

Wednesday, 24 February 2021

(10.00 am)

PETER ROGER STEVENS (continued)

SIR BRIAN LANGSTAFF: Good morning, Mr Stevens.

A. Good morning, Sir Brian.

SIR BRIAN LANGSTAFF: You are where you were yesterday, in the same chair I see.

A. Yes.

SIR BRIAN LANGSTAFF: And we are as we were yesterday.

Yesterday there were around 220 or so people remotely watching, perhaps a shade more from time to time, and I'm expecting very much the same today.

A. Right.

SIR BRIAN LANGSTAFF: So that's where we are.

A. I hope the sound problems have been resolved.

SIR BRIAN LANGSTAFF: Beg your pardon?

A. I hope the sound problems have been resolved.

SIR BRIAN LANGSTAFF: So do I, yes. I'm sorry I had to ask you to repeat it, which is not a good start, is it? But anyway, we'll see how we go. I'm hopeful.

Thank you for asking.

Ms Richards.

Questions by MS RICHARDS (continued)

MS RICHARDS: Mr Stevens, a few more questions on the Macfarlane Trust before I turn to ask you about the

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people could ask for for which the Trust would provide help, up to a maximum amount of money for each item. That publication then becomes an incentive to people to say: well, I think I need a new washing machine, I need a new dishwasher, or whatever, I need a new mattress, I need the driveway relaid, I need some double glazing, up to -- and it's going to cost so much. And surprisingly, or maybe not surprisingly, the estimates tended to come towards the top end, towards -- close to the maximum published in those guidelines. It just becomes -- it's just -- I think it's human nature.

Q. But the Trust would still have to be satisfied that there was a need for that item or that work?

A. Yes, but it's very difficult -- I mean, if somebody says, with their clinician's backing, that they need a new washing machine or they need a new mattress or they need some help with gardening or something, it's very difficult for the Trust then to say: actually, we don't think you do.

One of the things we didn't touch on yesterday was there was a proposal in the -- *during my chairmanship*, of -- we appointed some regional support workers. So we had people on the ground around the country who could visit beneficiaries, help them,

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other Alliance House organisations.

I wanted to go back over a couple of points from yesterday. I'd asked you about the possibility of pursuing a media campaign and you responded as to what your thinking was at the time. We know that both BBC and ITV had made documentaries through reputable programmes, including Panorama and World in Action, in the 70s, 80s and 90s about contaminated blood. Were the trustees aware of that, as far as you can recall?

A. As far as I can recall, yes. If the programmes were there, they were probably -- people probably knew about them.

Q. Do you recall whether the trustees ever considered approaching either of those organisations or those involved in either of those programmes?

A. No, I don't recall that suggestion being made.

Q. And then, when I was asking you yesterday about publication of the office guidelines, you referred to the concern, and, indeed, it's documented contemporaneously, that they would become shopping lists.

A. Yes.

Q. Can I ask you to elaborate on what you mean by that

A. Yes. When guidelines were published earlier on in the life of the Trust they itemised the sort of things

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discuss their problems and maybe, you know, see what they needed. That proposal was rejected by the Partnership Group, who regarded them as being potentially spies. So what would have seemed quite a good idea, that the Trust should have people on the ground giving -- actually having conduits of communications between the Trust and beneficiaries, were turned down on the basis they were going to be spies.

So they would have -- our idea was that such people would have helped to -- would have helped with preparation of applications for grants.

Q. If an applicant applied for an item with the support of their clinician, it being their clinician's view that they needed it, why would the Trust feel the need to cast any doubt on that? Isn't that exactly what the Trust was for? Why try to deter such applications through not publishing the guidelines?

A. It would be nice to believe that clinicians were always capable of being objective.

Q. Mr Stevens, it might be said that the Trust was proceeding upon the basis that it would mistrust the veracity of applications being made to it until proven otherwise.

A. No, it might be said that the Trust didn't have enough

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1 money and we were very careful with money we were
2 giving away, and so we had to be -- take more trouble
3 than we might have wished to examine applications for
4 grants.

5 I'm sorry, it's the common theme running all
6 the way through our conversation about this Trust and
7 about -- when we're going to come to the others. With
8 one exception, none of them were funded properly.

9 **Q.** In relation to the regional support workers, how were
10 they going to be funded?

11 **A.** We would have had to have obtained extra funding from
12 the Department of Health.

13 **Q.** If that wasn't available, or indeed even if it was
14 available, that would be funding that would otherwise
15 be available for direct assistance to beneficiaries
16 Wasn't that one of the concerns about regional support
17 workers?

18 **A.** Possibly. I can't remember.

19 **Q.** I wanted to ask you a little next about the MFT's
20 approach to grants and loans. How was it decided
21 whether a registrant would receive a grant or a loan?
22 Were there any written or established criteria that
23 were followed?

24 **A.** Not that I can recall. I think generally if people
25 wanted a loan they would ask for it, and we would then

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1 **A.** I don't think -- I think if we got to the stage where
2 debt was a problem and had to be -- had to be repaid,
3 and we had to help repay it, there was clearly no
4 point, I don't think, in asking for -- for us to
5 become the people to whom the money was owed rather
6 than the bank.

7 **Q.** Were some loans secured against homes and others not?

8 **A.** Yes.

9 **Q.** What was the reason for any distinction between the
10 two different circumstances?

11 **A.** Possibly the size of the -- probably -- possibly the
12 amount. I don't remember the protocol for determining
13 which debts were secured and which weren't.

14 **Q.** During the time you were at the Trust, were there, as
15 far as you can recall, any loans to beneficiaries
16 secured against properties that were cancelled or
17 amended by the Trust so that no or a reduced repayment
18 was required?

19 **A.** I cannot remember.

20 **Q.** Do you --

21 **A.** That you asked suggests that it did happen.

22 **Q.** No, it's an open question, Mr Stevens, as to what you
23 can recall.

24 In what circumstances, if you can recall, would
25 the Trust write off a loan?

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1 say -- we would then examine why they wanted a loan,
2 whether a loan or a grant would be appropriate.

3 I don't think that there was a rigid protocol
4 as to when loans were made. Obviously, loans were --
5 came into the picture when it was a question of
6 housing purchase or substitute for mortgages. I don't
7 remember that -- I don't remember a fixed idea.

8 **Q.** As a matter of practice, did the Macfarlane Trust
9 assist any beneficiaries by paying off or contributing
10 to debts, credit card or store card balances or
11 matters such as that, with no payment expected back to
12 the Trust?

13 **A.** Yes.

14 **Q.** Did the Trust likewise assist beneficiaries in paying
15 off or contributing to debts with payment expected
16 back to the Trust?

17 **A.** I think, although it was broadly Trust policy that we
18 wouldn't repay debt, because after all debt was not --
19 the occurrence or the existence of debt now is not
20 covered by any definition of need now. Nevertheless
21 if people were under pressure from banks to whom they
22 owed money, that could be classed as need and so then
23 if necessary we would help.

24 **Q.** But would you sometimes help by advancing money that
25 you expected to be repaid or was it --

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1 **A.** If it was clear that its existence was an
2 insupportable burden for the debtor.

3 **Q.** Again, were there any -- leave aside whether they were
4 published or not, were there any policies or criteria
5 operated by the Trust in that regard?

6 **A.** No, I think this was done on a case-by-case basis.

7 **Q.** Just a couple of questions in relation to the equity
8 sharing arrangements. What steps were taken to ensure
9 that the applicant took and received independent legal
10 advice?

11 **A.** Oh, I think the rules that were put in place by
12 Clifford Grinstead, I'm sure we would have covered that
13 in the rules, that there was an insistence that the
14 applicant was properly legally advised.

15 **Q.** The policies certainly refer to that. It was more
16 a question of whether, practically, the Trust took
17 steps to ascertain or facilitate that. Do you know
18 what the position was as a matter of fact?

19 **A.** I cannot believe that we would not have insisted on
20 that.

21 **Q.** Then, did the Trust ever consider imposing a cap on
22 the total value of any equity appreciation, for
23 example, to the equivalent of what the interest charge
24 might have been?

25 **A.** No, I don't believe so. I'm only aware of -- I can

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1 only think at the moment of one equity sharing loan
 2 where the amount of the appreciation was such that it
 3 would have -- that would have entered into
 4 consideration. On that particular loan I can remem ber
 5 we did actually reduce the amount of the equity sha re
 6 that the Trust took. That was -- we allowed the
 7 borrower to increase the share that went to the
 8 borrower rather than to the Trust.

9 **Q.** Now, I asked you yesterday about the position in
 10 relation to widows, and I think it's clear from you
 11 evidence and from your written evidence -- please
 12 correct me if I'm wrong -- that the Trust acknowl edged
 13 that the arrangements for widows were inadequate, b ut
 14 that reflected, as I understand the evidence that y ou
 15 give, the limited resources available to the Trust; is
 16 that right?

17 **A.** Yes.

18 **Q.** In terms of other dependants, what support was
 19 available for children who had lost one or both of
 20 their parents?

21 **A.** There was support available but I think, if you
 22 recall -- it was done on a case-by-case basis. There
 23 was no fixed -- there were no fixed arrangements. We
 24 just tried to look at the particular circumstances and
 25 do what was -- what seemed to be suitable at the ti me.

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1 **A.** There was a bereavement project that ran for a few
 2 years chaired by one of the trustees, that I'm sure
 3 would have covered this. It was not something in
 4 which I participated actively so I couldn't tell yo u.

5 **Q.** Can you recall what, if any, attempts were made at the
 6 Macfarlane Trust during your time there to engage with
 7 families who may have fallen out of contact, fallen
 8 out of the loop owing to the infected person having
 9 died some years previously?

10 **A.** No, I don't recall the Trust taking an initiative I like
 11 that. I think had we felt it was necessary then we
 12 would have asked the haemophilia centres to take th
 13 first step. They are the places where the records
 14 existed where they had relationships with the peopl
 15 with whom we had lost trust, the first point of
 16 contact.

17 **Q.** I wanted to ask you next about what efforts were ma de
 18 by the Macfarlane Trust to involve beneficiaries in
 19 decision-making.

20 Dealing, first of all, with the 1988-1992
 21 period, there is reference in the minutes -- I can
 22 take you to them if necessary but they don't
 23 necessarily provide much information -- there's
 24 reference in the minutes in 1990 to an idea of
 25 establishing a consultative panel. It's unclear from

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1 **Q.** Was there any support available for children who ha
 2 lost one or both parents once the child ceased to b
 3 a child and became an adult, aged 18?

4 **A.** Once they had left full-time education, the answer is
 5 no.

6 **Q.** What, if any, support was available to those parent
 7 who had lost their children? Leave aside those who
 8 had adult children upon whom they were financially
 9 dependent, which was referred to in the policy we
 10 looked at yesterday. Those who lost a child on who
 11 they had no financial dependence at the time of the
 12 child's death.

13 **A.** I'm trying to remember -- I'm trying to think what the
 14 rules were -- what rules we set ourselves. I don't
 15 know. I would have thought that if parents had los
 16 a child and the parents were not dependent upon tha
 17 child, then they would be covered by the normal
 18 bereavement rules. They would be given some -- the re
 19 would be some money available right at the outset and
 20 it would take *(unclear)*.

21 **Q.** Can you recall during your time at the
 22 Macfarlane Trust what, if any, attempts the Trust m ade
 23 to engage with those who had lost children or lost
 24 parents to provide at least some form of non-financ ial
 25 support?

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1 the records I've seen whether such a panel was ever
 2 established.

3 Can you recall whether it was before you left
 4 in '92?

5 **A.** That's 29 years ago.

6 **Q.** I appreciate you may not be able to but do you have
 7 any recollection --

8 **A.** I don't recall, no. I don't recall. At some stage
 9 when I was absent from the Trust the Partnership Group
 10 was established which may have been the result of t hat
 11 initiative.

12 **Q.** In terms of user trustees, do you accept that the
 13 insight of trustees who were by personal necessity
 14 experts in the condition suffered by the Macfarlane
 15 beneficiary group, an expert in the challenges and
 16 difficulties that might arise, were an important
 17 addition to the board's expertise?

18 **A.** I'm not going to generalise on that. Some were ver
 19 helpful; some were not.

20 **Q.** Were attempts made to include amongst the user
 21 trustees widows or partners of those who died?

22 **A.** Bear in mind that the user trustees are nominated b
 23 the Society so it was not our decision. There was
 24 certainly one partner who was a trustee for a while
 25 yes.

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- 1 Q. Were there any steps taken to try and ensure
2 a balanced board, so this isn't specifically about
3 user trustees, Mr Stevens, but to try and, for
4 example, have on the board a trustee with social care
5 or nursing or psychological background to bring
6 a professional understanding of the isolation or
7 stigma or suffering of the community that the MFT was
8 serving?
- 9 A. I think to the extent that we were able to guide the
10 Department of Health in their nominations and the
11 Society in theirs there would have been some
12 suggestion of the sort of people we were looking for.
13 I can certainly think of one at the Department of
14 Health nominees who came from -- who was -- worked in
15 the social side at one of the London hospitals. So we
16 did have that. Whether that -- whether she arrived
17 with those qualifications, that background, because we
18 asked for it or whether it just happened, was
19 happenstance, I don't know.
- 20 Q. During your time as chair were user trustees to you
21 mind treated and given equal respect and parity with
22 other trustees or were they regarded as a secondary
23 class of trustee?
- 24 A. Sorry, which trustees are you referring to?
- 25 Q. User trustees during your time on the board?

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- 1 a depletion of the Trust fund and you say that the
2 trustees believe that the political risk of a change
3 in the Government's funding policy can't be
4 ignored. Then you refer to the long-term review and
5 the conclusion is to adhere to the reserves policy of
6 holding a minimum level of £4 million.
- 7 Now, that's a substantial amount by way of
8 reserves which is obviously then unavailable for
9 provision to beneficiaries. Given that by this time
10 the Trust was receiving £2 million to £3 million per
11 annum, why continue to maintain such a high level of
12 reserves?
- 13 A. I would say that on the basis that we were spending
14 £3 million a year we could even have justified putting
15 the reserve level up. Remember, the reserve level
16 was, when originally calculated, was based on the
17 belief that if we thought the Government funding was
18 going to be failing, we had to maintain -- we had to
19 have in reserve enough to keep up existing commitments
20 to beneficiaries going for a year, at the end of which
21 we would then give them notice that we were going to
22 have to reduce. That was where the £4 million came
23 from based on the £2 million annual expenditure.
- 24 So if one's going to be spending 3 million --
25 if we have an annual commitment of spending £3 million

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- 1 A. No, they weren't -- they weren't second class at all.
2 They were just members of the board. As I said, so me
3 were more useful than others and there were some whom
4 I consulted more frequently than others who I knew
5 I would not be getting a very good steer from.
- 6 Q. I wanted to ask you next, Mr Stevens, about the
7 Trust's reserves policy. So if we can look at
8 MACF0000009_105, please.
- 9 This is a document authored by you dated 7 May
10 2003 headed "Reserves policy", and the third paragraph
11 explains how the Trust had had for some years a policy
12 of maintaining a minimum level of reserves of
13 £4 million. It explains that policy was first set and
14 agreed at a time when top-up funding was unpredictable
15 and irregular, both in timing and in amount.
- 16 Then if we go further down the page towards the
17 bottom half we can see you say that the trustees are
18 greatly encouraged by two recent changes in the
19 Department's funding policy towards the Trust.
20 Then -- and you talk about the reduced mortality rate.
- 21 Then if we go over to the next page you say the
22 trustees have considered the possibility that these
23 commitments would permit the minimum reserves level to
24 be reduced or even eliminated, but you then refer to
25 the possibility of investment risk resulting in

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- 1 a year then you might reasonably expect the reserve
2 level on that basis to go up possibly even to
3 6 million. We didn't do that. We didn't -- we did
4 think that it was prudent to maintain a reserve level
5 of £4 million.
- 6 Q. If you had had an unequivocal guarantee of continued
7 funding from the Department, so not necessarily
8 increased funding but at least continued funding on
9 a long-term basis from the Department, would you have
10 been able, do you think, to reduce the reserves level?
- 11 A. I don't see politicians or their civil servants
12 capable of giving an unequivocal guarantee which one
13 could rely on forever.
- 14 Q. Is the answer --
- 15 A. The jargon is that, you know, no administration can
16 bind its successors.
- 17 Q. So if you had had what seemed to be a promise or
18 assurance of future funding you would still have
19 wanted to keep the reserves because you wouldn't feel
20 confident that subsequent administrations would adhere
21 to that; is that right?
- 22 A. Correct, correct. After all, bear in mind that it
23 wasn't so long after that in terms of years that the
24 Trust was taken away from us completely and handed
25 over to some agency. I have no idea what they're

16

1 doing now.

2 **Q.** Can I ask you to look at a witness statement from -

3 well, I will put it up on screen. WITN4079001, it'

4 from someone who was a trustee of the Macfarlane Trust

5 from 1995 to 2000. So it's only a short overlap

6 I think with your return. It's Mr Hill.

7 If we could go, please, Soumik, to page 6,

8 I think. As I just wanted draw attention to

9 paragraphs 21 to 24 and ask for your comment. So

10 Mr Hill says this:

11 "If I had one overarching comment to make about

12 the Macfarlane Trust it is that in my time as

13 a trustee I felt there was too much emphasis on

14 preserving its financial resources and too little o

15 distributing them. Equally, I felt there wasn't

16 enough effort put into ensuring that funds were topped

17 up adequately and in a timely manner. As trustees, we

18 seemed to spend far too much time talking about how

19 the assets of the Macfarlane Trust were standing up

20 and it seemed to me too little time was spent looking

21 forward and making assessments of future needs. While

22 I suspect very little of this future assessment

23 occurred, if it did happen, then it must have taken

24 place later between the officers and staff of the

25 Trust; very little of it ever took place in my

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1 make upon Mr Hill's evidence about his experiences and

2 impressions of the way in which the Trust approached

3 matters?

4 **A.** No. I had a very short, very short time of the --

5 I was in the Trust for a very short time when he was

6 there, so very short, very little overlap. I don't --

7 I would argue with him on those comments, many of

8 them.

9 I think we made requests for -- well, we've

10 already covered it, in any event, the way we asked for

11 money, the frequency with which we asked for money and

12 the force with which those requests were made. We

13 covered that yesterday.

14 Consideration of future requirements for money

15 was certainly considered all the time in the office

16 and we've covered in the various reviews we talked

17 about yesterday.

18 If he felt that the Trust was, what would you

19 say, was -- I think the words he used was a front man

20 from Government there to distribute largesse as

21 frugally as possible. If he felt that was the case

22 well, that's probably not very far from the truth.

23 The Macfarlane Trust was set up originally -- I think

24 I used the phrase at one stage "acting as quasi-agent"

25 or something for the Department of Health. We were

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1 presence at trustee meetings or in my presence outside

2 of meetings. I got the impression that the officer

3 didn't attach sufficient importance to this, but to me

4 it was central to the Trust's role. The whole

5 operation process and the basis for its existence

6 began to sit uncomfortably with me. I felt like I was

7 expected to function as a front man for the

8 Government, there to distribute its largesse as

9 frugally as possible. The Government was making

10 payments that were very much on its own terms and

11 I felt like I was a party to the handing out of huge

12 money. I began to think that the whole basis for the

13 Macfarlane Trust's existence was a false one. It was

14 not so much there for providing for the needs of

15 a deserving and suffering group of people. Instead

16 I felt it existed to keep a lid on any future

17 financial demands and through its financial support to

18 its registrants to calm down the prospective of

19 ongoing attempts to challenge Government about its

20 role in the causes of the blood contamination crisis.

21 From time to time, the Macfarlane Trust would approach

22 the Government for more money but I do not believe the

23 requests were made as forcibly as they could and

24 should have been."

Do you have any observations or comments to

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1 doing, even looking after a group of people who had

2 been damaged by the Government and setting up an

3 inadequately funded charity was the Government's view

4 of what to do about the people.

5 We will probably come later on today about

6 alternatives that might have been considered which

7 only -- possibly, which might not have been thought

8 about originally but developed in the course of time

9 as people began to understand what the problem was.

10 **Q.** You can take that down, thank you, Soumik.

11 Assisted conception and financial support to

12 contribute to or enable assisted conception for

13 beneficiaries and their partners was an issue that

14 comes up time and time again in the Macfarlane Trust's

15 minutes. I can take you through all the minutes if it

16 would assist but I'm going to try and approach it on

17 a more general level and please tell me if you want to

18 look at individual documents.

19 It would appear from the minutes that in

20 relation to the first period that you were at the

21 Trust, the '88 to 1992 period, that there wasn't an

22 clear policy on assistance for artificial insemination

23 of any other form of assisted conception.

Do you have any recollection of discussions?

24 **A.** I'm sure that's right. It would not have been thought

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1 about very much in those early years.

2 **Q.** We looked at the strategic review yesterday, the 1999

3 strategic review. That suggested the Trust should

4 provide guidance and policies on fertility treatment.

5 Again, the documents in some sense speak for

6 themselves but do you recall the extent to which that

7 was something which the trustees were concerned about

8 and wanted to assist with?

9 **A.** We were aware that there were people among the

10 beneficiary community who very much wanted help. The

11 view we had taken all the way through, which was

12 I have to say supported by our paymasters, was that

13 we were not there to provide financial help for

14 services that the National Health Service should

15 itself provide. So the policy we drew up in terms of

16 assisted conception was that we would contribute to

17 expenses relating to it, travel, accommodation, but

18 not for the service itself.

19 I think similarly advice about assisted

20 conception was something which would best be provided

21 by clinicians in the National Health Service rather

22 than by us.

23 **Q.** I just want to ask you about a couple of documents on

24 this topic. I think you are right in terms of the

25 policy that was adopted in I think 2004 was a policy

21

1 assisted means."

2 Why as a matter of principle, as an independent

3 body, was the Trust seeking approval from the

4 Department for its proposed policy change?

5 **A.** I think possibly because the Trust's attitude to

6 assisted conception had been discussed with the

7 Department on many occasions. If we were going to

8 make financial contribution to the costs of the

9 assisted conception itself and not to the ancillary

10 costs, that was going to again require an increased

11 amount of funding, so that it was before we changed

12 policy, if we are venturing into policy, it was

13 important I think to ensure that we would have the

14 funds to support it and that might require the

15 Department of Health putting its hand in its pocket

16 a bit further.

17 **Q.** If we look at Mr Conlon's reply, MACF0000014_054 --

18 **A.** As far as I can recall, it was not a particularly

19 helpful reply.

20 **Q.** Yes. We can see it's a letter dated 9 February 2005.

21 He sets out various matters by way of background. If

22 we just go to the last paragraph we see:

23 "I do not therefore feel that providing

24 additional assistance for registrants of the

25 Macfarlane Trust to undertake treatment programmes for

23

1 of contributing to ancillary costs.

2 If we then go please to MACF0000014_049.

3 You'll see this is a letter from Mr Harvey,

4 31 January 2005, to Mr Conlon at the Department of

5 Health. It refers in the second paragraph to the

6 Trust's existing policy:

7 "... to meet ancillary costs arising from

8 treatment programmes, such as travel, but not to fund

9 either in part or full the direct costs that form part

10 of the assisted conception process."

11 Then it refers to the trustees having been

12 asked to consider a recommendation from the National

13 Support Services Committee that a degree of financial

14 support would be available.

15 A decision was taken to ask the Department of

16 Health for its views. You will see that it sets out

17 there the relevant extract from the Board of Trustees's

18 minutes:

19 "It was resolved in the first instance to write

20 to ask the Department of Health what their attitude

21 was to the difficulties caused by the apparent

22 postcode lottery that seemed to exist within the

23 current NHS provision and to seek approval from the

24 Department that the Trust was proposing to support

25 registrants in their attempts to advance conception by

22

1 assisted conception, would be appropriate."

2 So that was the Department's view.

3 **A.** Yes.

4 **Q.** I'm trying to establish what happened next.

5 **A.** We asked them.

6 **Q.** Because the minutes do not provide an entirely clear

7 picture of what happened next.

8 If we go to one further document, it's

9 MACF0000101_130. If we go to the next page we can see

10 minutes of a meeting of the NSSC on 23 February 2005.

11 And if we go to the bottom of the page, you

12 were present at that meeting.

13 "Assisted conception.

14 "The policy recommendation to the Board has

15 been agreed. The MFT policy on assisted conception

16 is:

17 "Applicants should attempt to obtain through

18 the NHS as many of the tests and procedures as are

19 available.

20 "As Sperm Washing is not available via the NHS,

21 the NSSC will consider applications towards a maximum

22 of three cycles of sperm washing at a maximum cost of

23 £2,000.

24 "The NSSC will consider applications for

25 funding for other aspects of assisted conception where

24

1 there is evidence that the NHS will not fund these or
2 that there would be inordinate delays due to waiting
3 lists'."

4 Now there doesn't appear to be any further
5 consideration in the board's minutes of meetings over
6 following months, so do we correctly understand that
7 this was, then, the Trust's policy from that point
8 onwards? It effectively rejected the Department of
9 Health's view?

10 **A.** Unless the board -- unless everyone on the board
11 decided against -- decided to reject the NSCC's view,
12 I think you can take it that that then became the
13 Trust's policy.

14 **Q.** This is early 2005. It's probably going to be too
15 late for some families by then. Do you think that the
16 Macfarlane Trust took too long to come up with
17 a settled policy on the provision of assistance,
18 financial assistance?

19 **A.** No, I don't. Considering the fact that NHS was its elf
20 formulating its own policies on assisted conception
21 during this time and techniques were developing the
22 whole time, I think we moved as fast as we -- as fast
23 as could be considered reasonable.

24 **Q.** The final issue I want to ask you about for now
25 relating to the Macfarlane Trust concerns some

25

1 haemophilia -- you do not -- and are infected with
2 hepatitis C -- you are not -- so they might be said to
3 deserve at least equal treatment. That is, of course,
4 something that we are unable to give."

5 If we just go over the page four lines down you
6 say:

7 "I do suggest that you might give some
8 consideration to the fact you are but one of some
9 hundreds of people who look to us for assistance, many
10 of whom are less articulate than you, do not have the
11 benefit of owning any property, as you do, have
12 dependent families, which you do not, and whose health
13 is much more compromised than your own."

14 Now, I'm not going to ask about individual
15 decisions taken in relation to this or any particular
16 registrant but more the manner and tone of the
17 communication.

18 If we just go back to the first page and look
19 at the fourth paragraph, you said halfway through that
20 paragraph:

21 "Nor do I in any way imply that you do not
22 deserve the Trust's support."

23 If you were not seeking to imply that this
24 registrant did not deserve the Trust's support, why
25 did you write in these terms, and do you consider it

27

1 communications with or about registrants. And the
2 first document I want to ask you about is WITN30700 02.

3 This is the letter which you wrote on
4 13 March 2006 to Clair Walton. I'm not going to go
5 through it paragraph by paragraph but I just want to
6 pick up a couple of points with you. You say in the
7 first paragraph, third line:

8 "It is rare for me, as Chairman, to write
9 outside the normal protocols when considering requests
10 for assistance, but the circumstances of your
11 particular request and the level of support we have
12 given you over the years persuade me to do so on this
13 occasion.

14 "Your reaction disappoints but does not,
15 I confess, greatly surprise me."

16 And then you say that trustees will consider
17 the individual case.

18 You refer to trustees having bent over
19 backwards to assist the registrant. You say the
20 registrant had been receiving more "by some multiples"
21 than any other beneficiary. And then you say this in
22 the next paragraph, half way down:

23 "Nor do I in any way imply that you do not
24 deserve the Trust's support. But I must point out
25 that the majority of those whom we help have

26

1 was appropriate to write in these terms?

2 **A.** I -- some while ago the person -- can I use her name
3 here?

4 **Q.** Yes.

5 **A.** Clair Walton wrote a witness statement in which she
6 made some comments about me and I was asked by the
7 Trust to comment on those, which I did.

8 There was a reference in her statement to
9 a subsequent letter by my successor,
10 Christian Fitzgerald, the existence of which I had no
11 idea until I read it in her statement. I asked for a
12 copy of that letter and it was not forthcoming.

13 I have subsequently seen that letter, when
14 I was preparing my own written statement in response
15 to the Northern Ireland invitation, and I said in
16 that, as I recall, that I had no further comment to
17 make. That is still my position. I have no further
18 comment to make on the correspondence I had with
19 Clair Walton or the need for it.

20 I could, I'm sure, go further, but at the
21 moment that's my position. I have said what I have
22 said. I have written my response to her comments in
23 her written statement about me. That's as far as I'm
24 prepared to go.

25 **Q.** I'm going to ask you to look at another communication

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now. It's at CGRA0001054. It's the response to th is email I want to ask you about, but just to put it i context, this is an email from you to Gordon Clarke , who was I think another trustee of the Macfarlane Trust, and you refer to there being, in the third paragraph, "an under-current of ill-feeling a the moment", and to various other matters, grievances being expressed about the Macfarlane Trust.

I want to ask you about the reply. It is at CGRA3330155.

Mr Clarke, who I can't ask about this, says:

"Good to hear from you but sorry that you are getting so much stick from 'the great unwashed'."

Who did you understand, on receiving this email, him to be referring to as "the great unwashed"?

A. I assumed he was talking about the group on the beneficiary community who were contributing to the bulletin board that we, as trustees, couldn't see, and were accusing me of lying, which I didn't understand, so he used -- he used a phrase to which I know at least one of the beneficiaries took great exception.

Q. Was this a term, "the great unwashed", that was use more widely amongst trustees to describe some or al of the beneficiary community?

A. I had never heard it used in the Trust in the conte xt

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and was used by another Victorian author, I believe , about 18 -- a few years after that.

So maybe at the time it had -- it was felt to have some relevance but I think nowadays it's not the sort of thing one should say in any context.

MS RICHARDS: Now the communications that appear under this document reference are not complete and are no in the right order so if we can go, first of all, t page 5 we can see, if we look at the top part of th page, this is a communication from Haydn Lewis to y ou dated 28 November 2004. It's headed "Private lette chairman MFT":

"(Private confidential)

"Peter.

"I hope you and your family are keeping well ..."

He says:

"... I am not finding sleep that easy to achieve at the moment."

Then he sets out some suggestions, refers to the business case, refers to concerns, suggests a solution for trying to achieve an enhanced form o payments, suggests a communication to all registrants with a questionnaire to obtain a democratic policy for what he describes as "the first time in the history of

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of the Trust before or since, which is, as you know a term that was invented, I think, it's -- by an author in the first part of the 19th century, in a novel.

Q. Do you --

A. -- (unclear) I can't remember his name --

Q. Would you agree it's a wholly inappropriate way for a trustee to describe some or all of those who have been infected with HIV and have had their lives devastated?

A. I think it's probably an inappropriate term anyway, in any context.

Q. The last series of communications are at WITN2368016.

SIR BRIAN LANGSTAFF: Just before you do that, I have noticed the draft transcript has that last answer a s:

"... it's probably an inappropriate term anyway in any context."

I heard it as "anywhere, in any context".

It seems to me totally inappropriate, there's no "probably" about it, and I think you probably agree with that.

A. I didn't hear all you said, Sir Brian, but yes, I think it's -- it is a phrase that might once have had some connotations, but -- after all it was used by this author I mentioned in a book he published in 1830

30

the MFT". And then, towards the end of his email, says:

"I would like to request the total spent in personal expenses over the first 12 months by the past [Chief Executive] ... and the same total for the fir st 12 months of the current [Chief Executive] ...

"Hope you will be able to provide me with answers to my requests and suggestions.

"Kind (but weary) regards,

"Haydn."

So it was, would you agree -- you may not agree -- you didn't agree, I think, with the merits of the proposals he was putting forward, but it was a courteously expressed and private letter to you?

A. Yes.

Q. If we look towards the bottom of the page, we can s ee this is you on 29 November forwarding Mr Lewis' let ter to Martin Harvey and saying this:

"Martin,

"Notwithstanding the heading, I thought you'd love to join me in starting the week with an insigh into the thoughts of Haydn Lewis.

"I shall try to compose a reply in the course of the day. I shall point out to him that I am una ble to provide him with information about expenses with out

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1 asking you.
 2 "It is irritating that somebody so thick" --
 3 **SIR BRIAN LANGSTAFF:** I think it should be "somebody"
 4 probably.
 5 **MS RICHARDS:** I am going to ask about that in a moment:
 6 "... so thick can come up with such meddlesome
 7 suggestions."
 8 First of all, in terms of what appears to be
 9 a typographical error, are you able to assist with
 10 whether that should have been "somebody" or "some
 11 boyo"?
 12 **A.** Somebody.
 13 **Q.** Was it appropriate for you to forward a private and
 14 confidential letter to you to Mr Harvey?
 15 **A.** Only because it would be difficult for me to answer
 16 the letter without reference to the Chief Executive.
 17 **Q.** You could have identified the points you wanted to
 18 explore with the Chief Executive and extracted those
 19 points as discrete matters rather than forwarding the
 20 whole letter that was expressed to be private and
 21 confidential, could you not?
 22 **A.** I could have done that. The relationship -- my
 23 relationship with Martin Harvey was such that
 24 I regarded anything that was private and confidential
 25 to me -- if I had to share it with Martin, I would

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1 beneficiaries, who was the person who objected to it
 2 strongly.
 3 Gordon Clarke, Martin and I went to Cardiff and
 4 met with Haydn and Gareth and with this other
 5 beneficiary and apologised for the use of our
 6 language, for what we said, and the apology was
 7 accepted, and thereafter we carried on normal
 8 relationships with these people.
 9 Gordon, Martin, Haydn and Gareth are no longer
 10 with us, sadly. I believe the other beneficiary is
 11 still alive. So out of the six people involved, four
 12 are now dead.
 13 I don't know the status of this email to which
 14 you are referring. It was hacked. I don't know
 15 whether that means it's stolen. It's been sitting in
 16 the files of, I think, The Haemophilia Society all
 17 these years. It's now come to light again. I -- s
 18 you can tell me whether it is stolen property that
 19 should no longer exist or whether it remains in open
 20 circulation for years and years and years to come.
 21 I don't know what the word hacking implies about the
 22 documents that are taken.
 23 What I do know is that the people who took it
 24 and the people to whom they gave it, and other
 25 documents in this hacking episode, thereby gained

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1 regard that as still being within a very restricted --
 2 (*unclear: overspeaking*)
 3 **Q.** Was it appropriate for you to describe a beneficiary
 4 of the Macfarlane Trust, someone infected, someone,
 5 indeed, whose brother was infected, someone whose wife
 6 was infected, so someone whose personal circumstances
 7 could only be described as deeply tragic, as "thick"?
 8 **A.** Totally inappropriate.
 9 **Q.** Why did you --
 10 **A.** This is disgraceful use of language.
 11 **Q.** Does it tell --
 12 **A.** Can I put this in context? This email was one of some
 13 hundreds that were hacked from the Trust in the course
 14 of 2005 I think. I can give you the -- I can show you
 15 the documents where the board discussed this.
 16 The hacking was referred to the police who were
 17 unable to provide any help. We never did find out who
 18 did the hacking. We did engage some consultants to
 19 come along and improve the Trust's electronic
 20 security.
 21 The -- not surprisingly -- or rather, whoever
 22 did the hacking passed this email and one or two
 23 others to Haydn, and to his brother Gareth, and the
 24 previous email that you considered, about "the great
 25 unwashed", was also shown to another of the Trust

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1 access to a lot of private, confidential and, in some
 2 cases, very sensitive information about other people.
 3 The head of support services, Jude Cohen, was passed
 4 some information that came out of this hacking
 5 episode, as a result of which she lost her job. The
 6 trustees took a very dim view of it.
 7 So this was a wholly -- it was an extremely
 8 difficult episode in the Trust's life. I agree
 9 completely that I used some wholly inappropriate
 10 language about Haydn in a private -- private emails to
 11 Martin.
 12 **Q.** Why did --
 13 **A.** I shouldn't have done that. The fact that the emails
 14 were given from -- were from me to Martin on a private
 15 basis, on a personal basis, certainly is irrelevant
 16 I should not have used that language and I didn't
 17 thereafter. I apologised for it. As I said, my
 18 apology was, as far as I know, accepted by Haydn and
 19 Gareth. So I am interested in the fact that it comes
 20 up in the Inquiry. I'm interested in the fact that
 21 this document still exists and that the Inquiry feels
 22 that it can ask questions about it.
 23 **Q.** You have accepted the language was inappropriate. Why
 24 did you talk about a registrant in those terms?
 25 **A.** I don't know.

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1 Q. Would you agree it's just --
 2 A. It's too early in the morning to say I've been
 3 drinking, so -- I mean, Haydn and I had engaged in
 4 considerable amounts of considerable email
 5 communications and Haydn's were always long, verbatim
 6 and quite trying to read at times. So this was the
 7 culmination, I think, of a long series of
 8 communications with him and it probably just tried my
 9 patience.
 10 Q. If we go to the second page of this document, please,
 11 the first is an extract from a communication from
 12 Haydn in which he says he's weary of dealing with the
 13 Trust and that his wife will be doing so from now on.
 14 Bottom of the page -- I ask you to note the date of
 15 your email to Mr Harvey. It's 13 December 2004. Can
 16 we just go further down the page, please. You say:
 17 "I recall I shall never have a private email
 18 from Haydn Lewis again, happy day", and then "Callooh
 19 Callay" -- so you quote from the Jabberwocky.
 20 Then you say this:
 21 "Otherwise, what a monumental waste of time not
 22 just this afternoon but all the previous hours spent
 23 nurturing that lot of moaners."
 24 That afternoon there had been a meeting of the
 25 Partnership Group. We can look at the minutes, if you

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1 time. I certainly don't know now. So this is the
 2 sort of stuff that we were being -- we were hearing at
 3 the Partnership Group time and time again.
 4 Eventually, I think the Partnership Group
 5 ceased to exist. I do not know whether the
 6 Partnership Group itself folded or whether the Trust
 7 decided not to support it any longer. I can't
 8 remember. I think that was after my time.
 9 Q. But was it your general view, as this email might
 10 suggest, that the Partnership Group meetings were
 11 a monumental waste of time and the beneficiaries
 12 participating in it were a lot of moaners?
 13 A. Not all the time, no.
 14 Q. But some of the time?
 15 A. Some of the time.
 16 Q. Then --
 17 A. There were many people, many beneficiaries of the
 18 Trust, from whom we never heard or we only heard when
 19 they said thank you. There are others who had very
 20 negative views, which they expressed very forcibly.
 21 So I knew, I know now, that the Partnership Group was
 22 not representative of the beneficiary community. I
 23 was composed of members of the beneficiary community
 24 who had particular axes to grind.
 25 Q. If we go to the first page -- this is the last

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1 want, but it's a perfectly ordinary Partnership Group
 2 meeting on 13 December 2004. Do we correctly
 3 understand your email to be suggesting that meeting
 4 spent in the Partnership Group are a monumental waste
 5 of time and that the Partnership Group were regarded
 6 by you, or some of them, as a lot of moaners?
 7 A. If you were to look through the minutes of the various
 8 Partnership Group meetings, you will see that there
 9 was quite a lot of unpleasant feeling, difficult words
 10 that in the end -- I mean, I remember for a while the
 11 Partnership Group was chaired by one of the
 12 beneficiaries who gave up in the end and said he
 13 couldn't stand it any longer.

14 So it was difficult. It all comes back to the
 15 same problem, that we were a charity inadequately
 16 funded and people had expectations or hopes from the
 17 charity that we couldn't possibly, possibly meet. And
 18 so they expressed their frustrations, anger, at us
 19 rather than the Government because we were the fall
 20 guys. We were the people who were in that position
 21 and in the end it became -- or it became quite trying
 22 on our patience to listen to personal attacks. As
 23 I said in my note to Gordon Clarke that you put up
 24 earlier, I was accused of lying. I didn't know what
 25 I was being accused of lying about at that particular

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1 document on this series I want to ask you about -- top
 2 of the page --
 3 **SIR BRIAN LANGSTAFF:** Just pause there for a moment. The
 4 question which led to the answer "Not all the time,
 5 no" was dealing with two matters. Your view
 6 expressed, albeit as a composite, is that the
 7 Partnership Group was a monumental waste of time --
 8 that's point 1 -- and the beneficiaries participating
 9 in it were a load of moaners.

10 When you said -- you were asked whether that
 11 was still your view, "Was it your general view",
 12 rather, and you said, "Not all the time, no", were you
 13 referring to the monumental waste of time or to the
 14 load of moaners or both?

15 A. I think I was probably referring to -- I think I was
 16 probably referring to the Group, Partnership Group as
 17 it was then constituted, and what it tended -- and the
 18 ground it tended to cover. So it was -- had the
 19 Partnership Group taken constructive and helpful --
 20 engaged in constructive and helpful discussion about
 21 the policy and made some instructive suggestions to
 22 the trustees, then I would not have, regarded it as
 23 a monumental waste of time but it didn't do that. Its
 24 discussion tended to be negative and hypercritical
 25 and, as I said, just not representative of many of

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1 people in the beneficiary community who simply wanted
2 to get on with our lives and were grateful for the
3 help -- and expressed their gratitude to the Trust for
4 the help it provided.

5 **SIR BRIAN LANGSTAFF:** Thank you.

6 **MS RICHARDS:** Then if we look at the top half of this
7 page, again these are -- we don't have a full set o
8 email communications but if we pick it up with your
9 email:

10 "Martin, what's with these people? Funnily
11 enough when you set it out as you have done it make
12 one wonder why infected intimates are treated exactly
13 as registrants since they do not have haemophilia t
14 worry about. We might see if we can review that wh en
15 get round to looking at repay at the NSSC. That
16 would be a way of pissing off the Lewis contingent.

17 You presumably were aware, and indeed I think
18 it's reflected in what you say there, that Haydn's
19 wife Gaynor was herself infected with HIV?

20 **A.** Yes.

21 **Q.** You seem to be proposing a review of the way in whi ch
22 infected intimates were treated, in part at least, as
23 a way of, as you put it, pissing off the Lewis fami ly.
24 Would that be an appropriate basis for a review of
25 policy towards infected intimates?

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1 a friend. Gordon had a huge background of work for
2 the haemophilia community around the world and in this
3 country. He was a very distinguished servant of th
4 haemophilia community. He was -- before his death he
5 was honoured (I think an OBE). So to use -- to
6 believe that his use of the phrase "great unwashed" in
7 any way signified his underlying attitude to the
8 people whom he gave his life serving is just
9 ridiculous. He was -- this is again another remark ,
10 maybe ill-considered, but made between two friends.

11 **Q.** The communications we've looked at might be said to
12 show a degree of disdain or contempt for some or al
13 of the beneficiary community whom you and Mr Harvey
14 and Mr Clarke were expected to be serving through y our
15 role as trustees.

16 Do you have any comment on that suggestion?

17 **A.** No, I wouldn't regard the suggestion as deserving o
18 comment.

19 **Q.** Did you feel a degree of disdain or contempt as
20 a matter of fact for some or all of the beneficiari es
21 of the Macfarlane Trust?

22 **A.** From somebody who started with the Macfarlane Trust in
23 1987 or '88 when it got going and eventually left the
24 whole infected blood operation when it was taken away
25 from me over 30 years later, of course I didn't.

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1 **A.** No, which is why the fact that you have taken it
2 seriously indicates you don't understand the
3 relationship between Martin and myself.

4 **Q.** Perhaps you --

5 **A.** I'm not saying something there that I feel as
6 a Chairman seriously we ought to do. I'm simply
7 saying it as a throwaway remark to a friend.

8 **Q.** It was some form of joke, was it?

9 **A.** Mmm?

10 **Q.** It was some form of joke, was it?

11 **A.** It was some form of, yes -- it's a tongue in cheek
12 remark that does not -- does not token any serious
13 thought or consideration or policy.

14 **Q.** Just going back to -- I'm not asking for it to go b ack
15 on screen but going back to the "great unwashed"
16 comment from Gordon Clarke, did you on receipt of t hat
17 email respond to Mr Clarke in any form saying it wa
18 inappropriate to use that term to describe some or all
19 of the beneficiaries?

20 **A.** No.

21 **Q.** Why not?

22 **A.** Because I understood that Gordon himself wouldn't -
23 that this is not a serious consideration -- I mean,
24 serious remark that Gordon would normally have
25 applied, except when talking in a private email to

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1 **MS RICHARDS:** I'm going to move on to the Eileen Trust
2 next.

3 Sir, we're not quite at 11.15 but it might
4 sensible to take the break announced then start wit
5 the Eileen Trust after the break.

6 **SIR BRIAN LANGSTAFF:** Yes. We'll take a break then until
7 11.40. 11.40, please.

8 (11.09 am)

(A short break)

10 (11.40 am)

11 **SIR BRIAN LANGSTAFF:** Just before we start again,
12 Ms Richards just let me just mention to those who a re
13 watching remotely that those who were hoping to wat ch
14 on YouTube may have missed the first ten minutes of
15 our proceedings this morning. They can be assured
16 that the full YouTube will be uploaded after today.
17 There was a technical hitch which affected that but
18 did not affect the Zoom presentation. My apologies to
19 anyone who may have been discomforted by that.

20 Ms Richards.

21 **MS RICHARDS:** Mr Stevens, the Eileen Trust was set up
22 in 1993. You joined a few years later, in 1999. How
23 did it come about that you joined the Eileen Trust as
24 trustee and chair?

25 **A.** I was invited to by Alan Tanner and Cliff Grinstead

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1 when they asked me to rejoin the Macfarlane Trust.
 2 They said: and by the way, we've joined the
 3 Eileen Trust as well. And take over as chair of that
 4 when I was -- Angus stepped down from there as well
 5 **Q.** Obviously, the trust or scheme was already
 6 established, and we will be hearing from a couple of
 7 other witnesses relating to the Eileen Trust, but I do
 8 just want to ask you to look with me at the original
 9 scheme document and ask a couple of questions about
 10 that.

11 It's EILN0000016_001.

12 Now, this is a scheme I think for England,
 13 Wales and Northern Ireland. There was a separate but
 14 not dissimilar document covering Scotland. It's
 15 entitled "Scheme of payments for those infected with
 16 HIV through blood or tissue transfer".

17 That, as I understand it, is why in your
 18 statement you refer to the Eileen Trust as
 19 "the scheme", because that's how it was so described
 20 in the founding documents; is that right?

21 **A.** If I did so refer to the Trust in my document, then
 22 that was -- as I say, I tried to distinguish
 23 the scheme and the Eileen Trust. That was my
 24 intention anyway. So if I used those terms at any
 25 stage interchangeably, then that was a mistake.

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1 the following year.
 2 The scheme document set a very, very tight
 3 timetable for applications, I think based on the
 4 belief that most or all people who would apply would
 5 be relatives of those who had already died as a result
 6 of a blood transfusion received I think typically
 7 during post partum haemorrhage.

8 There were never many applicants for the
 9 Eileen Trust. Probably about 100. Dozens of those
 10 who were early recipients of payments from the scheme
 11 had already died and I believe that the very tight
 12 timetable and the general lack of publicity and the
 13 fact that the Eileen Trust was set up outside the
 14 period of that timetable were designed to deter
 15 estates from approaching the Eileen Trust for
 16 assistance.

17 Unfortunately for the architects of the scheme,
 18 who had put in a let-out for the timetable so that
 19 people were able to join the scheme and the
 20 Eileen Trust many, many years later. The idea of the
 21 scheme was that people would be adjudged whether or
 22 not they were eligible for payments from the scheme
 23 If they were, and they received those payments from
 24 the Department of Health, then they were eligible to
 25 apply for help to the special needs fund that became

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1 **Q.** It may be my misunderstanding then, Mr Stevens. Can
 2 you tell us then what did the difference was between
 3 the scheme and the Trust.

4 **A.** Yes. I think I can only do so by referring backwards
 5 to the Macfarlane Trust in its early days.

6 In the case of the Eileen Trust, the scheme was
 7 set up by the Department of Health -- I don't know at
 8 whose instigation but it may have been -- the push
 9 might have come from The Haemophilia Society, which is
 10 rather strange. The scheme of payments follows
 11 precisely the tariff categories established for the
 12 Macfarlane Trust settlement payment which was
 13 administered by MSPT2.

14 The amounts of money attached to the tariff in
 15 the Eileen Trust scheme -- you see, I've done it
 16 already -- in the scheme, were the same as the MSPT
 17 payments plus the MSPT1 £20,000 *ex gratia* payment. So
 18 adding those two together, the scheme of payments that
 19 we're looking at here was identical to the MSPT1 and 2
 20 payments.

21 Then, in the second page -- or third page of
 22 this document, second page of the text of this
 23 document I think, there's reference to intention to
 24 set up a -- I think they called it a "special needs
 25 fund", which became the Eileen Trust. It was set up

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1 the Eileen Trust.

2 There was a considerable period when the scheme
 3 payments were channelled to the beneficiaries through
 4 the Eileen Trust in which we, the Eileen Trust -- the
 5 word is connived, without realising by doing so we
 6 were in breach of our charitable undertakings.

7 It took a long time for the exact relationship
 8 between Eileen Trust and the scheme to be fully
 9 understood and to my shame it took me a long time to
 10 understand that the Eileen Trust was not, as it had
 11 been seen right from the outset, a mini MFT. It was
 12 something -- it was actually something totally
 13 different. The circumstances in which people were
 14 infected were totally different. None of them had
 15 bleeding disorders -- well, actually, one did. One
 16 lady had thalassaemia, which is a sort of bleeding
 17 disorder. They had totally different expectations,
 18 totally different needs. It took a long, long time to
 19 get out of the habit of thinking of the Eileen Trust
 20 as a mini MFT. We eventually got there, and -- well, I,
 21 looking back, the Eileen Trust was brilliant in many
 22 ways and the Eileen Trust community were lovely
 23 people, but I -- my only regret is that I didn't wake
 24 up early enough to realise that Eileen Trust and MF
 25 were so totally different and had to be handled

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1 totally differently.

2 Even in the present century, The Haemophilia
3 Society seem to be expecting to have the right to
4 nominate trustees to the Eileen Trust. It had nothing
5 to do with The Haemophilia Society at all. So it's
6 very strange.

7 And the relationship between the scheme and the
8 Eileen Trust was I think probably improperly
9 understood by the Department of Health, so that the
10 scheme became known as the Eileen Trust scheme. We
11 had no means of knowing -- of judging applications for
12 the Eileen Trust, who had to prove that their
13 HIV infection arose from the receipt of blood -- could
14 have been tissue but it was always blood -- through
15 NHS treatment. That job had to be done by the
16 Department and they didn't have -- the department of
17 the Department on whom this burden fell were not
18 equipped to make these judgments, make these
19 assessments.

20 So it was very awkward. There was a period
21 when we were saying that -- I'm sorry, I'm rambling
22 a bit -- when we were saying that, unlike the
23 Macfarlane Trust, people could be coming to the scheme
24 and then to the Eileen Trust for years and years and
25 years to come. I think that is no longer true because

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1 the Secretary of State. You have expressed your view
2 as to the Department's lack of expertise so to
3 determine but the scheme was they would decide and
4 then the Eileen Trust would then accept that person as
5 a person in principle eligible to make applications to
6 the Trust for discretionary payments?

7 **A.** That's correct.

8 **Q.** Now the Eileen Trust, I think we can see if we look at
9 EILN000016_053, it was a much smaller trust in terms
10 of the numbers of registrants?

11 **SIR BRIAN LANGSTAFF:** I think you may be missing a zero.

12 **MS RICHARDS:** EILN000016_053. My apologies.

13 So this is the annual report for the year
14 ending 31 March 2001, so probably roughly your first
15 year as chair or the early part of your time as chair.

16 **A.** Yes.

17 **Q.** If we go to the third page, we can just see, if we're
18 going to the top part of the page, first of all,
19 "Objectives":

20 "The Eileen Trust was established in 1993 to
21 administer a fund provided by [HMG] to assist people,
22 other than those with haemophilia, who had contracted
23 HIV through NHS treatment with contaminated blood
24 products. The Trust's objectives, as set out in the
25 Trust Deed are 'to relieve those qualifying persons

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1 I think anybody who was infected with HIV through
2 blood transfusions in the early to mid-80s and had not
3 been diagnosed by now would be dead by now. The last
4 petition that we had in the Eileen Trust, as I can
5 recall, was I think in the first decade of the
6 century, the noughties or whatever you call them --
7 I think they're called -- who was infected through
8 a contaminated transfusion given to her this century.
9 And the hospital that gave her that contaminated
10 transfusion recognised the error and paid her
11 a stonking amount of money, so there could be no
12 question that she qualified for assistance -- which
13 she should not have received, because that was
14 a stonking amount of money, had her children not made
15 off with the money and left her destitute. So she
16 required assistance from the Eileen Trust and
17 received it.

18 But the previous applicant who was infected
19 during the 80s I think came to us, oh, in the
20 early 2000s. I don't think we had anybody later than
21 that but I might be wrong on that. Sorry, that's
22 a rambling answer.

23 **Q.** That's okay. Just so that I can understand clearly
24 eligibility for the scheme, whether someone was
25 a qualifying person, was a matter for determination by

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1 ... who are in need of assistance or the needy
2 dependants of qualifying persons and the needy
3 dependants of qualifying persons who have died."

4 Then we can see that as at 2001, the Trust is
5 providing assistance to "a small number of
6 registrants". The second paragraph below "The Trust's
7 Task" tells us there were ten registrants and two
8 infected intimates at that point being supported, and
9 that you had been notified of a further possible
10 registrant, and nine families of deceased registrants
11 involving 13 children under 18, together with
12 a further three young people under 25.

13 Then the next paragraph tells us:

14 "In addition to the provision of financial
15 support the Trust provides a range of advice and
16 counselling for partners and families who have been
17 bereaved. A number of children and young people for
18 whom the Trust provides assistance are orphans whom
19 the Trustees and staff make special efforts to help in
20 whatever way is possible."

21 Then reference is made to the staff team,
22 including a social worker and benefits adviser.

23 The document there makes particular reference
24 to orphans, and we've seen in relation to the
25 Macfarlane Trust documents that there was no

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1 particular policy in relation to orphans. Was there
2 in practice any difference of treatment between
3 orphans who were qualifying persons under the
4 Eileen Trust and those who were beneficiaries under
5 the Macfarlane Trust?

6 **A.** I don't know the -- the proportion of the Eileen Trust
7 community who were orphans was a very much higher than
8 for Macfarlane Trust because -- the core constituents
9 of the beneficiary community were deceased mothers.
10 So there were a lot of children left without mother
11 and some of them without fathers as well.

12 So whether there was a difference in treatment,
13 I couldn't tell you. But it was a much more prominent
14 problem for the Eileen Trust than the
15 Macfarlane Trust.

16 **Q.** Do you know what steps were taken by the Department,
17 or indeed by the Trust from time to time, to ensure
18 that people, doctors, were aware of the existence of
19 the scheme and to try to reach out to potential
20 qualifying persons?

21 **A.** I think -- efforts by the Department were conspicuous
22 by their absence. We would occasionally say to the
23 Department -- we in the Eileen Trust would
24 occasionally say to the Department: there must be
25 another push to find people. And from time to time,

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1 were no discharge notes anywhere.

2 So these applications took a couple of years,
3 without any help from the Department at all. The
4 Trust, through our case worker Susan Daniels, gave
5 such help as we could in saying: have you tried this,
6 have you tried that.

7 In the end neither of them was accepted to the
8 scheme, therefore they didn't become trust
9 beneficiaries. I thought that one of those
10 assessments was probably correct. I had my doubts
11 about the other one, but there was no means of proving
12 it.

13 **Q.** If we have a look at EILN0000007_012, please.

14 So this is an internal Eileen Trust document --

15 **A.** I think this probably precedes my role but I don't
16 know.

17 **Q.** Yes, it's not dated and it's not signed but I don't
18 think anything perhaps would have changed. So we can
19 see --

20 **A.** I remember all the names of those -- of the office
21 staff there.

22 **Q.** So it's described as a small organisation in the
23 second paragraph, and then we see under the heading
24 "Policies" it says:

25 "The Trust is small and Trustees and staff deal

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1 in response to these nudges, they would include some
2 reference in the -- one of their regular monthly or
3 weekly bulletins they put round hospitals and doctors,
4 and they would mention it.

5 But I can't remember when the last one was. It
6 was a long time ago. I'm not just saying that because
7 my memory failure but I don't think -- there was --
8 this is not a high probability for the Department.

9 **Q.** Was there ever any problem with the Department taking
10 a long time to process applications by potential
11 qualifying persons?

12 **A.** Well, certainly in the later years and during my
13 chairmanship, yes. I mean, there were two
14 applications and, I mean, it took two years, simply
15 because the applicants, who were both men, believed
16 they had received infected, contaminated transfusions.
17 I think one of them didn't know where, didn't know
18 when, had moved around so many times -- I mean, he had
19 no records. It was very, very -- it was a very
20 difficult case but he got no help from the Department
21 at all.

22 Another one knew which hospital he believed he
23 had been injected in and knew roughly when but, again,
24 there were no records, records had been destroyed.
25 I think he had changed GPs sufficiently that there

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1 with any request for help on its own merits and
2 subject only to the terms of the Trust Deed and
3 charity law. This means that the financial help must
4 be related to need, and in this context 'need'
5 recognised will mainly be related to the additional
6 costs of living with HIV or to maintaining health or
7 to the care of sickness which is not otherwise
8 provided for."

9 Then there's a reference again to office
10 guidelines and to that not being exhaustive:

11 "... trustees will consider all applications
12 for help that fall outside these guidelines."

13 That suggests a fairly similar approach, in
14 general terms at least, to the approach taken by the
15 Macfarlane Trust?

16 **A.** Well, I mean, to use the phrase, it was run --
17 certainly before I became involved, and even after
18 I became involved, it was run like a mini MFT. The
19 guidelines documents are precisely the same as those
20 that the Macfarlane Trust used. You know, it was
21 just -- looking back now, it is -- as I said earlier,
22 it is a source of regret to me that I didn't
23 understand the difference between the two trusts and
24 the two beneficiaries early enough. I just --
25 I suppose when I was concentrating on being Chairma

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1 of the Macfarlane Trust, I was carrying on the same
2 sort of philosophy that had guided the handling of the
3 Eileen Trust in its early years. It took a long time
4 for me to get round to understanding those were
5 different.

6 **Q.** I want to come back to that issue. I just want to
7 ascertain first what in practical terms the
8 Eileen Trust did and how it operated.

9 If we look further down the page, we can see
10 that the help available, the financial help available
11 was -- comprised grants. And then if we go over the
12 page we can see regular payments and then winter
13 payments. So that same -- three different types of
14 financial --

15 **A.** Just the same as the Macfarlane Trust.

16 **Q.** Then if we go to the bottom of the page, "Other Help
17 Available", it says:

18 "A significant part of the Trust's service is
19 not necessarily concerning with direct financial help
20 at all. Advice and information are always available
21 either by telephone or letter. With a qualified
22 Social Worker and Benefits Adviser on staff we have
23 considerable experience and expertise on ..."

24 And then a number of matters listed there.

25 If we go to the top of the next page, it's said

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1 quite so forthcoming by saying this advice and this
2 help and counselling was available.
3 **Q.** Just to see if I've correctly understood that, in
4 principle, the same advice and assistance was
5 available to both Eileen Trust and Macfarlane Trust
6 beneficiaries. In practice, because the Eileen Trust
7 was dealing with a very small number of beneficiaries
8 and the Macfarlane Trust had a much larger number, it
9 was easier -- I don't mean that in a pejorative sense
10 I'm just trying to establish the facts -- it was
11 easier potentially to make that available to all
12 recipients of the Eileen Trust?

13 **A.** Yes, I think the other consideration is the majority
14 of the Macfarlane Trust registrants had a first port
15 of call, which is their haemophilia centre. The
16 Eileen Trust registrants had no -- nothing like that
17 at all. They didn't have ongoing relationships except
18 one or two cases with the hospital. They didn't have
19 dedicated centre, like the haemophilia centres. So
20 they would have had nowhere else to go, nowhere else
21 to turn to except the Eileen Trust. The Macfarlane
22 Trust registrants had -- *(interruption)*

23 Sorry about that. We have a -- that's our
24 local fish delivery from Grimsby trying to get into
25 the community.

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1 that "first level advice" and "further action" can be
2 recommended on matters such as insurance problems,
3 mortgages, wills, et cetera.

4 And then:

5 "We are not able to offer a full counselling
6 service but if you would like to discuss any problem
7 with someone who can lend a friendly and discreet ear,
8 then please ring the telephone number given."

9 Now, was that kind of practical non-financial
10 advice, information and support unique to the
11 Eileen Trust because of its small nature and small
12 number of registrants or was it equally something that
13 was delivered through the Macfarlane Trust or intended
14 to be delivered through the Macfarlane Trust?

15 **A.** Given the same people were involved, the same --
16 providers of advice were the same, of the two trusts,
17 because they were interested in the same people,
18 services would have been available for the
19 Macfarlane Trust, but the Macfarlane Trust, because it
20 had so many more people in the beneficiary community,
21 could have swamped those people in Alliance House who
22 were giving out help to the Eileen Trust.

23 So I suspect that this document, while it could
24 easily have been written for the Macfarlane Trust,
25 probably the Macfarlane Trust would not have been

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1 **Q.** If we go to EILN0000011_197 it's a report from Susan
2 Daniels, 27 September 2004. If we just look at the
3 first paragraph it says:

4 "The financial adviser has made a visit to
5 a widow near [blank] which arose as a result of the
6 Chairman's request to contact ET registrants offering
7 assistance."

8 Now, it sounds from that as though there had
9 been a request from you proactively -- for the
10 financial adviser to make contact with Eileen Trust
11 registrants to see what assistance they needed.

12 Can you recall anything about whether the
13 Eileen Trust took a more proactive approach than the
14 Macfarlane Trust was able to?

15 **A.** Yes, I mean, that certainly happened because only
16 dealing with a couple of dozen people. So we were
17 able to be proactive, we were able to make sure that
18 there were good contacts and there were several that
19 referred -- more than one referred to there.

20 The final paragraph that's on the screen, 5087,
21 I visited them with Susan quite early on in my period
22 as Chairman. A particularly difficult family -- the
23 family were not difficult, the relationships in the
24 family were difficult. So, yes, it was something we
25 were able to do in the Eileen Trust because the

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1 numbers were manageable.
 2 **Q.** In your witness statement if we go to WITN3070003,
 3 please, and we go to page 30. You say in
 4 paragraph 156, which is the second paragraph from the
 5 top of the page, this is on the issue of operationa
 6 costs:

7 "Until 2009 operational costs of MFT and ET
 8 were funded by the Department of Health through
 9 a specific grant mechanism called section 64."

10 Then you explain that from 2009 onwards the
 11 method changed so that the Trust would receive an
 12 overall annual settlement, which was for both
 13 operational costs and for the financial assistance
 14 provided to dependants. I'm not going to ask you
 15 about the impact on Macfarlane because you had left by
 16 then.

17 In relation to the Eileen Trust you say this
 18 change resulted in a substantial reduction in overall
 19 funding levels.

20 Were representations made to the Department
 21 about that?

22 **A.** Well, of course. If you recall, from yesterday the
 23 offer, the response by Caroline Flint to a joint bi
 24 for further funding and an increase in funding by both
 25 trusts was met with something which was frankly

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1 pre-dates the change in the scheme of funding to which
 2 your statement referred but it's nonetheless a letter
 3 from you about funding difficulties. It may follow on
 4 I think from the Caroline Flint decision. It's head ed
 5 "Eileen Trust funding for 2007-2008". The second
 6 paragraph refers to the funding award to the Eileen
 7 Trust being as unacceptable to the trustees as the
 8 Macfarlane Trust award was. You then refer to ther
 9 being what is said to be important differences betwe en
 10 the trusts which enhance the belief that your fello
 11 trustees at the Department have adopted a formulaic
 12 approach and totally neglected the nature and history
 13 of the Trust and the policy hitherto adopted by
 14 ministers towards its funding.

15 What were those differences relating to the
 16 nature and history of the Trust and the prior polic
 17 of its funding that you were concerned about?

18 **A.** Well, the key differences between the trusts were t hat
 19 Macfarlane Trust started off with 1,254 registrants
 20 I think two or three new ones came along after that in
 21 the early years.

22 Eileen Trust it says in the column -- sorry,
 23 the highlighting of the paragraph --

24 **Q.** If we just remove the highlighting.

25 **A.** There we are the Trust had received no fewer than five

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1 insulting, when she said she was satisfied that an
 2 increase of 11 per cent, which wasn't 11 per cent a
 3 we showed you yesterday, it was just over 3 per cen t,
 4 was enough.

5 I mean, she just -- yes, the Eileen Trust went
 6 through exactly the same processes as the
 7 Macfarlane Trust in requesting, demanding more mone
 8 and if you are going to suggest that we should have
 9 had a public relations campaign on behalf of two dozen
 10 people or fewer, you know, I think we needn't go
 11 there.

12 **Q.** What practical difficulties did this result in for the
 13 Eileen Trust, this change in the mechanism of fundi ng
 14 of operational costs?

15 **A.** Well, we had to be more -- we had to take a tougher
 16 line on grant allocation. Fortunately, Susan Daniels
 17 made a huge contribution by running -- taking the
 18 Eileen Trust to run from home. So we had very litt le
 19 contact or call on the services of Alliance House a nd
 20 we were able to -- I was able to agree with
 21 Martin Harvey that the charge that initially
 22 Macfarlane Trust and then later Caxton made to Eile en
 23 Trust was considerably reduced in order to reflect the
 24 saving of costs. So we got by; we managed.

25 **Q.** If we go to EILN0000003_146, please, this letter

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1 new registrants in the last three years.

2 So, I mean, Macfarlane Trust had nothing like
 3 that. So I mean there can be no confidence that
 4 further new registrants might (*unclear*) in the future,
 5 and some did.

6 So that's the key difference, that Eileen Trust
 7 was -- beneficiary community was growing or had
 8 a tendency to grow, which was offset only by
 9 mortality.

10 **Q.** If we go over the page --

11 **A.** I think that's the most important one.

12 **Q.** If we go over the page -- sorry, actually, I need t
 13 pick this up at the bottom of the page. I think it's
 14 something you referred to earlier in your evidence but
 15 I wanted to double-check.

16 If you go to the bottom of the first page --
 17 sorry, Soumik -- you refer there to the scheme and
 18 say:

19 "The Department committed to a range of capital
 20 payments along the lines of those made to Macfarlan
 21 Trust registrants through MSPT2."

22 Then top of the next page you say:

23 "The funding award for 2007/2008 attempts to
 24 transfer the responsibility for making these payments
 25 to this Trust without the provision to" --

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1 A. *(Unclear: overspeaking)*
 2 Q. -- "to finance them."
 3 What was the issue there, please?
 4 A. Well, the Department said that, "Any payments under
 5 the scheme to new registrants should be made by the
 6 Trust and we won't -- we, the Department, won't fund
 7 those. You've got to come -- that's got to come out of
 8 of your normal funding allocation". I mean, it's just
 9 insupportable. With two new registrants a year who
 10 would wipe out completely the whole funding allocation
 11 for the year.
 12 Q. So the Department expectation -- *(unclear: multiple*
 13 *speakers)*?
 14 A. A ludicrous suggestion.
 15 Q. So the Department's expectation had been that the
 16 payments, the tariff payments that were due under the
 17 scheme, would be paid by the Trust out of its existing
 18 allocation?
 19 A. That's what they were suggesting, yes.
 20 Q. Did they back down from that?
 21 A. I think they did in the end, yes. I mean, I think the
 22 result of this letter was salient underneath the
 23 bullet points:
 24 "The element of the funding award betrays
 25 inadequate thought within your department."

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1 It's questionable whether this work has been
 2 sufficient given the risks of onward transmission of
 3 the infection from those affected."
 4 Then you refer to awareness of new application
 5 for registration. You're here raising that issue with
 6 the Archer Inquiry.
 7 Had the Trust through you or your colleagues
 8 previously pressed the Department to make more
 9 strenuous efforts to alert medical practitioners?
 10 A. We've already covered this, yes.
 11 Q. Was that something that was raised in regular meetings
 12 by you?
 13 A. It was certainly raised. I can't say that we had
 14 regular meetings. It was certainly raised, yes.
 15 Q. And then you say in the following paragraph, picking
 16 up in the end of the second line:
 17 "The smaller numbers have enabled the trustees
 18 to develop a much closer knowledge of each individual
 19 registrant's circumstances than is possible within
 20 MFT. It is probably fair to say that ET now gives
 21 a more personal service to its beneficiaries than MFT
 22 has ever managed with help of a dedicated case
 23 worker."
 24 So that's the more bespoke personal service
 25 that you were able to provide potentially sometimes

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1 I think they did actually rethink that and
 2 agreed that any new payments by the scheme would be
 3 financed directly by the Department.
 4 Q. Do you recall whether you had any meetings with
 5 ministers in relation to the funding of the Eileen
 6 Trust, so after the Caroline Flint meeting we've
 7 discussed yesterday, after you ceased being chair of
 8 the Macfarlane Trust but continued with your role with
 9 the Eileen Trust, did you have any subsequent funding
 10 meetings with ministers that you can recall?
 11 A. I can't recall any. I probably did, yes. I hope
 12 I did, yes. If you were to tell me who the ministers
 13 were who followed Caroline Flint then I could say
 14 whether I met them or not.
 15 Q. I'm afraid I don't have them off the top of my head
 16 If we then go please to your evidence to the
 17 Archer Inquiry in relation to the Eileen Trust, I want
 18 to ask you to look first at the written document you
 19 prepared. It's ARCH0002992, please. If we go to the
 20 second page, and we pick it up in the third paragraph
 21 we can see you saying:
 22 "The Department has made occasional efforts to
 23 alert medical practitioners to the existence of ET and
 24 therefore to the possibility of finding patients who
 25 were infected through NHS treatment during the '80s

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1 anticipating future needs because of the smaller
 2 number of registrants?
 3 A. Yes.
 4 Q. And then if we go to the bottom of the third page,
 5 please, you say in the last paragraph, you are
 6 referring -- you refer in the previous paragraph to
 7 the issue that I asked you a few minutes ago but you
 8 then referred to the capital payment saying:
 9 "They were by modern standards and by
 10 comparison with those made in other countries very
 11 small. The tariff for the ET settlement payments also
 12 discriminates against those who were still minors or
 13 were unmarried or had no children."
 14 Just pausing there, that's presumably an
 15 observation equally applicable to Macfarlane Trust
 16 settlement payments?
 17 A. I think many of the Macfarlane Trust beneficiary
 18 community felt these criticisms in relationship to the
 19 MSPT2 settlement payment very strongly, because the
 20 settlement payment was difficult for MFT registrant
 21 to argue against because it was agreed by their legal
 22 representatives.
 23 Q. And then if we go to the next page, top half of the
 24 page under the heading "The benefits system" you say
 25 this:

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"It has always been the belief of ET trustees and registrants that the Trust was the first line of support for its registrants."

Then you observe:

"It was constrained by level of resources available so that registrants also needed to have recourse to the benefits system."

That appears to be the opposite from the position that we discussed yesterday in relation to the Macfarlane Trust where the Macfarlane Trust was seen as last resort.

A. Yes.

Q. Why that difference of approach?

A. I don't know. I'm not sure that that first paragraph is entirely accurate. I think certainly in Eileen Trust we would say to people who wanted our help, "Have you been -- have you tried the Social Fund", for example, "Have you tried your local council". We would always ask people went somewhere else and looked at us as the fall-back.

Q. Because -- I haven't done a comparison of The Trust deeds but broadly speaking the Eileen Trust and the Macfarlane Trust were both charitable trusts with need as their primary object, so there would be no --

A. The core wording of the two Trust deeds is almost

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blame which can be excused. I am not talking accountability which can be referred upstairs. I am talking responsibility, which is permanent. I think the Department of Health are turning away from their responsibility. They are denying responsibility for the Eileen Trust registrants by cutting back the funding, by refusing to give adequate funding to the individuals as well as to the Trust. It's a total abdication of responsibility."

Now, why was it your view that the Department of Health was more responsible or even more responsible for the position in which Eileen Trust registrants found themselves in than Macfarlane Trust registrants?

A. My reasoning is set out on the previous paragraph, previous page. I'm saying that the people who administered transfusions were not haematologists, so they were taking it on trust that the transfusions were appropriate in those circumstances.

I mean, this may not be the way the National Health Service works. These are my views. The page we're looking at at the moment, my little dissertation on liability, accountability, responsibility, blame, is something which I hope may be right. I mean, the argument is something which I assume the Inquiry might

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identical.

Q. Then I wanted to look at something you said in your oral evidence to the Archer Inquiry. So if we could go please, Soumik, to ARCH0000005 and if we go to page 27 of the electronic pagination. So if we pick it up at line 9 onwards you say this:

"There is an additional issue as regards the Eileen Trust which makes it unique I think or makes it different from the Macfarlane Trust. Registrants at the Eileen Trust were infected through blood transfusions. I am not a medical historian but I believe blood transfusions have been going on for centuries and the treatments that these people were receiving were not being provided by haematology. They were being provided by orthopaedic surgeons, b heart specialists, whatever, a range of clinicians who would reasonably expect if their patient required a blood transfusion that the blood transfusion would not be a source of infection. They could not be expected to know that they were actually putting a life-threatening treatment into their patients. To my mind this makes the Department of Health even more responsible for the condition of the Eileen Trust [go over the page] registrants. I am not talking liability, which can be discharged. I am not talking

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consider.

As far as I'm concerned the people who administered the transfusions to the Eileen Trust registrants that turned out -- transfusions that turned out to be contaminated would not have expected them to be contaminated and therefore it seems to me that the Department of Health were even more responsible than they might have been for haemophilia, the infection of haemophiliacs.

But this is what inquiries are set up to do, and so you -- so I'm only saying, you know, these are my arguments. You can dismiss them, if you like, if you think it's appropriate.

Q. What I am trying to understand, Mr Stevens, is your basis for suggesting the Eileen Trust's position was unique. The relative knowledge of the doctors who administered the treatment, why does that make the position of one set of patients more deserving of recompense or recognition or acceptance of responsibility than another set?

A. I'm not sure I'm saying that, am I? I'm saying that I believe the Department of Health are more responsible because there were no -- and I may be wrong here totally in the way the NHS is set up, but there were no haematologists who were involved in the

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administration of transfusions to Eileen Trust or scheme registrants eventually. The people the Eileen Trust were looking after were infected on the basis of a single transfusion. I would not expect a thoracic surgeon to know the background of blood contamination.

Maybe I am misjudging the breadth of knowledge and involvement of people who would know in those operations but it seems to me that what I'm saying there, and I think I probably would still say that now, it seems to me that whereas the Department of Health, whatever the Inquiry finds out, had a broad responsibility for the use of contaminated blood for blood products that were administered over a period of years as a matter of course by experienced haematologists to people with haemophilia.

The people who gave single transfusions to people for treatment of non-chronic conditions in the course of surgery could not have been expected to know the risk that those transfusions might be contaminated and therefore somebody somewhere has to be more responsible for that, and I believe that's the Department of Health. That's what I believe the Inquiry is set up to find out. And I might be -- you might find I'm totally wrong, but that -- I'm expressing a view.

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Authority, taking over from 1 November and at 3 the minutes record this:

"Any funds remaining after the handover (other than what would be needed to finance the shutdown expenses) would be distributed between the registrants, those with highest need, receiving the most; a small payment would be made to most registrants so that they had an 'emergency fund'.

Then there's a later document, I don't know I need to take you to, not long after this, where we can see the funds were reduced in that way to something less than GBP 5,000, which was then, I think, gifted to the Macfarlane Trust.

So is this right that the Eileen Trust decided to use its remaining reserves by distributing those reserves amongst its registrants in the way in which we see described here?

A. Yes.

Q. Were you involved with or did you have any knowledge of the approach that was being taken at around the same time by the Macfarlane Trust to what was being done with its reserves?

A. No, not in detail. I knew -- I know that they had a -- some sort of scheme to run down their reserves, which, before, we discussed was GBP 4 million. I have

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Q. Can I just check, then this: were you, in what you told the Archer Inquiry, in any sense intending to suggest or hint that the patients who were haemophiliacs themselves bore some level of responsibility because they should have known of the risks?

A. No, not at all.

Q. Thank you.

A. Nothing to do with the patient. It's the people who are looking after them.

Q. Thank you.

There's then a final question on the Eileen Trust about the position of reserves towards the end of the life of the Trust. So if we could look, please, at EILN000002_029.

SIR BRIAN LANGSTAFF: I think you might need another thought.

MS RICHARDS: I think we might. In fact, actually I don't think we need to go to that document. We'll go to a slightly later one which makes the same point.

EILN000002_026. These are the minutes of a board meeting of the Eileen Trust on 7 September 2017. We can see if we look at the bottom half of the page that this is in anticipation of the new scheme administrator, the NHS Business Services

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no -- I was not involved in the detail. I don't know about that.

Q. I am going to move then to the Skipton Fund. You've explained in your witness statement that when the Skipton Fund was being established, there had been a dearth of preparatory work done by the relevant Government officials, and you and I think Mr Harvey had to do a lot of the preparatory work which you would have expected would be done by others. What kind of stuff did you have to do?

A. We would -- the broad principles of the operating practices for the Skipton Fund were, I think, agreed by the -- and plenary meetings, chaired by Richard Gutowski. Martin and I then had to go away and draw up detailed proposals as to how these operating practices would actually work. Just that.

Q. So the meetings that you describe taking place, who was involved in those meetings? You, Mr Harvey, officials from the Department of Health, any others that you can recall?

A. Well, yes. I don't have a full cast list but certainly there were representatives of the devolved administrations, health departments of the devolved administrations. One of whom was particularly helpful, some of whom were totally

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1 unhelpful. Charles Gore from the Hepatitis C Trust
2 attended most of them. There may have been -- I don't
3 know, The Haemophilia Society may have been involved,
4 I can't remember.

5 I really don't know. The list of names will
6 have to come from the Department.

7 **Q.** Now, there had been in Scotland, prior to the
8 ministerial announcement that led to the establishment
9 of the Skipton Fund, a report by Lord Ross and others
10 which made certain recommendations about compensation
11 for individuals infected with hepatitis C from blood
12 or blood products.

13 Can you recall consideration being given to
14 that report in these meetings that took place?

15 **A.** No, I can't.

16 **Q.** The Skipton Fund, as you have explained in your
17 statement -- and we'll look at some documents if
18 necessary -- was a scheme, a fund, whereby payments
19 were made that were pre-determined payments, stage 1
20 and stage 2. Were you involved in these plenary
21 meetings that you've discussed in discussions about
22 whether that was the right approach to take or had
23 that been determined prior to your involvement?

24 **A.** I can't remember exactly. I have the feeling that
25 there was discussion about -- essentially in these

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1 rather than there being schemes run directly by
2 devolved administrations?
3 **A.** Oh, I think there was discussion. I think it was
4 broadly accepted that there couldn't be -- it was
5 totally inappropriate that the devolved administration
6 should have their own schemes, and people felt that
7 things had to be done on a UK-wide basis, for reasons
8 of efficiency and probably equity.

9 **Q.** If we go to SKIP000032_214. This is an email from
10 you to Moira Protani, who I think was a solicitor
11 advising.

12 **A.** This is the meeting, yes.

13 **Q.** 10 November 2003. You refer to having had, in speech
14 marks, a "secret" meeting at Department of Health the
15 secret being that "people such as the Haemophilia
16 Society were not involved and we were being given
17 advance warning of what is now planned."

18 Can you recall why a meeting was taking place
19 in the absence of what you describe as people such as
20 The Haemophilia Society?

21 **A.** If there's any discussion of it at all -- I mean,
22 I covered this in my written statement -- I don't
23 recall it. But the meeting participants were
24 determined -- were invited by Richard Gutowski, and
25 I suspect the reason The Haemophilia Society got

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1 meetings about the idea of a two-stage approach and
2 what the quantum of the payment should be.

3 I think the meetings probably rubber stamped --
4 at least if they didn't actually make a decision, they
5 rubber stamped that decision. I don't believe I had
6 a particularly strong view. I spent quite a lot of
7 time in these meetings trying to catch up with what
8 hepatitis C was about and how it worked, and some of
9 the medical evidence was quite difficult to
10 understand, for me anyway.

11 **Q.** One of the recommendations of the Scottish report, the
12 Ross report, had been for there to be payments made
13 effectively beyond a certain -- or to some categories
14 of patients on a full compensation basis. Can you
15 recall whether there were any discussions about
16 whether a compensation principle should or should not
17 form part of the Skipton Fund approach?

18 **A.** I don't recall the word "compensation" being allowed
19 to be uttered in the precinct of Richmond House. So,
20 no, I don't think that -- I think the idea that was
21 being discussed in those plenary meetings always --
22 some *ex gratia* payments to help people deal with the
23 effects of infection. Certainly not the C word.

24 **Q.** Do you recall any discussions about why the
25 Skipton Fund was going to operate on a national scale

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1 involved was because a large proportion -- it turned
2 out to be about half -- of the beneficiaries of the
3 Skipton Fund were not people with haemophilia. So
4 that he was anxious that what we were talking about in
5 this meeting, was covered in that note, should not be
6 overly concerned with the people with haemophilia.

7 **Q.** Then if we look at the bottom half of the page --

8 **A.** Sorry, just to say, you know, who attended this
9 meeting was not my call.

10 **Q.** If we look at the bottom half of the page, it's three
11 indented paragraphs up from the bottom, where it
12 begins:

13 "- there would be no payments to bereaved
14 families, or to those who have cleared the virus
15 naturally. The first of these, in particular, is
16 regarded as unacceptable by The Haemophilia Society
17 and its political allies, so there may be campaigning
18 on it. This could put certain MFT Trustees in
19 a difficult position. For my part (as
20 a Society-appointed Trustee) I can live with the NH
21 making *ex gratia* payments, with no admission of
22 liability, to people it has harmed who are still alive
23 and are or will be incurring costs as a result of
24 their infection, while ignoring what would seem a bit
25 more like compensation who have been bereaved (even in

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1 those cases where such bereavement has resulted in
2 real financial hardship)."

3 What was your understanding of the rationale
4 for the Department's resistance to assisting the
5 bereaved?

6 **A.** I don't know. I mean, subsequently the scheme was
7 changed to admit people into the scheme. So why th
8 Department started off with that as a basis -- sorr y,
9 I can't -- you know, maybe on the basis they though
10 they could get away with it. I don't know. I don'
11 know why.

12 You haven't asked about the omission or the
13 exclusion of those who cleared the virus naturally.
14 I don't understand why that --

15 **Q.** I'm going to come on to that in a few minutes.

16 **A.** -- (unclear: overspeaking)

17 **Q.** I will come back to that. If we could have
18 SCGV0000256_051, please.

19 **A.** Just to say on that previous note, just glancing
20 through it, I mean, there are several points in tha
21 note, which was written towards the end of 2003 tha
22 did not -- on which scheme was different, what
23 eventually happened. Some of those are original
24 assumptions were just discounted. Sorry.

25 **Q.** That's all right. So there are some -- this is som

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1 as a company, limited company, rather than some other
2 form? We've seen trusts as the basis for Macfarlan
3 and Eileen so far.

4 **A.** Well, Skipton was performing a totally
5 non-discretionary non-charitable -- it was simply
6 going to be operating, to administer a scheme. So
7 there had to be some sort of vehicle for it. I thi nk
8 by the early part of the 21st century the alacrity
9 with which trusts were considered appropriate vehic les
10 had rather diminished, and the expect -- it was
11 natural to think of a corporate vehicle. So a comp any
12 limited by guarantee didn't require anybody to put up
13 any money for it. It was just -- seemed to be
14 a totally appropriate vehicle.

15 **Q.** Can you recall any of the detail of the discussions
16 about the amounts of the payments, the lump sum
17 payments that were going to be administered by the
18 Skipton and how --

19 **A.** No, I can't recall any detail. I'm sure there
20 probably was discussion. I can't recall the detail .

21 **Q.** Can I then come on to the issue you alluded to
22 a moment or two ago, which was that of natural
23 clearers. Did you get any understanding of why the re
24 was resistance to including natural clearers within
25 the scheme?

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1 email exchanges between various of those involved i
2 discussions. If we go to the second page we can se
3 there's an email from you to Richard Gutowski at th
4 Department of Health. And if we go towards the bot tom
5 of the page, you will see the reference there to
6 "Hep B". It says:

7 "This is a new point, again from Mark."

8 I think that is from Dr Mark Winter.

9 "He has 2 or 3 haemophiliac patients who
10 contracted Hep B through the same route. It would
11 seem logical to include them. Since numbers are bo und
12 to be very low, can they be included through the
13 administrative process without being publicly
14 announced?"

15 Can you recall there being any more substantive
16 discussion other than you, as it were, floating the
17 point here about the inclusion of hepatitis B
18 sufferers and why they were not included?

19 **A.** No, I can't recall any discussion, but my
20 understanding is that this point was dismissed, or was
21 not -- I don't believe hepatitis B was accepted as
22 something with which Skipton should be concerned.

23 **Q.** That can go down, thank you.

24 What can you recall -- again, any discussions
25 about why the Skipton Fund was going to be structur ed

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1 **A.** No. I think for once I've got to admit that this w as
2 not in -- exclusively Department of Health's
3 insistence. I think there was support for this fro
4 some of the clinicians that were at those meetings.
5 It was -- I mean, it was a very difficult issue and
6 I've pulled out some -- a note that -- the first
7 glimmerings of daylight on this were in 2011, which
8 was seven years after Skipton Fund began operating.
9 It was an extremely difficult issue. And I suppose
10 one of the reasons why natural clearers were excluded
11 was because they would have had no ill effects from
12 the infection. They had their health, their future
13 livelihood, their life expectancy was totally
14 unaffected by this short period of infection during
15 the acute stage in which they (unclear). They didn't
16 have to have any medical treatment for it, they jus
17 sit there with -- their bodies just threw off the
18 infection.

19 So I suppose that, from the point of view of
20 both clinicians and particularly the Department of
21 Health, they said: well, why should we pay these
22 people anything for something that has not affected
23 them? I suppose that's the background.

24 **Q.** If we look at SKIP000031_213.

25 So this is a letter you wrote to

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Professor Mark Mildred, who was chair of the Skipton Appeal Panel, and from whom we will be hearing in due course, 26 November 2007.

If we pick it up in the second paragraph, we can see you expressing the view, which I think is probably expressed here as a collective view on behalf of trustees, as something that has always been regarded as --

A. Directors not trustees.

Q. Sorry, directors, you are right -- regarded as a defect in the *ex gratia* scheme, which was the exclusion, as we see from the following paragraph, of natural clearers.

If we just go further down towards the bottom of the page, you there set out that:

"The result [of this exclusion] has been inequity in two respects. Firstly, a number of leading hospitals with major and experienced haemophilia treatment centres have made no applications on behalf of any of their patients with haemophilia who ..."

Go to the top of the next page:

"... have cleared the virus naturally, believing that they are unable to distinguish, with any scientific accuracy, between those who cleared the

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of the company, were concerned that we were coming up with not -- with these cases, like this young man referred to here, who met all the criteria for being natural clearers and yet actually clearly weren't.

So it was -- so we were looking for somebody to have the policy reconsidered, and the choice of that somebody was Mark Mildred.

I should not have written to him. He didn't reply to me. I have no idea whether he took it forward. As I say, four years after this letter was written there was a glimmering of a belief that some progress was being made in the treatment and so the last -- the bottom of what we are looking at on the screen says:

"... we have excluded about 180 applicants on the grounds of being natural clearers."

I think in the end, out of the -- I think in the end the number was about 500. It was quite -- and what it says there:

"What we do not know is the number who have been ..."

And I know what it says after that, which is that: who have been omitted from making applications -- on whose behalf applications have not been made by their haemophilia centre.

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virus during the acute phase and those [whose] clearance occurred later. On the other hand, similar other similar institutions appear to have taken the view that any of their natural clearers were likely to have had chronic stage infection."

And then you raise a second issue relating to a particular applicant and a particular set of circumstances.

First of all, do you know whether Professor Mildred took up the invitation to make representations to the Department about the natural clearers issue?

A. No, I don't. I mean it was -- the letter -- it was totally improper to have written to him. There was no direct contact between the Appeal Panel and the Fund, except that Nick Fish, who was the brilliant administrator of the Fund, also handled the administration of the Appeal Panel. But he was able to keep the two subjects separate in his mind and he did not talk to any of the directors about cases that were being put to the panel or cases on which the panel had adjudicated.

So I should not have written to Mark asking for his help. I should -- you know, but we were running -- we'd run out of options. We, the directors

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So, you know ...

Q. Was that first inequity in which the ability to even make an application effectively depended upon, or to make a successful application effectively, depended upon the policy of the haemophilia centre or clinician, was that inequity ever resolved as far as you can recall?

A. No, I don't think so. I think people on whose behalf applications were not made to the Skipton Fund, I don't think applications were ever made for them.

Q. Now --

A. Sorry -- to say their lives wouldn't have been affected by the infection anyway, so maybe that's reasonable.

Q. You described the MFT, I think, earlier as a quasi agent of the Department of Health. The Skipton Fund was in terms described as an agent of the Department of Health because it operated pursuant to an agency agreement with the Department. Is that correct?

A. Yes. I mean, this is another illustration of the brilliance of the Department of Health, that the Skipton Fund began operating in July 2004 and the agency agreement was finally settled, drawn up and signed in 2007. Yes, we were clearly agents. Our annual report every year started off by saying we are

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1 agents for the Department of Health.

2 **Q.** You anticipated my next question, Mr Stevens, which

3 is: why did it take nearly three years from when th

4 Fund first started operating for the agency agreement

5 to be finalised and signed?

6 **A.** No idea. It wasn't our job.

7 **Q.** It also took -- we can see it from the minutes, if

8 necessary, but you may recall -- it also took

9 a considerable period of time before the Department

10 established the Appeal Panel which met for the first

11 time in October of 2006. Do you know why that took so

12 long?

13 **A.** No.

14 **Q.** Had it been the Department's responsibility and not

15 the Fund's to establish the Appeal Panel?

16 **A.** Completely. The Appeal Panel was, as I said, it was

17 independent of the Fund. The membership was chosen by

18 the Department. The terms on which it -- I mean,

19 everything to do with the fund was handled by the

20 Department with exception of the administration of

21 Nick Fish.

22 **MS RICHARDS:** Sir, I want to go to the agency agreement

23 but it will take more than one or two minutes; so

24 perhaps do that at 2 o'clock.

25 **SIR BRIAN LANGSTAFF:** Yes. We will take a break now until

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1 think.

2 **A.** Looks -- there they are.

3 **SIR BRIAN LANGSTAFF:** Yes, we're back on. Thank you.

4 **MS RICHARDS:** So, we can see this is a version of the

5 agency agreement that incorporates later amendments

6 I don't think anything turns on that for present

7 purposes.

8 If we go to page 4 and we look at paragraphs C

9 and D. If we look at D first of all:

10 "Skipton has been formed to provide services

11 acting as the [Department of Health's] agent on the

12 basis set out in this agreement."

13 And then C:

14 "The Secretary of State for Health and the

15 Devolved Administrations have entered into a service

16 level agreement by which the Department of Health (DH)

17 acts on behalf of the Devolved Administrations in

18 relation to Skipton and the parties contribute their

19 proportionate share to the funds distributed."

20 So is this right, Mr Stevens, that the

21 Skipton's relationship was with the Department of

22 Health and then the Department of Health had its own

23 arrangements with the devolved administrations?

24 **A.** Yes, that's correct.

25 **Q.** Then if we go to page 10, if we look at the bottom of

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1 2 o'clock. 2 o'clock.

2 (12.59 pm)

3 (Luncheon Adjournment).

4 (2.00 pm)

5 **SIR BRIAN LANGSTAFF:** Yes.

6 **MS RICHARDS:** Mr Stevens, I'm just going to ask you to

7 look with me at the agency agreement for the

8 Skipton Fund.

9 Soumik, it's SKIP0000033_058.

10 Oh, the screen's not on ...

11 Sorry, Mr Stevens, there maybe a technical

12 issue.

13 **SIR BRIAN LANGSTAFF:** Mr Stevens, can you hear me?

14 **A.** Yes, I can.

15 **SIR BRIAN LANGSTAFF:** We have a technical issue with one

16 of the screens. Sorry, your evidence has been beset

17 with the odd technical issue. I do apologise.

18 We have a problem with the screen. We will

19 just pause for a moment because it's important that --

20 ah, we're probably back on, are we? No.

21 **MS RICHARDS:** We don't normally have documents displayed

22 on that screen, sir. We normally have Mr Stevens

23 displayed on that screen.

24 **SIR BRIAN LANGSTAFF:** Bear with us and we'll start as soon

25 as we're ready. It won't take very long, I don't

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1 the page, paragraph 2.5:

2 "Skipton acknowledges that:

3 "... as a Government Department, DH is directly

4 accountable to the Secretary of State for Health;

5 "... Government policy is subject to amendment

6 from time to time ..."

7 Top of the next page.

8 "... DH has a duty to act in accordance with

9 the policy of the Devolved Administrations.

10 And then this:

11 "... It [that's Skipton] may only alert DH to

12 operational issues and may not make proposals to amend

13 Government policy."

14 How in practical terms did that provision of

15 the agreement affect what you and your fellow

16 directors were able to do and say?

17 **A.** It didn't have very much effect. It did mean that,

18 for example, we were unable to raise or to make

19 proposals about the natural clearing issue to the

20 Department of Health but it didn't stop us discussing

21 the problems it caused. I don't really think that --

22 I don't really think this got in the way at all of our

23 day-to-day operations.

24 **Q.** We'll come back to the agency agreement in a moment

25 but if we look at SKIP0000031_003, this is, I think,

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a *pro forma* letter from you. It's undated but it's after the Archer Inquiry report and after the Government has published its response to the Archer Inquiry report, and you say in paragraph 2:

"I note your disappointment with the Government's response to the Report of the Archer Inquiry, and am aware that this disappointment is widely shared. Indeed, in my roles as a former Chairman of the Macfarlane Trust and current Chairm an of the Eileen Trust ... I share this disappointment and believe all those who were or are fellow Trustees of these Trusts are in accord.

"However, as Chairman of Skipton Fund Limited ... my reaction has to be neutral."

And then you refer to the clause we've just looked at. And then you respond, at the bottom of the page to what had been a request to you to make representations to Government about their response to the Archer Inquiry, and you say that would require you to be in breach of the agreement.

Top of the next page:

"I regret that both I and other representatives of [Skipton Fund Limited] are, therefore, unable to participate in the further campaigning that you support."

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this out but I don't recall anything, any particular issue. I certainly don't think that we objected to this clause preventing us from taking issue with the Department over the scheme. No, we just had accepted it.

Q. If we go back, please, Soumik, to the agency agreement, so SKIP0000033_058, and we go to page 16 and to the very bottom of page 16, it says:

"Confidential Information includes ..."

And then we go to the next page:

"... all information relating to the Claimants ..."

That's no doubt unsurprising:

"... as well as to the plans, intentions, affairs and/or business of Skipton; and

"... the negotiations relating to this agreement."

And then 9.2 provides that:

"Each party shall, subject to the overriding obligation of the [Department of Health] ...

"... keep all Confidential Information strictly confidential."

So at face value this would appear to suggest that no director of the Skipton Fund could talk to anyone other than the Department of Health about th

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So it would appear that you understood the provision in the agency agreement to prevent you even expressing views about the Government's -- or the adequacy of the Government's response one way or another to the Archer Inquiry, yet you could do that as chair of the Eileen Trust.

A. Yes.

Q. Did that not to some extent disenfranchise Skipton Fund beneficiaries?

A. Only to the extent -- only if they hadn't known about the provision in the agency agreement. This letter makes it quite clear that they would understand the problem and, therefore, they should take the action that I suggest there to get their point across.

Q. Do you know why -- we can take the letter down, thank you.

Do you know why the Government included that provision in the agency agreement, and was there ever any discussion about whether it should be included?

A. No, I don't know why. I don't recall any discussion. I think we just had to accept that and (*unclear*) and their lawyers are drawing up -- drew up the agency agreement, we had -- we believed it to be -- including our actions anyway, the more unrealistic -- we could at the time we were doing the drafting process, point

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plans, intentions, affairs and/or business of Skipton. Was that your understanding of the agreement?

A. I think that's a fair interpretation.

Q. Did that inhibit the work of the Skipton Fund at all as far as you can recall?

A. I don't think so, no.

Q. When you gave evidence to the Archer Inquiry -- it's ARCH0000005 I think, Soumik, and if we go to page 7, electronic pagination.

We can see bottom of the page you refer, in line 21 onwards, to Skipton being "an agent of the Department of Health", and then you say:

"... there are certain things that I might find it difficult to talk about, certain questions I might not be at liberty to answer ..."

Top of the next page:

"... freely because wearing my Skipton hat I am in an agency position."

And then there's reference in the discussion that you have with the Chair as to the confidentiality agreement.

Were there issues relevant to the functioning or funding of the Skipton Fund that you felt that you were unable to tell the Archer Inquiry about?

A. I don't recall without proceeding further down those

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1 minutes.

2 **Q.** I think if we go to page --

3 **A.** There's a question there about present funding, would

4 I regard it "as sufficient or is it going to cover"

5 and the next line says what my answer to that is.

6 **Q.** Yes. I mean, you did then set out certain things

7 about the Skipton Fund, and I'm not -- I just want to

8 ask you about one matter.

9 Page 16, please.

10 Bottom of the page, you were asked at the

11 bottom of the page about the retrospective application

12 of the Skipton Fund pre-July/August 2003 for bereaved

13 widows, and you were asked:

14 "Do you have a view about why it is has not

15 been applied retrospectively?"

16 And you replied:

17 "I personally have a view ..."

18 Top of the next page:

19 "... but I am probably not at liberty to give

20 my personal views."

21 Is that an issue on which you now feel able to

22 say what your view was or is?

23 **A.** It's not an issue on which I think I have a strong

24 view now. I've a feeling with the -- whatever the

25 problem was has been resolved by subsequent changes to

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1 which happened more than once, which required -- me and

2 we had to go back to people who had already been in

3 touch with the Fund and either been turned down or

4 whose payment were now going to be increased, we had

5 to do that. We had records of who they were. We had

6 to get in touch with them -- which was difficult in

7 some cases because you can't just write to somebody

8 who some years ago had lived at an address, talking

9 about hepatitis C, in case they had moved, in case the

10 letter got opened by somebody else. So that was

11 difficult. But that only -- as I say, that only

12 applied to people of whom we had already known. It

13 involved a huge amount of work generally by Nick,

14 Nick Fish, and sometimes he had to call in temporary

15 help to do it.

16 But as far as the intention of people who might

17 benefit from knowing about the Skipton Fund but had

18 had no relationship -- we -- there's nothing we could

19 do about it.

20 **Q.** Did you consider or ask the Department to consider

21 establishing links or lines of communication with

22 hospital trusts or representative medical

23 organisations or relevant Royal Colleges, for example,

24 to try to raise the level of awareness amongst medical

25 practitioners?

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1 the scheme and it was now -- I have no idea what's

2 happening now.

3 **Q.** Sticking with the Archer evidence and some of the

4 matters that you did feel able to give your views on,

5 if we go to page 13 -- sorry, page 14

6 electronically -- you will see towards the bottom of

7 page 14 you were asked, at line 22:

8 "How are people made aware of the fund -- of

9 the availability?"

10 And your answer was:

11 "By the Department of Health and the devolved

12 administrations using such resources as they have,

13 which is probably not really very well."

14 What can you tell us about the steps that were

15 taken, whether by the Department or by the

16 Skipton Fund itself, to raise the profile of the

17 Skipton Fund and to try and ensure that as many people

18 as possible were made aware of its existence?

19 **A.** As far as try and finding people who might not have

20 known about the Fund, there's nothing we can do about

21 it because we don't know who they are. So it was up

22 to the Department and the devolved administrations to

23 do what they felt to be appropriate. I had no idea

24 what they did or how they would have publicised it.

25 Whenever the nature of the scheme was changed,

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1 **A.** I don't think we ever suggested anything along those

2 lines. I think we felt it was up to the Department

3 and the devolved administrations to generate such

4 publicity as they believed to be appropriate.

5 **Q.** If we have a look at SKIP000057_053, please.

6 If we go to page 5, electronic page 5, you will

7 see this is the director's report for the year ended

8 31 March 2014, so this is going on for a decade after

9 the Fund first started operating.

10 If we look at the second half of the page,

11 please, Soumik, the third paragraph down on screen:

12 "The directors believe that there may still be

13 substantial numbers of potential applications in

14 respect of people who died before 29 August 2003,

15 where the estates are unaware of the existence of the

16 scheme. In the cases of people with haemophilia who

17 had been registrants of the ... (MFT) ... MFT might be

18 able to trace some of those estates. No such route is

19 known whereby the estates of non-haemophiliacs,

20 possibly the major proportion of this group of

21 potential recipients, might be contacted."

22 Do you know whether any steps were taken,

23 whether by the Department or anybody else, to try to

24 work out a route of getting that information or --

25 **A.** No, I don't.

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- 1 Q. Do you think that there should have been some kind of
2 policy or system in place, perhaps instituted by the
3 Department, to inform newly diagnosed patients of
4 their potential entitlement to apply to the
5 Skipton Fund?
- 6 A. I think newly diagnosed people would have been told by
7 their clinicians, by the hospitals who made the
8 diagnosis, who were -- I think were all aware of the
9 existence of Skipton. But the estates of
10 non-haemophiliacs who would not have been in touch
11 with clinicians or hospitals, I have no idea --
- 12 Q. So we can take that down.
- 13 A. -- what could be done about contacting them.
- 14 Q. But in relation to the newly diagnosed, your
15 expectation, as director of the Skipton Fund, was that
16 patients in that position would be told of the
17 existence or should be told of the existence by the
18 clinician of the Fund?
- 19 A. Yes.
- 20 Q. You told us earlier, when we were talking about the
21 Eileen Trust, of the work that Susan Daniels was able
22 to do to, in some cases, assist in tracking down
23 medical records. Was any assistance available from
24 the Skipton Fund along similar lines to help
25 applicants track down evidence or records?

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- 1 That probably happened more -- you know, most of the
2 time that was the process that happened. But -- an
3 particularly as years went on and Nick's knowledge and
4 understanding of the nature of hepatitis C infection
5 grew, he was able to make more and more decisions
6 himself.
- 7 Q. Was any training arranged for the administrator,
8 either the first administrator, who we will talk about
9 in a few minutes, or Mr Fish, as his successor, to
10 assist them in processing and understanding
11 applications, because they were ultimately having to
12 make some form of sometimes medical judgment, were
13 they not?
- 14 A. Yes, they had to make medical -- Nick hadn't made
15 medical judgments. He would consult the -- such
16 medical practitioners as we had available, which would
17 be in the later years (*unclear*) Thomas and Dusheiko.
- 18 In the early years medical opinions were
19 necessary -- I can't remember who -- who we'd go to
20 then because we didn't have any clinicians on the
21 board then. I think he would go back to -- maybe to
22 Mark Winter or somebody who -- you know, somebody who
23 knew us.
- 24 Q. Had there been any specific training arranged for
25 either --

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- 1 A. No.
- 2 Q. Was any consideration given to --
- 3 A. I think -- sorry. I think if there was an application
4 made to the Fund that required -- clearly required
5 certain documents to be found, Nick Fish would write
6 back and say: what you need to do is get hold of such
7 and such document, and I suggest you try the following
8 sources.
- 9 Nick was quite helpful but he didn't do the
10 hunting for them.
- 11 Q. No doubt we can ask Mr Fish about that when he gives
12 evidence.
- 13 In terms of the decision-making processes on
14 applications within the Skipton Fund, were all
15 applications ultimately considered by the
16 administrator, were some considered by directors? How
17 did it work?
- 18 A. They all started off with the administrator. If he
19 felt that there was a need for directors to be
20 involved in making a decision, he would bring it to
21 the attention of the director and point out what the
22 problem was. If he felt that it was -- the
23 application was straightforward, then he would come to
24 the director for signing because we would not make
25 a payment without a director having signed it off.

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- 1 A. No, no. I mean, Nick started off as the assistant
2 administrator to the book(?). So he had seen what the
3 process was and he saw what had to be done when he
4 took over in the job.
- 5 Q. Can I ask you to look at a passage in your witness
6 statement. It's WITN3070003.
- 7 If we go to page 41, if we look at
8 paragraph 196, towards the top of the page, you say:
9 "Evidence was meant to be clear-cut. Both
10 Stage 1 and Stage 2 application forms were designed to
11 place the burden of proof on the applicant's
12 clinician(s), some of whom did not appreciate this
13 addition to their workload."
- 14 Just dealing, first of all, with first sentence
15 of that paragraph. When you say "Evidence was meant
16 to be clear-cut", what do you mean by that?
- 17 A. Well, this was -- this goes back to something we
18 talked about earlier, where my memory of the way it
19 was supposed to operate was incorrect, and when
20 I subsequently after -- then I wrote a statement --
21 saw some of the written evidence, that -- it would
22 have been helpful to see that before.
- 23 The balance of probabilities, which I had
24 forgotten about, was embedded in everything we did.
25 So evidence was meant to be clear-cut. It wasn't

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1 meant to be clear -- it's wholly -- the only thing one
 2 could say, it was hoped that evidence would be
 3 clear-cut but we had -- we could take balance of
 4 probabilities into account.

5 **Q.** I think "balance of probabilities" was itself a phrase
 6 derived from the agency agreement?

7 **A.** Yes, three years after we'd started operating, yes.

8 **Q.** The second part of this paragraph refers to the
 9 expectation of the applicant's clinician, and you said
 10 there "some of whom did not appreciate this additio
 11 to their workload". It might sound from that that
 12 some potential applicants or some applicants were
 13 disadvantaged through not having a helpful clinician.
 14 Were any steps taken to try to address that, whethe
 15 with the Department order otherwise?

16 **A.** I don't think they were particularly disadvantaged.
 17 I think that probably some -- some people's
 18 applications took rather longer to process by their
 19 clinician than might have been the case if the
 20 clinician had been less grudging of his time.

21 This process of applications was all designed
 22 in the plenary of issues. Placing the burden of
 23 provision of evidence on the clinicians' shoulders was
 24 something that was -- something that was designed i nto
 25 the application process by people who were themselves

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1 **A.** They weren't involved in -- in the Skipton Fund's
 2 operations at all, nor did we expect them to have a ny
 3 detailed knowledge of the material.

4 **Q.** In terms of the state of the files, is that somethi ng
 5 that Mr Fish might be expected to have a better
 6 understanding of what the practices were?

7 **A.** Sorry?

8 **Q.** The state of the files, before the Skipton Fund cea sed
 9 to operate, how files were kept, what was expected to
 10 be found and located by way of documents within
 11 a file, are those matters which Mr Fish would be
 12 expected to have some knowledge of?

13 **A.** He might have because he was the person who knew wh at
 14 the files contained before. I'm not sure that he m ade
 15 the decision on what information should be passed t
 16 BSA. He might have been involved in that process.

17 The Chief Executive Jan Barlow was also heavily
 18 involved. I don't think the directors of the Fund
 19 were asked at all to assist in the provision of -- in
 20 the transfer of information. I certainly wasn't.

21 **Q.** If we go on to page 4 of this document -- no, next
 22 page, sorry -- you will see here this is the Inquiry's
 23 analysis of 314 files of cases where applications were
 24 declined by the Skipton Fund and there was no appeal,
 25 and you will see there some of the reasons that appear

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1 clinicians. So they knew -- they should have known
 2 how it would be received by hard working doctors in
 3 hospitals being badgered by their patients.

4 **Q.** Can we look at INQY0000244.

5 Now, this is just a note of some analysis by
 6 the Inquiry of Skipton files.

7 Can we go to the second page, please, Soumik,
 8 and look at the bottom of the page.

9 You'll see in paragraph 2.4, bottom of the
 10 page, that in terms of the files received by the
 11 Inquiry from Russell-Cooke:

12 "... not all applicant files still exist; and
 13 "... most files are incomplete."

14 Are you able to assist with what the systems
 15 were for keeping applicant files or ensuring that t he
 16 files were complete?

17 **A.** No, I -- the information that was passed across to BSA
 18 was -- as much as it was helpful but it was not
 19 confidential, so -- so I don't know what was passed
 20 across and what was retained.

21 Russell-Cooke are -- had been administering the
 22 process, administering the Skipton Fund simply beca use
 23 somebody has to look after the files. So they are
 24 doing it.

25 **Q.** Is --

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1 for the refusal of the application.

2 If we look at the third you will see:
 3 "Medical Records Destroyed/Unavailable."
 4 Quite a significant number of refusals there,
 5 76.

6 **A.** Yes.

7 **Q.** Then if we go towards the bottom of page you can se
 8 I think three lines up from the total there's an en try
 9 for:

10 "Application Form (eg the applicant's physician
 11 has not completed the form properly or has failed t
 12 provide enough detail)."

13 And there are ten such files.

14 Just dealing with that latter category, if the
 15 applicant's physician had not completed the form
 16 properly or not provided enough detail, why would that
 17 be a basis for refusing the application as opposed to
 18 going back to the clinician and asking for more
 19 information?

20 **A.** I suspect we were -- Nick would already have gone b ack
 21 to the physician and pointed out the deficiencies and
 22 failed to obtain any answers. I don't think -- we
 23 wouldn't just have thrown an application form on th
 24 floor because it was incomplete. We would take ste ps
 25 to try and make sure that it was properly completed ,

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1 but if the physician involved couldn't do it or didn't
 2 want to do it, there's nothing we can do. We can't
 3 invent information.

4 **Q.** If we go back up to slightly higher up the table, just
 5 then returning to the category of cases where the
 6 applications were declined because medical records
 7 were destroyed or unavailable, and we see 76 cases
 8 falling within that category, was there any policy or
 9 generally agreed approach as to how to deal with cases
 10 where through no fault of the applicant their medical
 11 records had been destroyed or could not be located?

12 **A.** No, all we could do was to go back to the applicant
 13 and point out the problem and leave it to the
 14 applicant to try and find a way around it, making such
 15 suggestions as we knew from our experience where the
 16 records might be found. But it wasn't up to us, I
 17 afraid, to do the chasing. It was up to the applicant
 18 and the fact the applicants in these cases didn't make
 19 appeals might be relevant.

20 **Q.** If we go to ARCH0002318, this is your written evidence
 21 to the Archer Inquiry -- well, it's jointly from you
 22 and Mr Harvey -- in relation to the Skipton Fund. If
 23 we go to the third page please, Soumik, we can see the
 24 bottom of the page refers to cases where there are no
 25 medical records which confirm the applicant was

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1 account of receipt of a blood transfusion post birth,
 2 post giving birth, for example, or in consequence of
 3 a road traffic accident or an attack or something of
 4 that kind, this would tend to suggest that unless
 5 there's some other record which at least corroborates
 6 the applicant's account, the application would, as
 7 a matter of automatic outcome, be refused.

8 **A.** If there are no records that there was a blood
 9 transfusion and the applicant has been working
 10 entirely from memory, we would -- the application
 11 would be declined but wouldn't just be told -- the
 12 applicant wouldn't be told, "Sorry, declined, go
 13 away". He'd be given advice about how to appeal to
 14 the Appeal Panel, what further information, if any, is
 15 acceptable to the Appeal Panel and there would
 16 certainly be adequate encouragement to go to appeal.

17 **Q.** That's imposing an additional burden, isn't it,
 18 though, on an applicant who may already be themselves
 19 very unwell?

20 **A.** True. Nothing -- that's the way the system was set up
 21 by other people, including ourselves. We developed
 22 this process. We went through the plenary meetings
 23 people said, "Yes, that is the way to go".

24 **Q.** Just so that I understand, are you saying that what we
 25 see set out in paragraph 8.3 of this document was how

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1 treated with blood or blood products. It says:
 2 "The directors of SFL exercise [next page]
 3 discretion where appropriate."
 4 Then some examples are given of where the
 5 records do show something that would demonstrate that
 6 transfusion would definitely have been needed. The
 7 at 8.3 you say this:
 8 "If there are no records available and the
 9 treatment with blood products is simply in the
 10 applicant's memory then the application must be
 11 declined and referred to the Appeal Panel if the
 12 applicant so wishes."
 13 Why was that approach taken? If an applicant
 14 was able to give a clear account of having received
 15 blood products or blood, but their records had been
 16 destroyed through no fault of their own, why was their
 17 account not, potentially at least, sufficient to allow
 18 the application?

19 **A.** We had applications from people who had a needle stuck
 20 in their arm and thought they had been given blood and
 21 they were actually being given saline solution or
 22 anything else that might have been put into them. So
 23 the applicant's memory was not always to be relied
 24 upon.

25 **Q.** But if you had what seemed a perfectly coherent

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1 the Department expected you to proceed?

2 **A.** I can't answer directly about the Department's
 3 expectations, but certainly -- it was certainly no
 4 secret from the people who participated in the plenary
 5 sessions that there would be times when we would be
 6 turning down an application because there were no
 7 records and would be referring to the Appeal Panel.

8 The way the referral to the Appeal Panel was
 9 made was a process that we developed ourselves and
 10 which relied very much on the administrator's goodwill
 11 and sympathy with the applicant. So I mean Nick had
 12 his system and somewhere I think I saw in the
 13 documentation the document he would provide to
 14 applicants saying how they should go about approaching
 15 the Appeal Panel, which is always helpful.

16 **Q.** We can take that down thank you, Soumik.

17 There were a fair number of applications
 18 refused because of evidence of intravenous drug use
 19 Your witness statement says that it was the view of
 20 the plenary planning meetings that intravenous drug
 21 use was a sufficient reason for rejecting an
 22 application:
 23 "Regardless of the credibility of a genuine
 24 route of transmission, the SF board had to accept this
 25 view as policy."

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1 Is this correct, that any evidence of
2 intravenous drug use meant that an application was
3 inevitably declined?
4 **A.** Yes.
5 **Q.** Was the Appeal Panel in any different position or did
6 that policy apply equally to the Appeal Panel?
7 **A.** No, I don't think so. I think the Appeal Panel would
8 take the same line.
9 **Q.** Why was that?
10 **A.** Do you like your tax money being given to somebody who
11 developed Hep C through intravenous drug abuse?
12 **Q.** Not quite what you say in your statement. Perhaps we
13 will look at it on screen, WITN3070003, page 42,
14 paragraph 204.
15 You're not I think simply saying there that if
16 it was clear that the route of transmission was
17 intravenous drug use the application would be
18 declined, which may be thought to be an entirely
19 understandable position, you're saying there that
20 intravenous drug use was a reason for rejecting the
21 application regardless of the credibility of a genuine
22 route of transmission.
23 **A.** Yes.
24 **Q.** So although there might have been credible evidence of
25 someone having received blood products or blood, an

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1 **A.** Yes.
2 **SIR BRIAN LANGSTAFF:** And that was the sole test, the
3 overriding test?
4 **A.** Yes, subject to something like this, where if there
5 was a --
6 **SIR BRIAN LANGSTAFF:** The reason I ask is just what you
7 have referred to because the third sentence here
8 suggests that the view was not one of the sufficiency
9 of evidence but a question of policy.
10 Do I understand it correctly or was the policy
11 something which was a policy of, or an approach,
12 rather, to understanding how the balance of
13 probabilities might be established?
14 **A.** I think the policy was adopted by the Skipton Fund
15 because of the view expressed at the plenary planning
16 meetings, that -- we were told that evidence of IVD
17 was sufficient to rule out an application at our
18 level.
19 **SIR BRIAN LANGSTAFF:** Was this published to those who
20 might be applicants to the scheme?
21 **A.** I cannot recall. I really can't recall that.
22 **SIR BRIAN LANGSTAFF:** Thank you.
23 **MS RICHARDS:** If we then go to SKIP0000030_045 this is
24 guidance on assessing an application for the £20,00
25 payment, and if we pick things up at the bottom of the

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1 evidence of intravenous drug use, as it were, sounded
2 the death knell for their application.
3 **A.** As far as we were concerned, the applicant could still
4 go to the Appeal Panel.
5 **Q.** But it doesn't sound as though they would get any
6 further with the Appeal Panel.
7 **A.** Well, maybe. That's not the problem of the Skipton
8 Board. That's the way the system was set up and
9 I can't remember the correspondence now from
10 Dr Ramsey, which I saw in the documents, the hearing
11 (*unclear*) the -- Dr Ramsey was consulted by the Appeal
12 Panel and answered the Appeal Panel. So I have no
13 idea what -- it says there I don't know what use the
14 panel made of Ramsey's reply.
15 **Q.** We can ask Professor Mildred, no doubt, about that.
16 If we go to SKIP0000030_045.
17 **SIR BRIAN LANGSTAFF:** Just a moment. We're leaving this
18 document now?
19 **MS RICHARDS:** We are.
20 **SIR BRIAN LANGSTAFF:** Can we just keep it on the screen
21 for a moment.
22 Did I understand your earlier evidence to be
23 that what the Skipton Fund were applying was the
24 burden of proof or a balance of probabilities as to
25 whether someone had been infected by blood?

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1 first page, section 3, for non-haemophiliacs:
2 "Is there any evidence to suggest that the
3 Claimant's infection occurred because of exposure to
4 NHS blood or blood products before September 1991?
5 Yes. Continue with this section."
6 Then if we go over the page:
7 "Is there evidence that a particular incident
8 or course of treatment with any NHS blood product was
9 responsible for the Claimant's infection? Yes.
10 Continue with this section."
11 Then the next question:
12 "Is there evidence that a source of infection
13 other than NHS blood or blood products could be
14 responsible for the Claimant's infection? Yes.
15 Reject application."
16 Now, this would seem to suggest that if there
17 was any evidence of another possible source of
18 infection the application was automatically rejected
19 rather than there being any attempt to establish on
20 the balance of probabilities which was the probable
21 cause or the most likely cause of the infection. I
22 that correct?
23 **A.** Yes.
24 **Q.** That's --
25 **A.** I can't remember when this guidance note was written

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1 or to whom it was addressed but anyway, yes, you're --
2 I mean, you're right in your interpretation of that
3 point.

4 **Q.** That's not consistent with the balance of
5 probabilities approach, is it?

6 **A.** It's completely consistent. If the balance of
7 probabilities is clouded because there was, for
8 example, IVDA or an injection, transfusion, one can
9 only say on the balance of probabilities we cannot
10 decide.

11 **SIR BRIAN LANGSTAFF:** I'm afraid that may be
12 a misunderstanding, at least as I see it, of the
13 balance of probabilities because it's almost always
14 the case that the balance of probabilities is
15 something which is clouded. That's why it's
16 a balance. There are probabilities on one side,
17 probabilities on the other.

18 The approach you're describing I think is much
19 more akin to the proof beyond reasonable doubt as i
20 used to be called or satisfying someone so they are
21 sure as it is now, the standard which is adopted in
22 criminal cases and not in civil litigation.

23 **A.** Right.

24 **SIR BRIAN LANGSTAFF:** If you will forgive me, that's an
25 observation from a lawyer. You are free to comment if

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1 Soumik, it's ABMU0000013.
2 So this is a letter dated 28 November 2008 from
3 Mr Fish to Dr Hay in his capacity as the then chair of
4 UKHCDO. We can see in the long paragraph it says:

5 "The alteration to the scheme came about when
6 it was discovered that the previous scheme
7 administrator, Mr Keith Foster, fraudulently completed
8 a number of application forms and misappropriated
9 a large sum of money from the Skipton Fund. As
10 a result, the Department of Health sent the NHS
11 counter fraud and security management service to
12 review the scheme's administrative procedures."

13 Then it suggests that the measures suggested
14 went beyond those finally settled upon by the
15 Skipton Fund directors. Then it says this:

16 "However, for all applications it is now
17 a requirement that we receive medical records to
18 confirm that the applicant received treatment with NHS
19 blood or blood products prior to September 1991.
20 Previously, the doctor only had to state that they had
21 seen such records and this is one of the loopholes
22 that Mr Foster exploited and that they are currentl
23 hep C positive or have undergone interferon-based
24 treatment."

25 So it would appear from this that Mr Foster's

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1 you wish but otherwise you may leave it as just
2 a reaction which I've unburdened myself of in the
3 source of this exchange.

4 **A.** I certainly -- I cannot -- I can't comment on your --
5 on your observation, Sir Brian. All I can say is that
6 on this particular point, further exploration of th is
7 particular point would have to go back to the people
8 for whom we are acting as agents in the administration
9 of this scheme. We didn't invent these operating
10 conditions.

11 **MS RICHARDS:** Do you know who authored this document? Was
12 it the Department or Skipton or do you not know?

13 **A.** I don't -- I cannot remember -- I'm sorry, I struggle
14 but I have no idea. Again, Nick Fish might -- might
15 know whether he ever consulted this document.
16 I suspect it came from -- was produced in the
17 planning, plenary planning meetings. If you were to
18 find out that I wrote it, it wouldn't totally surprise
19 me.

20 **Q.** We can certainly pursue that further with Mr Fish.

21 Mr Fish's predecessor, Keith Foster, the first
22 administrator, defrauded the Skipton of some £400,000.

23 **A.** Yes.

24 **Q.** I wanted to ask you about the Skipton's response to
25 that by reference to a letter from Mr Fish.

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1 fraud resulted in more onerous provisions for
2 applicants and their clinicians in order to establish
3 eligibility. Is that correct?

4 **A.** Yes.

5 **Q.** Had there been any evidence of fraudulent applications
6 by anyone other than Mr Foster?

7 **A.** No.

8 **Q.** How is what Mr Fish says there, a requirement to
9 receive medical records, consistent with what you
10 referred to in your Archer evidence and what I think
11 we discussed earlier that there was a discretion that
12 directors or the Appeal Panel could exercise in the
13 absence of medical records?

14 **A.** If the application -- if even after this change of
15 practice medical records were not available,
16 applicants could still make an application and we
17 could still exercise our judgment or decline it and
18 say go to appeal. So all the change of procedure did
19 was to make the preparation of applications more
20 difficult for the applicant and his clinician, more
21 reliable for us, but it didn't actually prevent people
22 putting forward applications without any medical
23 records at all.

24 **Q.** If we can then look at SKIP0000030_017 these are the
25 minutes of a meeting of the board of directors on

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1 August 2007.

If we go to the bottom of the second page, please, we can see under the heading Appeal Panel Mr Fish reporting that the Panel had considered 97 cases: 50 resolves in the appellant's favour; 43 rejected; further information requested on 4.

He also -- top of the next page -- reported that there are currently six cases yet to be heard then the next sentence:

"It was agreed that the fact that over half of the cases that went to appeal were upheld was not a poor reflection on SF's decision to decline certain applications because the Appeal Panel are able to take many more factors into account when reaching their decision."

Why was the Appeal Panel able to take more factors into account than the Skipton Fund itself?

- A. Because they were able -- they were able to and did ask people to supply as much supporting information as they wanted to, as they could get hold of.

The original application was based on an application form and we only required -- we only wanted information that was asked for on the form o that went to confirm particular points on the form. We didn't want applications coming in that were thr ee

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you should have been able to work it out.

So I think the balance between those applications we decided for -- for ourselves, which were over 90 per cent, (unclear) 90 per cent, and those that went to appeal, was -- was always about right, and the Appeal Panel -- eventually I think, I can't remember what the final score was in terms of success or failure of appeals but I think in the en the Appeal Panel upheld more than half of the Fund' decisions.

- Q. Last question on Skipton, SKIP000030_059, these ar the minutes of a meeting on 28 March 2017 of the board of directors. Go to the second page please, bottom half of the page.

You can see in the penultimate paragraph on that page the board expressed their surprise and disappointment that the NHS Business Services Authority had been announced as the successor to th company from 1 October 2017.

Why was the board surprised and disappointed by the Government's decision to reorganise the schemes as summarised there?

- A. All the Alliance House operations had agreed that w were going to put in a joint bid to be the single scheme administrator. The Department of Health

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inches thick. The Appeal Panel were quite happy to deal with appeals that were even thicker than that.

- Q. Was that for practical reasons of not having sufficient time and resources to consider more detailed applications?

- A. No, that was the process agreed in the plenary meetings, that to make it as simple as possible for the reporting clinicians to undertake the job, not to increase their burdens even further by saying pleas provide this, that or the other document, or it mig ht be helpful to the applicant if such and such information, such and such document was produced, simply the process was designed to be as straightforward as possible for the clinician helping his patient to fill in the application form.

- Q. Was there any attempt made to learn from the Appeal Panel's decision-making given that they were allowing a significant number of appeals.

- A. Over time, certainly, the Fund's success ratio vis-a-vis the Appeal Panel got better, but Nick -- I'm trying to remember. I have a feeling we did actual ly ask from time to time for the Appeal Panel's view about the sort of problems they were being confronted with, and we never received any comment back saying: surely you should have known this one, by n ow

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decision to transfer the businesses to BSA was made without further consultation with us at all, so we were surprised.

We were disappointed because we thought we could actually do the job quite well and, certainly as far as the charities are concerned, with considerably more sympathy for and consideration for our registrants, which was another point that concerned Skipton. So I think surprise and disappointment is a very natural reaction.

- Q. Before I ask you some questions about the Caxton fund -- we can take that down, thank you -- can I j ust ask you briefly to explain to us what MFET was, and what it did.

- A. MFET, always known like that, was set up to adminis ter the *ex gratia* annual payments that were made to recipients of Skipton 2, stage 2 payments. I think this is in response to Archer.

The original plan, and for once I was in agreement with the Department of Health on this, wh ich was rare, the original idea was that the payments - these are to MFET registrants, people, therefore, w ho were co-infected -- is that right? No, people with HIV. Yes, people who were co-infected because they received stage 2.

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The original idea that we had that Department of Health had, and I agreed with them, was that Skipton itself could manage these payments. It was set up to make tariff payments, not charitable payments, and these are not charitable. However, one senior member of the Department of Health team said no Skipton should be preserved for Hep C use only. Another vehicle must be established to make these payments. Clearly it couldn't be the charities because this is non-charitable work, so a new company had to be set up or a new operation had to be set up.

THE WITNESS: Reaching that decision took so long that a new operation couldn't be set up, so we dusted down MSPT2, changed its -- changed its objectives, changed its trustees, as far as we could, and the first payment was made, the first of these *ex gratia* payments were made by MSPT2.

Subsequently MFET -- there was then time to set up MFET as I think as a non-discretionary trust and MFET -- that's all MFET did then. It simply paid out quarterly or monthly, the equivalent of the annual *ex gratia* payments to the registrants of MFT and ET who had received stage 2 payments from Skipton.

Q. Caxton then. You were a founding trustee of Caxton and its chair for the first approximately two years of

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event of -- what the ministers repeatedly or each set of ministers seemed to want was that each of the charities should do the same things, behave the same way. These are three charities set up with different bodies, different community bodies, people who had different -- between the charities -- different conditions, different problems, and the charities were independent of each other and were required to be.

So this is a typical politicians' thing, read across, if we had asked ministers, "What do you mean by read across", the answer would I think be even longer than anything I say about it. So you know we largely ignored it. We just carried on as charities independent of each other, doing what we believed appropriate for our beneficiary communities.

Q. If we look at the next paragraph it says:

"The Department of Health had undertaken to provide funding for charitable disbursements of £2 million for the current year. It was expected that there would be additional funding from the DAs [that's devolved administrations] although it was not known how much or when the funds would be available", and then there's a reference to an opportunity for the minister to come and meet everyone.

It sounds from that as though there may have

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its operation.

If we look at CAXT0000108_017, please, Soumik. We can see these are described as the minutes of the meeting of the founding trustees and others, 4 August 2011 and we can see from the list of those present that you and Mr Evans, Roger Evans, and Mr Gore, Charles Gore, were the three founding trustees.

Then if we just go to page 3. Sorry, if we look briefly at page 2, just to put it in context, there's a section of the minutes headed, "The Genesis of the Caxton Foundation", and then there's a very brief summary of the position in relation to the Macfarlane Trust, the Eileen, the Skipton Fund and then at the top of the next page MFET.

Then we come on to the Caxton, where the minutes record you as having said this:

"Caxton was a further development aimed at bringing closure to the entire issue. A ministerial objective that there should be read across between the three charities would be difficult to achieve as each charity was an independent body."

What was this ministerial objective that there should be read across? What did that mean and what did they want you to do?

A. Read across to be otherwise spelt "nonsense", in the

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been the same uncertainty over long-term funding as you have described in relation to the Macfarlane, and Eileen Trusts. Was that the case?

A. Yes, there was. I'm not even sure that we reached £2 million in that first year. I don't think in the end, the Department of Health funded what we said we needed to spend, the rate of applications to be registered with Caxton was less than we hoped and expected and on this particular occasion we were able to do something about it because we knew who they were. It took a long time. Certainly by the time I left at the end of 2012 I don't think we were up to, fully up to where we had hoped to be or thought we would be by then. Only £2 million ever came in.

Q. Is this right, that the essential function of the Caxton Foundation was to provide or to consider the provision of discretionary payments to those who were eligible as Skipton stage 1 recipients?

A. Correct.

Q. If we go to the next paragraph, so it is the paragraph on the bottom of the page -- in fact it is already there I think -- you can see it records Mr Evans saying that:

"... it had been determined by the three founding trustees not to appoint beneficiaries or user

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trustees to the Caxton Board. There was a general consensus that, while the views of the beneficiary constituencies should be sought in a manner that was open and transparent, it was premature to consider the appointment of user trustees."

And then a view is expressed by Mr Gore. And at the bottom of the page:

"... Mr Lister agreed but concluded it was important for the trustees not to be seen as 'Ivory Tower' residents."

In the time that you were involved in Caxton, were there other user trustees?

A. No.

Q. Why was the Caxton Foundation not inclined to have user trustees?

A. I'm interested in that it was Roger Evans who state that because I would certainly regard myself as having been an obstacle to the appointment of user trustees, on the basis of the mixed experience we had at the Macfarlane Trust. Bear in mind that when Macfarlane Trust was first set up in 1988 two trustees in -- which went against the Charity Commission recommendation at that time. The Charity Commission -- sorry about the telephone -- the Charity Commission subsequently changed their view and

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any of that happened in those first two years.

Q. There was, I think, an issue about whether Skipton could or should pass details of those who had received stage 1 payments to the Caxton Fund, so that the Caxton Fund could make contact and essentially invite applications. Can you recall what the issue was?

A. I can't recall how that was managed within the DGPR requirements. No, I really can't -- I mean, Nick Fish would probably know about that because he would have been the source of information about Skipton people.

Q. I can ask, no doubt, Mr Fish or Mr Evans or, indeed in due course, Mr Lister about that.

Do you know what efforts were made by the Department at the outset to anticipate what the level of demand might be?

A. Well, they asked us. What else would they do? I mean, the Department has no -- had no information about and no interest in this, so they would say: how many people -- how much money are you going to need? How many people are you going to have to look after

Q. In the period that you were there, so the first 18 months/two years or so, what, if any, steps can you recall being taken to try to encourage applications to the Caxton Fund? Your statement notes that the number of applications was a long way short of the number of

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the Society then began appointing user trustees, some of whom were very good, some of whom were not so helpful.

We felt that -- or I felt that in the early days of this new charity, when we didn't really know very much about the people who would be coming to us to register, that it would be unhelpful to have user trustees at that stage.

Q. What --

A. It's quite like -- you know, it's quite possible that had Caxton been able to last a bit longer before the Department of Health took it in, they might have had some user trustees. I don't know. But by then it's outside my purview.

Q. It's recorded here that:

"There was a general consensus that ... the views of the beneficiary constituencies should be sought in a manner that was open and transparent."

A. Yes.

Q. In the time that you were at Caxton, were there any efforts to seek the views of the beneficiary constituencies, and if so what were they?

A. I don't recall any -- I don't recall any forum being established by which views might be sought or any consultation going on. I don't know. I don't think

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beneficiaries to Skipton.

A. No, I can't remember. I expect -- I would imagine that -- I mean, thinking what we could have done, I would imagine that unless I would have been sent by Nick to all Skipton stage 1 registrants pointing out that this operation existed for their potential benefit, it was up to them to get in touch.

I don't recall anything else. I can't think anything else would be appropriate at that stage.

Q. Do you recall whether any consideration was given to introducing social events or educational seminars as you had at Macfarlane Trust?

A. I don't recall that as being given much consideration again in those first two years.

Q. Do you recall in those first two years any particular approach to reserves and a reserves policy?

A. I think in the first two years we agreed that Charity Commission's requirement the Charity should have a reserves policy was noted and that Skipton had a policy. We didn't -- and then we produced a policy of so much money.

Q. If we go to CAXT0000108_039, these are the minutes of a meeting on 1 September 2011.

If we go to page 5 we'll see under the heading "The Draft Welfare Strategy Paper" reference to the re

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being a debate about the policy direction the board might follow. Point (1):

"That various classes of beneficiary (primary and secondary) should be treated equally in terms of identifying charitable need and providing relief regardless of how they fell into perceived poverty. The exception was those classified as 'Carers' ... "

(2) refers to the establishment of a National Welfare Committee.

"(3) ... the Foundation recognises the need for direct financial relief to beneficiaries should be a policy objective, together with individual social economic and/or educational empowerment."

And then over the page there's then reference to there being a:

"... need to identify a level of household income that the National Welfare Committee deem where a family might be 'in poverty'."

That was, I think, subsequently determined to be £14,000.

Then:

"(5) That both income and expenditure should be taken into account ..."

There would be an annual census.

(6), verification will be required in all

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"The Board received a paper considering the introduction of a regular payment scheme to Caxton beneficiaries."

And then I don't need to go through the detail of it. I can ask others who continue to be involved. But it would appear from this that, as at November 2012, there had not been a regular payment scheme yet set up. Are you able to assist with why it had taken that long to start considering a regpay scheme?

A. No, I can't think why that should have been. It doesn't strike me as being very long, a very long period at all, considering we only started the previous year. We couldn't arrive at a regpay scheme already on the shelf, as it were. It had to be considered by all the trustees and finding things that needed to be thought about was how many people were going to be eligible for it.

Looking further down that, we see that the number of beneficiaries likely to be eligible available for Skipton Stage 2 is 583, which is not very many. Only 40 people have -- can -- returned both parts of the census forms. So we knew very little about possible demands that were made on the Fund at that stage. So a regpay scheme wouldn't --

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cases.

"(7) both non-means tested benefits and means tested benefits should be income determinants."

I think there may well have been some variation to that.

And then at (9), in relation to carers:

"... each application for support will be considered separately by the National Welfare Committee."

Is that -- there may have been some changes policy over the following years, but is that broadly the welfare strategy that the Caxton Foundation adopted as far as you can recall?

A. As far as I can recall, yes. Unless subsequent minutes record variations or additions to those nine points, I think that's the policy that was accepted.

Q. Then if we go to CAXT0000109_105, this is minutes of the meeting of 1 November 2012. If we go to the next page.

A. This must be my last one.

Q. I think it probably was.

Next page, please. Sorry I don't have a reference noted of which page we need to look at.

Ah, yes. So "Regular Payment Scheme", we can see:

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I'm not surprised that a regpay scheme didn't come into consideration until the later stages of 2012.

MS RICHARDS: Sir, I note the time. I've not got very much more on Caxton, so I'm going to suggest I finish those questions and we then take the break, which will give legal representatives of Core Participants the opportunity to suggest further questions.

SIR BRIAN LANGSTAFF: Yes.

MS RICHARDS: Just, I think, one more document and a handful of further questions on Caxton, Mr Stevens.

If we go to CAXT0000109_061, please, this is a note from you dated 31 March 2012 on the topic of board composition and if we look at the second italicised paragraph, it says this:

"You might recall that there were a number of applicants for board seats who were not interviewed on the grounds that they were potential beneficiaries, an exclusion that was probably of doubtful legal validity. Several of these applicants came, not surprisingly, from the militant side. One is a press officer for Tainted Blood, another is the progenitor of new Contaminated Blood Campaign. While MFT has had some success with user trustees, they've not always been helpful, some finding it very difficult to leave the campaigning and representative aspect of their

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1 lives outside the boardroom. So were the recruitment
2 process to be open and unrestricted it might be
3 sensible to have determined what particular skills,
4 experience and attributes would be sought in order to
5 be able to have a set of criteria that were
6 defensible."

7 Do we correctly understand this, Mr Stevens, to
8 demonstrate that for grounds which you accept here
9 were probably of doubtful legal validity, the decision
10 was taken not even to interview applicants for board
11 seats simply because they were potential
12 beneficiaries?

13 A. Yes.

14 Q. Do you think that was appropriate?

15 A. My paragraph here would suggest it probably wasn't.

16 Q. I don't mean to go back over the ground that we've
17 already covered in relation to the Macfarlane Trust
18 but what's wrong with having on the board, for
19 example, of an organisation such as the Caxton
20 Foundation someone who has campaigning and
21 representative instincts and experience?

22 A. Because the Caxton was not a campaigning organisation.
23 It was a grant-giving organisation on which decisions
24 had to be made on grant applications on objective
25 grounds and grounds of fairness.

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1 an appeal against a decision, a first decision of the
2 National Welfare Committee, if the applicant was able
3 to produce additional information. Is that how it
4 operated?

5 A. I think so, in that if there's no additional
6 information it would be difficult for the National
7 Welfare Committee to change its mind.

8 Q. It would seem to preclude an applicant from being able
9 to go to the board of trustees and say, "Well, I know
10 the National Welfare Committee decided this but, look,
11 they were wrong to do so because I really" --

12 A. The applicant can always write in to the Chairman.

13 Q. And what would happen if -- is there any process as to
14 what would happen in that event?

15 A. Then the Chairman (who in those first two years was
16 me) would -- I think would take it to the -- would
17 start at step 5.

18 Q. Did applicants know that they could do that?

19 A. I have no idea if they even knew what this procedure
20 was.

21 SIR BRIAN LANGSTAFF: How many such cases did you have of
22 people who wrote directly to you about this?

23 A. Sorry, how many?

24 SIR BRIAN LANGSTAFF: How many cases did you have of
25 people who wrote direct to you, sitting in appeal?

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1 I don't think that campaigning is necessarily
2 a precursor to trustees would have say the same -- the
3 ability to be objective on behalf of other people,
4 other applicants.

5 Q. Not necessarily inconsistent with the ability to be
6 objective and fair --

7 A. Not totally. No, not totally. So --

8 Q. And --

9 A. So the further comments I make there by way of
10 introducing the discussion would seem to be reasonable
11 to open up the discussion and the interview process.

12 Q. Then the last document, Mr Stevens, is
13 CAXT0000069_009. This appears to be -- it's
14 a document headed "Appeals Procedure" in relation to
15 Caxton. So we can see point 2:

16 "If the request is declined, the applicant can
17 appeal against the decision. The appeal should
18 contain additional information in support of the
19 request."

20 It then goes back to the National Welfare
21 Committee. There can then be a further appeal to the
22 full trustees board.

23 "Applicant will need to provide information why
24 a grant should be agreed."

25 That seems to suggest that there could only be

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1 A. Sir, I can't remember how many appeals we had.
2 I can't remember how many letters came in to me.

3 SIR BRIAN LANGSTAFF: But you did get some?

4 A. I'm not even sure I did, no. I don't recall any.

5 SIR BRIAN LANGSTAFF: That follows on from counsel's
6 questions about how people would know. It doesn't
7 surprise me if they didn't know, no reason why they
8 should have known, that they may not have written to
9 you about it.

10 A. No, but I don't know how many appeals we had. I don't
11 recall any appeals. So that process was, as far as
12 I'm aware, available or made known to beneficiaries.

13 MS RICHARDS: Last question for now on the Caxton Fund.
14 When the Caxton -- sorry, Foundation -- when it was
15 being set up in 2011, was there any further
16 consideration, as far as you can recall, given by the
17 Department of Health to making provision for people
18 infected with hepatitis B?

19 A. No, not that I'm aware of. After all, eligibility to
20 become a registrant of the Caxton Fund was dependent
21 upon having received a Skipton payment. Skipton was
22 related only -- it was concerned only with
23 hepatitis C. So hepatitis B was not -- was irrelevant
24 at that stage.

25 Q. Nobody, as far as you can recall, raised it as

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1 something that should perhaps be included through
 2 widening the scope of the Skipton?
 3 **A.** Not that I can recall. No, I don't believe so.
 4 **MS RICHARDS:** Sir, I've got a couple of very general
 5 questions but what I am going to suggest is we brea
 6 now until perhaps 4.00, representatives of Core
 7 Participants send to Ms Scott and myself over the
 8 break any further questions they have arising out o
 9 Mr Stevens' evidence, and then we can complete his
 10 evidence at 4.00.
 11 **SIR BRIAN LANGSTAFF:** Yes. Well, we will do that then.
 12 So until 4 o'clock, Mr Stevens. Then we have the last
 13 session.
 14 **A.** Thank you, Sir Brian. Thank you.
 15 (3.26 pm)
 16 (A short break).
 17 (4.05 pm)
 18 **SIR BRIAN LANGSTAFF:** Yes.
 19 **MS RICHARDS:** Sir, and Mr Stevens, forgive the discourtesy
 20 of having my phone on, but I'm reading a question that
 21 I have been sent that is set out on my phone.
 22 **SIR BRIAN LANGSTAFF:** No offence is taken.
 23 **MS RICHARDS:** Good.
 24 Mr Stevens, the next lot of questions are going
 25 to dart around from topic to topic because they are

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1 the directors of the Skipton Fund?
 2 **A.** I think the outcome of the plenary meetings were --
 3 led to decisions that were made by the Department o
 4 Health which governed this. So I don't think we we re
 5 bound by decisions of plenary meetings themselves but
 6 by the attitude of the Department of Health to what
 7 the plenary meetings came up with.
 8 **Q.** If there was a policy or an approach put forward by
 9 the Department of Health that wasn't in the agency
 10 agreement itself, did you regard yourself at Skipto
 11 as required to act in accordance with the decision of
 12 policy of the Department of Health?
 13 **A.** I can't recall -- I can't think of what the
 14 circumstances of such a hypothesis would be (*unclear*).
 15 **Q.** Okay. I will move on from that then to the way in
 16 which the first stage application, so pre-appeal
 17 applications, were considered by the Skipton Fund.
 18 You referred to the material that was
 19 considered by either the administrator or the board of
 20 the Skipton Fund being effectively streamlined or
 21 limited, and then more information could be considere d
 22 by the Appeal Panel?
 23 **A.** Yes, the applications for stage 1 were made on the
 24 basis of the application form. After the Foster
 25 episode certain aspects of that form had to be back ed

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1 questions I have been asked to ask by Core
 2 Participants to the Inquiry. So they will go from one
 3 Alliance House organisation to another.
 4 The first is this: whilst at Macfarlane Trust,
 5 was there any explicit understanding or
 6 agreement between the Trust and the Government that
 7 the Trust would not undertake fundraising or
 8 campaigning activities or seek publicity?
 9 **A.** No.
 10 **Q.** Then, in relation to the Skipton Fund, was there an
 11 policy as regards the backdating of stage 2 payments,
 12 for example to the date of diagnosis?
 13 **A.** Not that I can -- no, I don't think so. The stage
 14 payments were at a flat rate until altered to
 15 a non-flat rate, so they could only have been paid
 16 once. So -- so presumably the question relates to the
 17 backdating eligibility?
 18 **Q.** I simply ask the question I was asked to ask.
 19 **A.** I think the payment could only be made when the
 20 application had been put in and cleared.
 21 **Q.** The next couple of questions are in relation to the
 22 Skipton Fund.
 23 Was it your view that the outcomes of
 24 discussions in the plenary planning sessions to which
 25 you referred created policies or decisions which bound

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1 up by additional documentary evidence, but that was
 2 quite limited so we were not expecting -- we were n ot
 3 encouraging huge amounts of documentation. All we
 4 needed to know was -- needed to see was proof of
 5 a transfusion. We undertook the necessary steps to
 6 get proof of identity, get proof of the consultant'
 7 identity. I think that -- it just basically limite
 8 the application form.
 9 **Q.** Didn't that run the risk of prejudicing claimants
 10 because it stopped them putting forward their full
 11 case?
 12 **A.** I don't believe so. I think the claimants -- the
 13 application form was designed to -- specifically to
 14 cover all the circumstances in which a reasonable
 15 application for a stage 1 payment might be made. I
 16 was designed and approved -- designed and approved by
 17 the plenary meeting, which included a lot of
 18 clinicians, practising clinicians. So I don't believe
 19 this should have militated against an applicant who
 20 had a good basis for an application. If somebody was
 21 deterred from putting forward material they thought
 22 would support the application or the application form
 23 didn't actually cover, they would have an opportunity
 24 to do it by going to appeal. We didn't want to add
 25 storage.

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1 Q. In your --
 2 A. Remember that Skipton was not a charity. Skipton was
 3 not concerned with welfare or background
 4 considerations of the circumstances of a claimant.
 5 All we were after was proof that the person -- the
 6 applicant was hepatitis C positive and that this arose
 7 from an NHS-derived transfusion. That's basically --
 8 and there were no -- no circumstances militating
 9 against it. That's all we were after.
 10 Q. In your evidence earlier today relating to the
 11 Eileen Trust, you observed that the Eileen Trust
 12 beneficiaries were without the support of
 13 a haemophilia centre and had nowhere but the Eileen
 14 Trust to turn to. Was the same not true of the
 15 Macfarlane Trust's widows and other dependants of
 16 those who died?
 17 A. It could have been but I think the majority of -- the
 18 majority of the people who the Macfarlane Trust
 19 registered who had died were well known and had been
 20 looked after by their haemophilia centres, who
 21 therefore would have known their families as well, and
 22 would -- I think would generally have kept in touch
 23 with them. So the social workers attached to or
 24 working with the haemophilia centres would still have
 25 contact with the bereaved relatives.

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1 where the user trustee was present but I can't say
 2 what the frequency was of people being invited.
 3 Q. In relation to the Caxton Foundation, registrants or
 4 the Macfarlane Trust or the Eileen Trust were excluded
 5 from making applications to the Caxton Foundation.
 6 A. Yes.
 7 Q. Whose decision was that as far as you can recall?
 8 A. Probably the -- I would think probably trustees of the
 9 two -- Macfarlane and Eileen Trust and the Department
 10 of Health between them. Macfarlane and Eileen looked
 11 after their people.
 12 Q. Why was that the position? Why shouldn't
 13 a co-infected registrant be able to make an
 14 application to Caxton rather than Macfarlane?
 15 A. Because there was no -- neither Macfarlane nor Eileen
 16 Trust regarded their -- the scope of their concerns as
 17 being limited only to HIV and the underlying
 18 haemophilia or other health conditions. They both
 19 operated on a whole person basis, and so somebody
 20 who -- a registrant of one of those -- a co-infected
 21 registrant of one of those charities would be regarded
 22 as being deserving -- being eligible for the whole
 23 range of support available from that charity.
 24 Q. Would you accept that the Macfarlane Trust lost touch
 25 with bereaved partners who were themselves potentially

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1 Q. So it was your understanding -- is this right -- that
 2 in circumstances where a patient had died, an
 3 NHS centre would nonetheless have a continuing
 4 relationship with the relatives of the patient who
 5 died?
 6 A. Yes.
 7 Q. Was there any basis, factual basis, for that or was
 8 that assumption that was made?
 9 A. One of our trustees was -- did just that at one of the
 10 major hospitals.
 11 Q. Was that in relation to the Royal Free?
 12 A. Yes.
 13 Q. Did you have any evidence or understanding as to the
 14 practice at any other haemophilia centre?
 15 A. Not directly, no. I know I went to St Thomas' at some
 16 stage long after my son had died, with my other son,
 17 and was greeted very warmly and in a very friendly
 18 fashion. But I don't think that they had been in
 19 touch before I was having to go there (*unclear*).
 20 Q. Were Macfarlane Trust user trustees regularly or
 21 usually invited to meetings with the Department of
 22 Health?
 23 A. I don't think "regularly" would apply. Usually.
 24 Maybe usually. Looking through the notes of those
 25 meetings, there were quite a few of those meetings

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1 in need of support and assistance?
 2 A. Not all but probably some, yes.
 3 Q. Do you have a view as to whether the Macfarlane Trust
 4 might be said to have failed the bereaved community to
 5 some extent?
 6 A. Well, as I said all the way through my written
 7 statement and in the (*unclear*) oral statement, we
 8 never had enough funds to do what we wanted to for the
 9 bereaved. So I'm sure that there -- people -- there
 10 are people who were bereaved who felt that they were
 11 not being properly looked after by Macfarlane Trust,
 12 and I would have some sympathy with those views.
 13 Q. Did Macfarlane Trust take into account payments from
 14 the Skipton Fund and reduce the regular payments that
 15 the Macfarlane Trust would make, and if so why?
 16 A. I don't think we did, no.
 17 Q. Would you accept that if that did happen, that would,
 18 in effect, be penalising the co-infected?
 19 A. No, I don't think so.
 20 Q. What role did -- this is Macfarlane Trust, sorry,
 21 Mr Stevens.
 22 What role did Mr Spellman play as part of the
 23 Trust, in particular in formulating strategy as to how
 24 to approach the Department of Health for more funding?
 25 A. Pat Spellman was a long-time trustee of

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1 Macfarlane Trust. He acted like all the other
2 trustees and did what they were required to do.
3 Certainly when it came to how we should approach the
4 Department of Health for more funding, I would
5 expect -- I would look to Mr Spellman to be able to
6 give me some specialist advice on the likely reaction
7 within Richmond House.

8 **Q.** As he was a former senior civil servant, as
9 I understand it, within the Department, did it occur
10 to you that he might have a less than neutral or
11 a subconsciously or unconsciously biased view, given
12 that he had worked for the Department for so many
13 years?

14 **A.** No, I think that would be a highly improper statement
15 to make about him. I've known him for a long time,
16 obviously. I would think, if anything, his experience
17 would have -- made him more aggressive.

18 **Q.** Why did you cease to be chair of the Macfarlane Trust
19 in 2007 but continue with the other trusts and
20 schemes?

21 **A.** I had come to the end of my time at the
22 Macfarlane Trust. I felt I'd done enough. I can't
23 say I was overwhelmed by candidates to follow me in
24 the Eileen Trust. And I enjoyed working at the Eileen
25 Trust; it was much smaller, it had a -- it took less

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1 think that there was -- I don't think we handled
2 reserves in the Eileen Trust in quite the same way as
3 the Macfarlane Trust. It wasn't so explicit.

4 **Q.** Is there any particular reason why a different
5 approach was taken?

6 **A.** We were smaller, the balance sheet was less under
7 scrutiny. It was easier to do what we did.

8 **Q.** In relation to the Skipton Fund, you took on the
9 Skipton Fund role at a time when the Macfarlane Trust
10 business case needed developing and pursuing. Why did
11 you take on that extra role rather than devote
12 yourself solely to the Macfarlane Trust business case?

13 **A.** I took it on because I was asked to. I thought it
14 would be an interesting challenge and that it might
15 possibly help the Macfarlane Trust if I showed
16 willingness. I don't actually think that that latter
17 reason eventuated in the end but -- maybe it did.
18 Again, you can't prove a negative.

19 **Q.** I asked you earlier about the Ross committee's report,
20 so the Scottish report in spring of 2003, and you had
21 no memory of that. Does that mean that you can't
22 remember any consideration of it or do you think that
23 it was, in fact, not considered?

24 **A.** I don't recall your question generating even from me
25 an answer that I didn't remember it. I recall the

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1 of my time, less challenging. So I was very happy to
2 continue with them. There was no other option at that
3 stage. Skipton came along -- no, I was already
4 Chairman of Skipton. Skipton was interesting, an
5 intellectual challenge.

6 **Q.** In relation, again, to the Macfarlane Trust and the
7 reserves which the Macfarlane Trust held pursuant to
8 its policy, during the time that you were there, did
9 the existence of those substantial reserves play
10 a part in the Department's refusal of extra funding?

11 **A.** Not that I'm aware of.

12 **Q.** In relation to the -- what you described as I think
13 confidential or sensitive information that was hacked
14 at the Macfarlane Trust, were registrants whose
15 information had been accessed informed about that?

16 **A.** I don't know.

17 **Q.** Again in relation to now to the Eileen Trust, were
18 reserves maintained for the Eileen Trust in a similar
19 fashion to the Macfarlane Trust?

20 **A.** No, not really. We said we had a reserve policy in
21 line with the Charity Commission's requirements, but
22 when I was searching my written statement, I looked
23 through the Eileen Trust annual reports, most of which
24 I'd written, and I could find, actually, no
25 quantification of what the reserves were. So I don't

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1 Ross committee report. I recall it being referred to.
2 Sorry, what was your question?

3 **Q.** It's whether you think it wasn't considered in the
4 plenary planning sessions or --

5 **A.** There was -- the Scottish Executive presence on
6 plenary meetings was particularly helpful,
7 particularly well informed. So I'm quite sure that
8 there was reference made to the Ross report even if it
9 necessarily didn't come labelled as such.

10 **Q.** Was that Bob Stock, who you referred to I think in
11 your statement?

12 **A.** Yes. Bob Stock was -- on the various devolved
13 administration people and even probably Department of
14 Health people, Bob was easily the most helpful and
15 best informed, the most instructive.

16 **Q.** So is this right, forgive me for pressing, I just want
17 to make sure I have understood the position correctly.
18 You think that there was probably some consideration
19 of the Scottish Executive or the Ross committee report
20 but you can't now recall what as a matter of fact that
21 consideration was?

22 **A.** That's correct, yes. I'm not aware of anything that
23 Bob said or his colleagues -- or that Bob said would
24 have a label "Ross committee", and if it did
25 I wouldn't necessarily have known.

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- 1 Q. Can you recall again -- this is about the planning for
2 the Skipton Fund -- can you recall where the
3 distinction between stage 1 and stage 2 recipients
4 emanated from or who it emanated from?
- 5 A. No, as you recall that long file note or letter fro
6 November 2003, I think from me to Moira Protani, it
7 was already mentioned at that stage. So where --
8 whether it generated within the Department of Health
9 to -- I don't know where it came from but it was lying
10 around even at that stage.
- 11 Q. Which aspects of the Skipton Fund's processes were, as
12 far as you can recall, decided on by the Department of
13 Health, and which were left to the Skipton Fund to
14 decide for itself?
- 15 A. The operating processes were developed by the Fund in
16 line with -- came out of the plenary meetings.
17 I don't think -- I don't think Department of Health
18 made any specification about what we should do or how
19 we should do it.
- 20 Q. If the Skipton Fund declined an application because of
21 lack of evidence of transfusion or blood products,
22 might an applicant be advised to see if there was any
23 available evidence from the HCV register now
24 maintained by Public Health England?
- 25 A. I don't think that was part of the suggestions that

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- 1 A. Are you talking with the benefit of hindsight?
- 2 Q. With the benefit of hindsight, yes.
- 3 A. I think if you look at the way the various operations
4 were set up and turned out and what job they did,
5 Skipton clearly was the one that did not suffer from
6 lack of money. Maybe one can argue that, as
7 originally set up, it was -- the amounts of money were
8 niggardly, because they were increased later on, maybe
9 some of the cut-off dates were unhelpful and they were
10 changed, but broadly Skipton was not governed by an
11 annual budget that constrained the work that it did
12 Also it was -- it was not a charity. Macfarlane was
13 never funded adequately and was a charity so it could
14 never -- it was set up to disappoint people. In that
15 it was brilliantly successful.
- 16 Eileen Trust was similarly ill-funded and
17 similarly a charity but the numbers of people involved
18 was so small that -- and also were a much less
19 homogeneous community than that of the
20 Macfarlane Trust and so there was less room for --
21 less encouragement for people to get together and talk
22 about it. I referred briefly to somebody who shall be
23 nameless, which is number 5002, yesterday, in the
24 Eileen Trust, who for several years in the early part
25 of this century said really should have an event to

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- 1 Nick would provide to somebody. If indeed that
2 register existed, then I don't know.
- 3 Q. Would he be the best person to ask about that?
- 4 A. Yes.
- 5 Q. Then you have expressed your views on differences
6 between the Eileen Trust and the Macfarlane Trust.
7 Did your views on those differences inform or affect
8 how Macfarlane Trust beneficiaries were treated as
9 compared to Eileen Trust beneficiaries?
- 10 A. No.
- 11 Q. In your dealings with the Department of Health there,
12 at that stage and in relation to any of the schemes,
13 trusts, funds, companies we've discussed, was the
14 establishment of a no fault compensation scheme ever
15 raised?
- 16 A. Not that I can recall. If it was then I thought
17 something would have been written about and it would
18 appear in the list of documents, the pile of
19 documents. I don't recall that coming up in
20 discussion at any stage.
- 21 Q. Given the experience you had across all of the
22 Alliance House organisations that I've asked you about
23 yesterday and today, what, if anything, do you think
24 should or could have been done differently or better
25 than it was?

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1 get people together. And I said no, we shouldn't,
2 they are different ages, different backgrounds,
3 different -- the only thing they have in common
4 is HIV, but some of them don't have any underlying
5 health conditions because of that. I was totally
6 wrong. I was totally wrong. We eventually had
7 a weekend event and it became -- and these became
8 annual events that were really very, very enjoyable
9 for all concerned, including the trustees who attended
10 them, and they helped a lot with getting to -- with
11 the exchange of views between registrants and
12 trustees.

13 So Eileen Trust, there were elements of success
14 about Eileen Trust but it -- they're a very, very -
15 very, very peculiar operation.

16 Caxton I don't know and I can't -- I wasn't
17 involved enough in Caxton's running before it was
18 taken over.

19 So I think, with the benefit of hindsight,
20 I would say what should have been done right at the
21 outset is a substantially-funded organisation that was
22 not charitable. Given the fact that it was going to
23 start with Macfarlane Trust -- you know, I'm not going
24 to change that as well. Then -- the Macfarlane Trust
25 should not have been set up on the basis it was. And

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1 if it had been funded properly and was not charitable,
2 then it was everything else that would have been
3 *(unclear)* anyway.

4 But when you think that Alliance House paid
5 out -- I can't remember the number now, it was in m
6 written statement, I can't remember -- a large --
7 half a billion pounds or in excess of that, of which
8 a very substantial portion came through Skipton, that
9 rather suggests that everything else was just playing
10 round the edges, it was not really frightfully -- i
11 Macfarlane Trust -- if the two MSPT schemes hadn't
12 existed, the Macfarlane Trust was just tinkering round
13 the edges. It was not really contributing at all.

14 Those two schemes came into being because of
15 the pressure of litigation and they themselves --
16 well, they gave quite a lot of money away but -- the
17 tariff structure in MSPT 2 was pretty awful.

18 **Q.** Would you agree that one might not need the hindsight
19 of 2021 to see that the funding of the
20 Macfarlane Trust was problematic? That was the ver
21 point you yourself and your colleagues were making
22 through the presentation of the business case in 2005.

23 **A.** I don't think it needs hindsight from 2021. I think
24 the inadequacy of Macfarlane Trust funding was --
25 I was certainly talking about as soon as I became

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1 we felt it had been taken away from the beneficiari es
2 as well. I don't know whether the Department
3 consulted any of the MFT beneficiaries. They
4 certainly didn't consult the Eileen Trust
5 beneficiaries. I don't believe they consulted Skipton
6 or Caxton beneficiaries. They just made that
7 decision. So that's why we felt aggrieved.

8 **SIR BRIAN LANGSTAFF:** The second question is this: you
9 have the possibly unique perspective of someone who
10 served two terms as a trustee of the Macfarlane Trust,
11 separated by quite a period of time in the 1990s when
12 you weren't a trustee.

13 When you came back for your second period in
14 office, did it strike you that the position had
15 changed, that instead of HIV being effectively
16 regarded as a death sentence, the trust, which you had
17 told us was originally set up with the expectation it
18 might last five or seven years, at least for what you
19 called the primary beneficiaries, but now there was
20 a landscape of HAART people surviving but ill and with
21 all the consequences of age coupled with HIV and the
22 underlying condition of haemophilia -- rather
23 different position. Did it seem to you that the
24 Department recognised that at all in the way they
25 approached the Macfarlane Trust?

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1 Chairman, and I believe that Adam and Clifford would
2 have been making the same points before me to -- when
3 I wasn't there, although maybe more decorously. An
4 I think we knew even in the first four years when
5 I was there that there was something wrong.

6 **MS RICHARDS:** Mr Stevens, those are my questions and the
7 questions I'm proposing to ask that I have been asked
8 by Core Participants to advance.

9 Sir, do you have questions of Mr Stevens?

10 **Questions by SIR BRIAN LANGSTAFF**

11 **SIR BRIAN LANGSTAFF:** Yes, I do.

12 You have said on more than one occasion that
13 the trusts and funds were taken away from you.

14 What did you mean by that?

15 **A.** That when the Department decided to go with a single
16 scheme administrator we in Alliance House believed
17 that we could actually do quite a good job of that,
18 even though it would mean a complete change in our
19 thinking about the objectives and method of working on
20 some of them. I guess it would have become
21 a non-charitable organisation for a start. But
22 I didn't mean started actively planning preparing
23 a presentation on this when the Department of Health
24 said, "We're going -- staying with BSA".

25 So we felt it had been taken away from us and

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1 **A.** I don't think I was struck by that bearing in mind
2 that when I left in 1992 MFT was still existing on its
3 original £10 million. While I was away there had been
4 further funding from the Department. I can't
5 remember -- well, I don't know really -- whether this
6 came in similar bite-size -- in similar large chunks
7 or in smaller chunks and on what basis. But clearly
8 it's very difficult now to think what struck me as
9 1999 and what strikes me in 2021 to pitch my mind back
10 is quite difficult. But I suppose on reflection, the
11 Department was behaving differently, slightly
12 differently. There was an awareness -- I'm not sure
13 that the -- I'm not sure that the concept of HIV as
14 being a manageable condition was commonplace at that
15 stage. I'm not sure that I thought that.

16 Looking at the schedule, I know you will be
17 talking to Charles Lister and Charles was easily the
18 most effective and realistic and sympathetic of the
19 civil servants with whom I dealt, and he might have
20 a view about -- he would be helpful to answering that
21 question. I'm not sure that I'm really capable of
22 thinking back that far and thinking what were my
23 impressions at that stage.

24 **SIR BRIAN LANGSTAFF:** The next question is this: you've
25 expressed on more than one occasion what might be seen

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1 as a rather dim view of politicians and the
2 department. That's a general view you had, was it,
3 before you started your work with Macfarlane or was it
4 one which developed in office?
5 **A.** As regards the officials, probably developed as
6 a result of my work with them, once we'd got beyond
7 Charles Lister and then discovered that they were
8 human. I'm not saying that Charles is superhuman but
9 I discovered -- I've since discovered (*unclear*) flaws.
10 As far as the politicians are concerned,
11 I think my view of politicians was always slightly
12 jaundiced but it has become somewhat more pronounce
13 as I've got older. Nothing to do with the Trust, just
14 the fact that my next birthday, I'm 80, and by now
15 I have a fairly dim view of politicians, simply
16 because I'm old.
17 **SIR BRIAN LANGSTAFF:** The view you express from time to
18 time at the beneficiary end was that some of
19 beneficiaries you didn't -- or you expressed your view
20 about them in what might be described as robust terms.
21 You might I think, using your own word earlier,
22 indecorously perhaps to some.
23 So there you were doing a job which, do
24 I understand it correctly that you weren't paid for
25 any of the work you did except perhaps some of the

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1 **A.** Thank you.
2 **SIR BRIAN LANGSTAFF:** I think you have given an answer in
3 your own way. Yes, that's all that I think I want to
4 ask you. Thank you very much.
5 **A.** Thank you.
6 **MS RICHARDS:** Mr Stevens, I have one very short question.
7 It is a point of factual detail only.
8 During the plenary planning sessions that you
9 have referred to that led up to the Skipton Fund being
10 operational, were any haemophilia clinicians involved
11 in that process?
12 **A.** Well, I think so but I couldn't tell you for certain.
13 I mean, the ubiquitous Mark Winter might have been
14 involved. I simply can't remember.
15 **Q.** There are no further questions then, Mr Stevens. I
16 there anything that you would wish to add to your
17 evidence?
18 **A.** No, I don't think so. There's a question in the
19 written statement about -- the very final question
20 almost, I think -- did I think the Alliance House
21 organisation was well run. What a thing to ask me.
22 So I wrote a fairly rambling answer, which I suppose
23 the processes in the last couple of days might lead to
24 some slightly different wording, but we've already
25 sort of covered the ground really about, with the

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1 work you did helping to set up Skipton?
2 **A.** That is correct. The only time -- the only
3 remuneration I received for any of this work was
4 during a period of 2003-2004 particularly when I felt
5 I was doing a job that a Department of Health official
6 should have been doing, should already have done.
7 I felt I was being exploited and I said to Gutowski,
8 "I'm going to put a bill in for this", and he accepted
9 that.
10 **Q.** So you were doing this work without pay, occupying
11 quite a bit of your time. Do I understand that
12 correctly too?
13 **A.** A lot of my time, yes. It has been my principal --
14 it's certainly been the principal occupation during my
15 retirement.
16 **SIR BRIAN LANGSTAFF:** Dealing with people whom it was not
17 always a pleasure, putting is mildly, to deal with as
18 you saw it, why did you do it?
19 **A.** I suppose I started down this road and -- forgive me.
20 Sorry.
21 **SIR BRIAN LANGSTAFF:** If it's too personal a question
22 don't feel obliged to answer.
23 **A.** It's personal.
24 **SIR BRIAN LANGSTAFF:** Very well. I am not going to ask
25 you to answer that.

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1 benefit of hindsight, should some of that -- have been
2 done differently. Yes, I think it should.
3 **MS RICHARDS:** Thank you.
4 Sir.
5 **SIR BRIAN LANGSTAFF:** Over the last couple of days you've
6 given us a very considerable insight into all the
7 trusts and schemes at different periods because you
8 have the advantage, for us, of being able to say
9 something about each. And you've described, in a way
10 which certainly gives me insight, what the
11 frustrations were for someone such as yourself who, if
12 I may say so, has a fairly firm view about what other
13 people should be doing, which you're quite happy to
14 express in robust terms. The frustrations of being in
15 an organisation in which not enough money to do what
16 you wanted was being given by the Department, serving
17 beneficiaries who were complaining, not without
18 justification, that they weren't getting enough
19 support in various ways from the Trust, and it must
20 have felt frustrating, as I see it, to be between the
21 rock and the hard place.
22 Thank you for that insight into what it was
23 like and telling us how the different organisations
24 acted differently so that we have, I think, a clear
25 view of aspects of their running.

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1 It strikes me as well, and this is something
2 I particularly would like to thank you for, that
3 you've been perfectly prepared to accept that on
4 a number of occasions what you thought or said was
5 wholly wrong, and it seems to me it takes some courage
6 to be able to do that on this public stage.

7 Can I thank you for that and can I thank you
8 also for surviving without complaint the vagaries of
9 technology from time to time which have bedevilled
10 your evidence more than they have, I think, any other
11 of the witnesses that we've had. So thank you very
12 much for coming -- I say "coming", being there to give
13 us your evidence.

14 A. Thank you very much for your courtesy, and thank you,
15 Jenny, for yours. To say I've enjoyed it is probably
16 not quite right but I have appreciated it. I am glad
17 I had the opportunity to put things over as I saw
18 them. I don't think there's anything else I want to
19 add but thank you very much for your hospitality.
20 I feel that in a way that I've invited you into my
21 house.

22 SIR BRIAN LANGSTAFF: Well, we shall leave now suitably
23 masked up, once I put my mask back on.

24 But tomorrow, Ms Richards?

25 MS RICHARDS: At 10.00, the evidence of Ann Hithersay.

1 SIR BRIAN LANGSTAFF: So tomorrow at 10.00. Until then.
2 (4.51 pm)
3 (Adjourned until 10.00 am the following day)
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