forefront of everything we do. These 21 are not just words. Our actions are prompted and 22 directed by the guidelines and the testing that are in 23 place to protect both donors and patients and we are 24 subject to regular inspections by independent 25 regulators. Our safety policy is formulated by two</p> <p style="text-align: center;">Page 39</p>
<p>1 around who is allowed to donate, of which more in 2 a moment, but also in the technology and processes used 3 for testing and manufacturing blood components. 4 We also invited the Inquiry team to visit any part 5 of our organisation to show how modern blood testing and 6 manufacturing is now performed. We are glad to hear the 7 Inquiry is keen to take us up on this invitation. 8 I'd like to say something now about NHSBT's 9 relationship with the public. The first thing to say is 10 that we are of course extremely grateful to all those 11 who become blood donors and we thank them for their 12 continued support and commitment to our blood service. 13 The NHS could not run, as it currently does, without 14 them. They are everyday heroes in what they do to save 15 and improve other people's lives. 16 Next a number of things about the need to maintain 17 the trust of all members of the public in the blood 18 services we provide. We recognise how important this 19 is. We would hope that all of this would be obvious but 20 sometimes it is important to say things expressly even 21 if they should be clear implicitly. Any one of us here 22 today may have been or may be in the future a recipient 23 of a blood component. Transfusion of a human substance 24 can never by its very nature be entirely risk free and 25 to receive one you must be unwell or sufficiently in</p> <p style="text-align: center;">Page 38</p>	<p>1 separate advisory committees: JPAC, already referred to, 2 and the Advisory Committee on the Safety of Blood, 3 Tissues and Organs. 4 All blood donations are routinely tested for 5 Hepatitis B, Hepatitis C, Hepatitis E, human 6 immunodeficiency virus, syphilis, and for the first time 7 donors, human T-lymphotropic, before they are released 8 into the supply chain. If any blood donation tests 9 positive for infection, it is not released into the 10 blood supply chain and therefore cannot be issued to 11 a patient. The donor is also given appropriate support 12 and advice. 13 Also, every donor completes an extensive donor 14 health check questionnaire before each donation. This 15 is designed to detect donors who have a recognisable 16 risk of infection who can then be excluded or subject to 17 further testing. Those considered at risk are 18 considered asked to defer donation until it is safe for 19 them to do so. For example, if a donor has travelled to 20 an area where malaria is present, they asked not to 21 donate for four months even though they have remained 22 well throughout, due to the risk of passing on an 23 undiagnosed malarial infection. 24 If someone has had their ears pierced, even though 25 the risk of getting Hepatitis B from such is very small,</p> <p style="text-align: center;">Page 40</p>

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<p>1 they are also asked not to donate for four months. 2 These are very low risks indeed but demonstrate the 3 lengths we go to to protect recipients of blood today. 4 We have also, with the other UK blood services, 5 established a UK wide haemophilia vigilance system 6 called SHOT, Serious Hazards of Transfusion. This is 7 a blood supply surveillance scheme where all hospitals 8 in the UK report as a condition of their registration 9 any recognised or unexpected reactions to blood products 10 to this body. 11 This operates through a group of internal and 12 external experts who work with professional independents 13 and make recommendations to hospitals and blood 14 services. It allows us to understand how changes we 15 have made may have impacted on patients and also allows 16 us to pick up early signs of any unexpected impending 17 problems. 18 Whilst we hope that the rigour of our current 19 systems offers some reassurance going forward, we are 20 constantly vigilant to any possible threat to the safety 21 of the blood supply. Most importantly, we also 22 appreciate that this does not at all address the 23 historic issues that have brought us here and we fully 24 understand and believe in the need to answer questions 25 and provide explanations to those whose lives have been</p> <p style="text-align: center;">Page 41</p>	<p>1 and Social Care to ensure that any documents from our 2 predecessor organisations that have not already been 3 identified are made available. 4 Those whose lives have been so tragically affected 5 have waited a very long time for an investigation that 6 satisfies their concerns. It has come too late for some 7 and to say that that must be a matter of huge regret for 8 all does not remotely do justice to the situation. 9 However, we have an opportunity here to help provide 10 answers to those who so unquestionably deserve them. We 11 intend to take it. 12 SIR BRIAN LANGSTAFF: Thank you, Mr Cory-Wright. 13 Simon Bowie QC appears to make the opening statement 14 on behalf of the Scottish National Blood Transfusion 15 Service. 16 Opening statement by Simon Bowie QC 17 MR BOWIE: Good afternoon, ladies and gentlemen, 18 Mr Chairman, Sir. My name is Simon Bowie and 19 I represent the Scottish National Blood Transfusion 20 Service or SNBTS. I am instructed by the Scottish 21 Health Service Central Legal Office. 22 At the outset I and SNBTS would like to offer our 23 deepest sympathy to all those who have been affected by 24 the subject matter of this Inquiry, something which has 25 been spoken about so eloquently by so many over the past</p> <p style="text-align: center;">Page 43</p>
<p>1 devastated, from whom and on whose behalf we have heard 2 so powerfully. 3 In conclusion, we hope that all of this provides 4 some assurance to the Inquiry and to those infected and 5 those affected and to the wider public as to NHSBT's 6 desire and determination to assist the Inquiry process 7 as fully as possible. 8 We are acutely aware of the particular importance 9 that this Inquiry is able to submit its report quickly 10 in order to benefit as many people as possible. 11 We reiterate, our absolute commitment to honesty, 12 openness and transparency and to assisting the Inquiry 13 in every way we can. 14 We have provided the Inquiry team with initial 15 evidence and disclosed a large amount of information to 16 it. As we have already said, we have also met with them 17 to discuss arrangements for them to inspect 18 a considerable number of documents and undertake 19 searches for what they consider relevant to the Inquiry. 20 We have confirmed to them that they will have access to 21 search and examine any of the documents that we hold. 22 We will continue to work closely with the team to ensure 23 that all requests for information are properly dealt 24 with in a timely manner. We will also be working 25 closely with the Inquiry and the Department of Health</p> <p style="text-align: center;">Page 42</p>	<p>1 few days. 2 In this statement I am going to say a few words 3 about the following: first, who SNBTS is and what it 4 does; secondly, its relationship with the other UK blood 5 services; thirdly, its views specifically about the 6 terms of reference, and fourthly, and perhaps most 7 importantly, its attitude towards this Inquiry 8 generally. And I'll deal with the last of these first. 9 SNBTS is pleased to be here as a Core Participant at 10 the very outset of this significant Inquiry. It 11 recognises that the issues which will be addressed 12 during the Inquiry are of great importance to those 13 people who have been infected and affected but also to 14 organisations like SNBTS within the NHS, and of course 15 to the general public as a whole. 16 SNBTS recognises that as a Core Participant it has 17 a contribution to make to the work of this Inquiry. In 18 that regard, it has sought to engage positively with the 19 various requests made to it by the Inquiry team. It has 20 been able to respond promptly when asked to produce, for 21 example, the large amount of documentation which it 22 holds. 23 Going forward, I can assure the Inquiry team and the 24 Chairman, Sir, that SNBTS will continue to adopt this 25 attitude. It knows how important it is to the work of</p> <p style="text-align: center;">Page 44</p>

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<p>1 the Inquiry and to it securing its objectives that 2 organisations like SNBTS fully engage with the process. 3 In the coming months and years SNBTS hopes to make 4 a material contribution to the work of the Inquiry and 5 looks forward to assisting the Chairman and Inquiry team 6 in whatever ways it can. 7 Likewise, I know that the Scottish Health Boards 8 have the same attitude and will do likewise. 9 SNBTS was also a Core Participant in the Penrose 10 Inquiry and fully engaged with it over a number of 11 years. Having that involvement, it is believed that 12 SNBTS is well qualified to assist in the work of this 13 Inquiry. 14 What does SNBTS do and what is its relationship with 15 the other UK blood services? The Scottish National 16 Blood Transfusion Service sits within NHS National 17 Services Scotland and is part of NHS Scotland. It is 18 the specialist provider of blood, tissues and cells in 19 Scotland. As an organisation it is quite separate and 20 distinct from its counterparts in England, Wales and 21 Northern Ireland, being set up and run within 22 a peculiarly Scottish political, legal and social 23 framework. It does, however, collaborate closely with 24 the other UK blood services in, for example, ensuring 25 the development and maintenance of guidelines and</p> <p style="text-align: center;">Page 45</p>	<p>1 reference. In relation to the terms of reference, it 2 would respectfully appear to SNBTS that all of the 3 issues identified are of significant public importance 4 and would not for its part seek to prioritise any issue 5 or issues in particular over others. SNBTS will assist 6 in all relevant matters and looks forward to working 7 with the Chairman, the Inquiry team and all of the other 8 participants in the coming months. Thank you very much. 9 SIR BRIAN LANGSTAFF: The opening statement on behalf of the 10 Welsh Blood Service by Debra Powell QC. 11 Opening statement by DEBRA POWELL QC 12 MS POWELL: Thank you, Sir, and good afternoon to you and to 13 everyone here. 14 I represent the Welsh Blood Service with 15 Miss Susanna Rickard. The Welsh Blood Service is not 16 a freestanding entity of itself. It is a division of 17 Velindre University NHS Trust. Legal & Risk Services of 18 NHS Wales Shared Services Partnership are the appointed 19 legal representatives for Velindre. Although Velindre 20 University NHS Trust is the statutory body, I shall 21 refer throughout and for the sake of ease to the Welsh 22 Blood Service. 23 It is right that I start by saying that the Welsh 24 Blood Service recognises the huge importance of the work 25 that the Inquiry is to undertake. The fact that so many</p> <p style="text-align: center;">Page 47</p>
<p>1 standards. 2 As well as ensuring the supply of blood, SNBTS also 3 supplies human tissues and cells such as bone, heart 4 valves and tendons, all of which are vital for the 5 numerous operations carried out every day across 6 Scotland. Its core purpose is to ensure that NHS 7 Scotland has adequate blood supplies to meet the 8 transfusion needs of all patients in Scotland. 9 In that regard it is critical that it maintains 10 public confidence in the nation's blood supply. SNBTS 11 believes that this Inquiry will be important to that 12 end. 13 Finally, SNBTS relies on its relationship with the 14 public because it is only with the willingness of the 15 public to donate that SNBTS can do the work it does. 16 The organisation carries out all of these functions by 17 working in close partnership with communities, donors, 18 hospitals and healthcare professionals. It seeks to 19 ensure that it can supply donated blood, tissues and 20 cells for use in the treatment of all patients. Its aim 21 is to deliver a transfusion service for the benefit of 22 all patients in Scotland. In all of this its goal is to 23 treat with care and respect all those who are affected 24 by its work. 25 Lastly, some comments in relation to the terms of</p> <p style="text-align: center;">Page 46</p>	<p>1 patients in the past were infected with terrible 2 diseases as a result of receiving infected blood and 3 infected blood products that were intended to help them 4 was, as you, Sir, said in your opening remarks, 5 a catastrophe. 6 We are acutely aware that the lives of the victims 7 and of their families have been utterly devastated and 8 in many cases lost and we are very sorry for what 9 happened and for what they, for what you, have suffered. 10 We agree wholeheartedly with what has been said by 11 so many of the speakers so far, that the victims and 12 their families are entitled to answers to the questions 13 that they have been asking for so long. We fully 14 support the Inquiry and its terms of reference and are 15 committed to assisting the Inquiry honestly and openly 16 to enable answers to be given to those important 17 questions. And to respond to Mr Snowden QC this 18 morning, yes, and to be clear, our objective is to 19 assist the search for truth. 20 We have established a dedicated team to work on the 21 needs of the Inquiry generally. But perhaps the most 22 significant aspect of the assistance that we can provide 23 to the Inquiry, certainly at this stage, is in finding 24 and providing access to documents. We have begun the 25 work of providing you with information and</p> <p style="text-align: center;">Page 48</p>

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<p>1 documentation, Sir, in accordance with requests made by 2 your Inquiry team and further work is being undertaken 3 in locating documents that may be relevant to your work. 4 Although there have been other more limited 5 inquiries into the administration of infected blood and 6 infected blood products to patients in the UK, the Welsh 7 Blood Service were not asked to participate in or to 8 provide evidence or documentation to those Inquiries and 9 so much of the material that is now sought to be 10 provided to your Inquiry by the Welsh Blood Service is 11 being sought for the first time. 12 Inevitably, given the substantial period of time 13 with which the Inquiry is concerned, and the 14 organisational changes in the provision of blood 15 services in Wales throughout that time and since, the 16 process of finding the documents is not 17 a straightforward one. But strenuous efforts have been 18 and will continue to be made to make all potentially 19 relevant documentation available to your Inquiry team 20 and we wish to stress, as others have done, that it will 21 be for the Inquiry team to determine which of those 22 documents are relevant. That will not be a task we will 23 be undertaking. 24 I am going to say just a little about the evolution 25 of blood services in Wales over the relevant period.</p> <p style="text-align: center;">Page 49</p>	<p>1 non-remunerated blood donations from the general public. 2 It processes and tests those donations, and distributes 3 them to hospitals for patient care. It provides medical 4 consultant support to hospital blood transfusion 5 committees and clinical advice is given to hospitals as 6 required. It is authorised and licensed by the 7 medicines and healthcare products regulatory agency, 8 which audits the service at regular defined periods. 9 The safety of the blood supply chain is of paramount 10 importance to the Welsh Blood Service and it takes the 11 most rigorous steps in ensuring that it is safe for 12 donors to donate blood and safe for patients to receive 13 those blood products when they need them. 14 We want to take this opportunity to reassure the 15 public, whose help and support is so fundamental to the 16 maintenance of the blood supplies that underpin the NHS 17 today, that vital lessons have already been learned 18 about maintaining the safety of the blood supply chain; 19 that blood services today are worlds away from the blood 20 services of the past. 21 But that in no way detracts from the importance of 22 discovering how and why this treatment disaster happened 23 and you can be assured, Sir, that in the difficult task 24 ahead, you and your Inquiry team will have the full 25 cooperation of the Welsh Blood Service. Thank you.</p> <p style="text-align: center;">Page 51</p>
<p>1 In 1946, the national Blood Transfusion Service was 2 formally established in England and Wales with a number 3 of regional transfusion centres, including Cardiff. In 4 1948, it came under the control of the then new National 5 Health Service. Blood services in North Wales, though, 6 were provided from the Liverpool regional transfusion 7 centre, whilst the South Wales regional transfusion 8 centre at Cardiff covered mid South and West Wales. 9 In 1994, the blood services of England came under 10 the control of the newly created National Blood 11 Authority, but the South Wales regional transfusion 12 centre did not become part of the NBA and was under the 13 control of the Welsh office. 14 The Welsh Blood Service evolved from the South Wales 15 Regional Transfusion Service in Cardiff, at the time of 16 Welsh devolution in 1997. It became a division of the 17 Velindre NHS Trust, as it then was, in 1999, and at that 18 time it still covered mid, South and West Wales with 19 blood collection and distribution in North Wales managed 20 from Liverpool, still, under NHS Blood and Transplant in 21 accordance with the longstanding arrangements. 22 In May 2016, for the first time, the Welsh Blood 23 Service became an all Wales service when it became 24 responsible for North Wales. 25 Today, the Welsh Blood Service collects voluntary</p> <p style="text-align: center;">Page 50</p>	<p>1 SIR BRIAN LANGSTAFF: Counsel to the Inquiry. 2 Reply by counsel to the Inquiry, JENNI RICHARDS QC. 3 MS RICHARDS: Can I start by expressing our gratitude for 4 all the contributions we have heard over the last two 5 days. You have given the Inquiry much food for thought 6 and I hope you will understand that we will want to 7 reflect on much of what has been said. In particular, 8 you have told us about the issues that are of the most 9 importance to you. That is going to be of considerable 10 value to us in compiling the draft list of issues, 11 prioritising lines of investigation and planning the 12 hearings, and we offer a heartfelt thank you for that. 13 Some of you have also raised important procedural 14 points. Again, we want to reflect on those, not least 15 because there are still some further written submissions 16 to come and it is important that we consider everything 17 that's been said. 18 There are, however, a handful of points which I can 19 deal with now. 20 Firstly, I need to correct something Mr O'Neill 21 said. He referred to there being, in Scotland, "ongoing 22 police investigations". That isn't the case and it 23 isn't what I said, and I have clarified that with 24 Mr O'Neill and he is happy that I correct the position. 25 The two police investigations in Scotland, to which</p> <p style="text-align: center;">Page 52</p>

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<p>1 I referred on Monday, are not ongoing. They are 2 investigations that were closed a few years ago, but the 3 documents relating to them have very recently been 4 disclosed to the Inquiry, by Police Scotland, and will 5 now be assessed by the Inquiry for relevance, 6 cataloguing, indexing and onward disclosure to Core 7 Participants.</p> <p>8 Secondly, I want to return to the issue of the 9 participation or non-participation of the Scottish 10 Government. The Scottish Government spokesman was 11 reported by the BBC yesterday to have said this, and 12 I quote:</p> <p>13 "We are in the process of discussing a number of 14 issues with The Cabinet Office, such as the Inquiry's 15 terms of reference, in order to enable the Scottish 16 Government and NHS Scotland bodies to participate fully 17 in the Inquiry. As we have already set out, we expect 18 to become Core Participants to the Inquiry once these 19 issues are resolved."</p> <p>20 End of quote. You may be forgiven for thinking 21 there are a couple of minor issues to be ironed out as 22 the sole impediments to the Scottish Government's 23 participation in this Inquiry.</p> <p>24 In fact, what we understand the issues to be are 25 twofold. Firstly, the Scottish Government has asked the</p> <p style="text-align: center;">Page 53</p>	<p>1 As for the request for funding, the Inquiry is not 2 in a position to and will not be funding the Scottish 3 Government's costs, nor those of the NHS in Scotland.</p> <p>4 Can I deal, then, with some other matters, a handful 5 of matters that have arisen. As I said, much of what 6 has been said is material that we want to go away and 7 think about.</p> <p>8 Expert groups. There was some reference to them as 9 expert panels. They are expert groups, and that's not 10 mere semantics because "panel" is a term of art under 11 the Inquiries Act.</p> <p>12 The experts, who will after hearing your suggestions 13 become members of the expert groups, will not be 14 decision-makers. They will have the status of expert 15 witnesses providing independent evidence to the Inquiry, 16 and that's important because, as witnesses, their 17 evidence will be disclosed to Core Participants and 18 published on the Inquiry's website. It will not be 19 evidence given to the Chair behind closed doors.</p> <p>20 Mr O'Neill raised a couple of queries which I hope 21 I can answer in relation to experts. First, he asked 22 this: if there is consensus amongst the experts, but 23 Core Participants do not think their views are 24 well-founded, will there be an opportunity for the 25 experts' views to be challenged?</p> <p style="text-align: center;">Page 55</p>
<p>1 Cabinet Office to confirm that reconsideration of areas 2 considered by Lord Penrose will be kept to a minimum.</p> <p>3 Secondly, the Scottish Government has asked that the 4 Inquiry or the Cabinet Office meet the staffing, legal 5 and travel costs of the Scottish Government and the NHS 6 in Scotland of participating in the Inquiry.</p> <p>7 Can I deal with each of those in turn? I repeat 8 what I said on Monday: the terms of reference have been 9 set and they cover Scotland. We will, as we said on 10 Monday, avoid unnecessary duplication with Penrose and 11 we are very grateful to the assistance of Mr O'Neill and 12 his team in helping us identify noncontroversial matters 13 from the Penrose report that can be utilised.</p> <p>14 But it is for the Chair to interpret and fulfil the 15 terms of reference. It is not a matter for the Scottish 16 Government or the Cabinet Office. We intend to be and 17 are independent of government, and if the Scottish 18 Government considers that the Cabinet Office can tell 19 you, Sir, what to do, it is wrong.</p> <p>20 If the Scottish Government has submissions to make 21 about what can or should, or cannot or should not be 22 revisited from Penrose, then the appropriate means for 23 it to do so is to become a Core Participant and make 24 submissions on that issue openly, as all of you have 25 taken the trouble to do over the last few days.</p> <p style="text-align: center;">Page 54</p>	<p>1 The answer to that is: yes, in two ways. Core 2 Participants will first will able to propose questions 3 in writing to the experts once they have seen their 4 reports. If the answers to those questions don't 5 address the concerns, and if the issues are of 6 significance to the Inquiry and its terms reference, 7 then the likely course will be one or more of the 8 members of the expert group will be called to give 9 expert evidence and to be questioned.</p> <p>10 The second point Mr O'Neill raised in his written 11 submissions was to lay down the concern that you were 12 unaware of whether the intention was that expert groups 13 would be involved after the evidential stage in the 14 process and the extent to which they might influence 15 your final report, Sir.</p> <p>16 Again, I hope I can clarify the position. The 17 experts will not be giving private advice to the Chair 18 at the report writing stage or any other stage.</p> <p>19 It is conceivable, of course, that the expert groups 20 might have views to offer that might be highly relevant 21 to the question of recommendations if, as the Chair 22 hopes the Inquiry will be in a position to do, it makes 23 recommendations in due course.</p> <p>24 But, if so, that expert evidence about 25 recommendations will again be public and shared.</p> <p style="text-align: center;">Page 56</p>

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<p>1 The fourth point I wanted to deal with is Mr Lock's 2 and indeed the concern of some others about 3 Maxwellisation or the use of Salmon Letters. That is 4 the process which provides for people who are to be 5 criticised in a report to respond prior to publication. 6 Two concerns have been raised by Core Participants in 7 this regard. 8 Firstly, that it can lead to significant delays 9 before the final report is published and, secondly, that 10 it lacks transparency. Can I say we entirely understand 11 those concerns. I can, I think, provide some 12 reassurance on the question of delay. Our intention is 13 that significant criticisms will already have been aired 14 in the course of the investigation process and the 15 hearings, and so witnesses and organisations will have 16 had an opportunity to respond. 17 The consequence of that is that if we have to go 18 down the Maxwellisation or warning letters route at all, 19 it should not lead to significant delay because people 20 or bodies should not need very long to respond to 21 a criticism that's already been fully aired and 22 explored. 23 The second concern about lack of openness is not as 24 easily addressed for this reason: Mr Lock I think 25 invited the Inquiry to effectively jettison the entire</p> <p style="text-align: center;">Page 57</p>	<p>1 and certainly long before we get to the oral hearings 2 next year, the approach that the Inquiry will take to 3 that process. 4 Fifthly, a point raised by Mr Williams QC about 5 witness statements. He asked whether witness statements 6 will be in the witness's own words and, if necessary, in 7 the witness's own language, and the short answer to that 8 is yes. 9 The Inquiry gets witness statements by doing 10 something called issuing a rule 9 request. Again, 11 that's a requirement of the rules, addressed to the 12 witnesses is a series of questions that the Inquiry 13 wants the witness to answer. But how those questions 14 are answered and, indeed, in what language those 15 questions are answered is a matter for the witness. If 16 the witness wants to use strong terms, that is a matter 17 for the witness. 18 A further point that was made, I think by Mr Stein 19 QC, was that the Inquiry should be considering what was 20 known prior to 1970. We agree and that is the approach 21 we have been taking thus far and the approach that we 22 will continue to take. 23 There were some very helpful practical suggestions 24 about a timeline or a chronology, and we accept that 25 a shared or common understanding of key dates and key</p> <p style="text-align: center;">Page 59</p>
<p>1 process of Maxwellisation and, again, we completely 2 understand why he says that. But there are certain 3 requirements in the Inquiry Rules and you will 4 appreciate, and indeed no doubt expect no less, that the 5 Inquiry must act in accordance with the law and must act 6 fairly. 7 If, having heard all the evidence and read all the 8 evidence the Chair proposes in due course to make 9 critical judgments or findings about individuals or 10 organisations, as indeed he is being asked to do by so 11 many Core Participants, he would not, I am sure, want 12 any individual or organisation or organ of government to 13 be able to say: we're entitled to reject those 14 criticisms or those recommendations because the Inquiry 15 adopted a process that was unlawful or unfair. 16 It is vital that the legitimacy of the ultimate 17 conclusions and recommendations reached by the Chair is 18 not undermined. 19 Mr Lock very sensibly suggested that the Inquiry 20 consider this issue further and set out the ground rules 21 at an early stage, and that is a very good suggestion. 22 It is exactly what we'll do. We are going to look very 23 carefully at what has been said. We are going to look 24 very carefully at the requirements of the Inquiry rules 25 in that regard and we will set out, at an early stage</p> <p style="text-align: center;">Page 58</p>	<p>1 events will be important, and we are going to give 2 further consideration to the best way of achieving that, 3 practically. 4 Mr Stein also raised a question about document 5 ownership and whether there would be a clear record of 6 who provides the copy of a document to the Inquiry. The 7 answer to that, again, is yes, both in terms of the 8 Inquiry's own document management system and in terms of 9 the Relativity database, to which Core Participants will 10 have access. 11 My penultimate point in response to some submissions 12 made indeed by all Core Participants, but I have in mind 13 particularly some submissions made by Mr Snowden this 14 morning. Particular lines of Inquiry were suggested as 15 regards documentation, and mention was made of seeking 16 files from the Treasury and the Foreign Office. Those 17 are extremely helpful suggestions. We will be taking 18 those forward and, to make matters absolutely clear, we 19 ask for unredacted copies of documents to be provided to 20 us and we will scrutinise any claim for legal 21 professional privilege or public interest immunity with 22 rigour. 23 I have also committed -- having spoken to Mr Snowden 24 and to his junior -- that the Inquiry will take up the 25 extremely troubling issue he raised about destruction of</p> <p style="text-align: center;">Page 60</p>

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<p>1 medical records and charging for medical records. That 2 should not happen and the Inquiry team will address 3 questions to the relevant trust as a matter of urgency. 4 All the other points that have been raised, as 5 I say, we will take away and reflect. 6 The final observation that I want to make is this: 7 what came across with very great clarity and power, 8 particularly, if I may say so, from the opening 9 statements made by individual unrepresented Core 10 Participants, is that although this Inquiry is looking 11 back over decades, and that indeed is one of the great 12 challenges for the Inquiry, this isn't an Inquiry into 13 matters of history, but into matters which continue to 14 this day to have a profound effect on people's lives. 15 We are acutely conscious of the enormous 16 responsibility that rests on the Inquiry's shoulders and 17 we will do our best to fulfil that responsibility. 18 Thank you. 19 Concluding remarks by SIR BRIAN LANGSTAFF 20 SIR BRIAN LANGSTAFF: I have only a few words to say to 21 follow that. The first two words are "thank you". 22 Thank you in particular for what was described by one of 23 our contributors earlier on today as "the spirit in 24 which the Inquiry has begun", because the one thing 25 which has been palpable I think, I suspect to all of</p> <p style="text-align: center;">Page 61</p>	<p>1 purpose of the last three days and it has achieved that 2 purpose, and we must now go, having listened -- the 3 other part of listening is thinking about what's been 4 said and that's what we propose to do. We will engage 5 fully with those who are represented with your 6 representatives on all the issues, including vexed 7 issues, like having witness statements prepared in time 8 and so on, and indeed we can start those discussions 9 this evening, should that be necessary. 10 But can I add two further things, and they are both 11 really about visibility. These three days have made 12 this scandal visible, really visible in a way that I was 13 told, when we consulted on the terms of reference, you 14 felt it had not been before. Now, we have the press and 15 the media to thank for that. It has become visible and 16 visible to many who had not perhaps understood that they 17 were not on their own. Some of you have said to me in 18 the course of these three days that you hadn't really 19 understood that there were others in your position until 20 you came to this gathering, and that, perhaps, has been 21 one of the great advantages of everyone coming together, 22 properly together, for the last three days. 23 But what it means is that there may be others who 24 are watching on TV or reading the paper or looking at 25 social media, who had not, until these last three days,</p> <p style="text-align: center;">Page 63</p>
<p>1 us -- certainly, it is the way that I have felt it -- is 2 the spirit of enthusiasm, cooperation, togetherness and 3 a faith that this Inquiry will get the answers that you 4 deserve. I intend to do my very best to make sure that 5 it does. 6 Thank you very much. Can I just say you are 7 largely -- not entirely, but largely Core Participants 8 and the Inquiry cannot work as it should without the 9 full participation of all its Core Participants. One of 10 the encouraging things about today was not only your 11 desire to participate, which is clear, but the promises 12 that we have had from the Department of Health, the 13 Blood Transfusion Services -- if I can describe them 14 like that across each of the three countries -- to help 15 as Core Participants. It is a pity that the Scottish 16 Government has not yet joined them, though I would hope 17 that in due course -- I hope in quick course -- it will. 18 The reflection of the mammoth nature of the task 19 which we are undertaking has been the sheer number of 20 those of you who have managed to come today despite all 21 the difficulties of that, and I don't underestimate 22 them. 23 I welcome that willingness and I thank you for it. 24 You have given me, as indeed Jenni Richards has 25 said, many things to think about. Well, that was the</p> <p style="text-align: center;">Page 62</p>	<p>1 understood that they were people who shared what you 2 share. I do appeal to them, and I would ask those who 3 can, in the media, to help with this, to remind everyone 4 who wishes to come forward: it is not too late. Every 5 witness statement is important. If we are to get to the 6 truth, it is a collaborative effort from all parties and 7 that may include those whose voices have not yet 8 surfaced. 9 If for any reason there are people who feel that 10 they may have suffered the effects of transfusion or 11 contaminated blood products in the past, but have not 12 yet put their hands up or have not felt able to, can 13 I invite them to do so. Their rights to privacy will be 14 respected insofar as we possibly can. You will know 15 from your experience that is so, and it will be so. 16 But the second consequence of the visibility of 17 these three days is that you may think that the Inquiry 18 will be invisible for the next six or seven months. 19 A number of you have said, "It is so nice to see that 20 the Inquiry's started", it did actually start on 2 July, 21 when the terms of reference were agreed by Parliament. 22 By saying, "It is so nice to be here at the start of 23 the Inquiry", misses the fact that for those months, 24 very nearly three months since 2 July, the Inquiry has 25 actually been hard at work and you have seen how hard at</p> <p style="text-align: center;">Page 64</p>

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<p>1 work it has been from the disclosure that we have 2 sought, seeking documents, getting documents which some 3 people have never seen before, and considering how best 4 to bring you together to hear what your priorities were 5 and to hear how we could improve the procedures of the 6 Inquiry. We are open always to listen to better ways of 7 doing that, whoever wishes to advise us of them. 8 What it means is that for those couple of months or 9 so you have not really felt that the Inquiry was going 10 on, and it has been, and it will do for the next six or 11 seven months. It may seem to you that, as memories of 12 this fade, that it was empty promise. 13 Let me give you an assurance that tomorrow morning, 14 before 9 o'clock, I shall be hard at work, as my Inquiry 15 team have been since 2 July, a larger team than it was 16 then, but it needs to be, and we shall stay hard at work 17 until the job is done. 18 We do not so much start as continue our search for 19 the truth. Thank you. 20 (4.30 pm) 21 22 Opening statement by SAMANTHA MAY5 23 24 Opening statement by ELEANOR GREY QC14 25 26 Opening statement from VAUGHAN28 27 GETHING (read) 28 Opening statement by30 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000</p>	<p>Opening statement by Simon Bowie QC43 Opening statement by DEBRA POWELL QC47 Reply by counsel to the Inquiry,52 JENNI RICHARDS QC. 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