

Wednesday, 1 February 2023

(10.00 am)

SIR BRIAN LANGSTAFF: Yes, Ms Jones.

Closing statement by MS JONES (continued)

On behalf of 297 individual Core Participants and the Hepatitis C Trust

MS JONES: Good morning, Sir Brian. Good morning, everyone.

As I explained yesterday, I will now go through the last part of our submissions. This section will focus on redress. I will then close our submissions with our clients' voices.

Before I turn to that, sir, there are just two matters for me to address. The first relates to a mistake I made during my part of yesterday's submissions, for which I apologise.

When I was discussing the exchange between counsel and Professor Hopkins, I said that Mr Hill was counsel when in actual fact it was Ms Richards. So my apologies to you, sir, and Ms Richards.

The second point, sir, is to confirm our position on Parliamentary privilege. In respect of the issues relating to Parliamentary privilege, we broadly agree with the submissions of Counsel to the Inquiry that there are factors that point in both directions. We are aware that the Speaker's Counsel takes a robust and

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There can be few such striking examples of adding insult to injury than causing deaths and debilitating illnesses and then forcing victims to beg for scraps from the table. Almost all of those who we represent have stories of such treatment. Many were refused compensation because of the negligence of the Health Service in failing to record their treatment or losing their records, others were stigmatised and disbelieved, being treated as though they were con artists who had picked up diseases as a result of their own choices.

Our clients have been excluded from the schemes because of blood received after the cut-off date of September '21, even though no one can explain why that cut-off date was chosen, and they have been excluded because the infection they contracted didn't have the right name: it was HBV rather than HCV or HIV.

If the Government wished to create a scheme which looked as though they were helping out while paying out as little money as possible, then they achieved their goal: this begrudging, destitution-level support, which has also understandably damaged the faith that our Core Participants have in the Government's commitment to providing any compensation scheme.

So it is against that backdrop that the future

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expansive view of the scope of Article 9. Without wishing to duck the issue, we would suggest that it would be more than possible, if you wished to do so, to address the issues raised in written submissions and the concerns expressed without impinging upon Parliamentary privilege.

But, sir, that's all we've got to say on that matter. If you want us to expand any further, we will of course do so in written submissions.

SIR BRIAN LANGSTAFF: No, I don't think that will be necessary. I think it's unlikely that I will have to actively resolve the issue in this particular inquiry, although I have perhaps some views to express. But I shall think about that.

MS JONES: Thank you, sir.

Turning now to redress and, to begin with, looking at financial redress. Our Core Participants, when they asked for redress were given either nothing or ex gratia payments which were too little and too late. I intend to focus this morning on future arrangements which should be made for financial compensation but I wish to open my remarks regarding the trusts and schemes by recognising the cruel, humiliating, and insulting way in which the ex gratia payments have been made to infected and affected individuals to date.

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compensation scheme must be developed. It must address and avoid the failures of previous schemes and it must provide generous and prompt compensation to those affected by this tragedy. And we use the word "compensation" deliberately, sir, because there has been serious wrongdoing here.

In relation to the recommendations that we set out in our written submissions, I would like first to turn to who should be eligible for compensation. Like other Core Participants, we largely welcome Sir Robert's recommendations. However, there are a few areas in which we would urge you, sir, to go further; in particular, the inclusion of HBV within any compensation scheme, the removal of the cut-off date of September '91, as well as the inclusion of natural clearers.

It is of the utmost importance for our Core Participants that financial compensation is prompt, generous, and secure. The financial support they receive must continue for the rest of their lives, and we endorse Sir Robert's suggestion that this should be formally guaranteed by the Government. This must also be reflected in the structure of the future scheme. It must have open-ended funding that can meet the needs of all applicants rather than being ring-fenced.

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1 The £100,000 interim payment already paid to some
2 should be extended to those not eligible under the
3 current schemes. Those who, for instance, are included
4 by virtue of the cut-off date or infection with HBV
5 should immediately receive an interim payment. The
6 estates of those where there is no bereaved partner
7 should receive the 100,000.

8 Further, we strongly endorse Mr Snowden KC's
9 suggestion that this Inquiry should call for further
10 interim payments to be made, given the length of time
11 the creation of any new scheme is likely to take.

12 The future compensation scheme must be created with
13 the infected and affected community. Redress must be
14 made with them rather than doled out to them without
15 their involvement. As we have seen through this
16 Inquiry, the infected and affected community know their
17 needs best, and are best able to identify and advocate
18 for change.

19 Whilst we broadly endorse Sir Robert's suggestion of
20 a tariff-based scheme, we emphasise that this
21 incorporate proper, individual assessment, especially of
22 past and future special damages. The assessment should
23 be holistic. Tariffs should be developed in
24 consultation with the infected and affected community,
25 who must have a meaningful opportunity to contribute.

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1 the suffering person's -- the victim's award. And he
2 then gets it subject to a duty to pay over to the
3 individual carer, where it might be thought more simple
4 and more appropriate for the carer to be compensated not
5 as the individual's loss but as their own loss.

6 **MS JONES:** I agree, sir. And if you decide to offer ideas
7 in relation to a future compensation scheme, then we
8 would support the idea that an applicant, an affected
9 applicant who has provided the care, should be entitled
10 to receive financial compensation -- it wouldn't be
11 compensation -- financial support for the care they have
12 provided, rather than, as you say, monies being paid to
13 the infected individual, who then has to pay it out.

14 **SIR BRIAN LANGSTAFF:** In particular, what I have in mind is
15 that the calculation may not be an easy one, but there
16 must be a large number of carers, people who have been
17 affected persons, as we've described them, who have
18 sacrificed their own careers, their own earning
19 opportunities, in order to provide care in the very
20 special circumstances where, because of stigma, no one
21 else could.

22 **MS JONES:** And that's right, sir. And you might choose to
23 go further than the current law of tort, that I believe
24 suggests that a person that doesn't work but provides
25 care can receive payment for the time and the costs of

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1 **SIR BRIAN LANGSTAFF:** Just pausing there for a moment. Many
2 of those who are listening will understand expression
3 "special damages". Certainly the lawyers will. But in
4 case there are some who don't, by "special damages" you
5 mean actual financial losses; in contrast with "general
6 damages", which is a sum to be assessed to compensate
7 for what, in one sense, can't be compensated for at all:
8 the injury, the loss, the suffering, which somebody has
9 endured.

10 **MS JONES:** Yes.

11 **SIR BRIAN LANGSTAFF:** Is that broadly right?

12 **MS JONES:** That is broadly right. Actual financial loss.

13 But, sir, also if, for example, an infected person has
14 received care from their loved one or a family member,
15 then that is known as gratuitous care, and the costs of
16 gratuitous care should also be included within --

17 **SIR BRIAN LANGSTAFF:** Well, it's capable of assessment in
18 financial terms, although I'd be interested if you want
19 to make submissions, now or for that matter later, as to
20 what you say this Inquiry should recommend, bearing in
21 mind it is not itself dealing with court compensation,
22 with the principle which would apply if it were court,
23 which is that the loss suffered by a carer is not the
24 loss of the carer, but it's the loss of the person who
25 requires care. Hence, it gets added to the infected or

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1 the gratuitous care but cannot recover loss of earnings.

2 Sir, you might feel that actually, assessing an
3 affected individual's loss of earnings might be a more
4 appropriate way for the scheme to operate.

5 **SIR BRIAN LANGSTAFF:** Well, there are actual financial costs
6 to providing care which the individual who provides the
7 care will suffer, but there are also physical,
8 psychological costs too, which must be borne in mind,
9 plus the ever-present risk of cross-infection.

10 **MS JONES:** Yes, sir. And I would hope that the compensation
11 scheme that would apply for affected applicants would
12 include general damages for those types of injuries: the
13 psychological impact and the stigma, as you suggest,
14 sir. And I believe in Sir Robert Francis's report, he
15 does set out tariffs for stigma and the social impact of
16 somebody who is infected and affected. If that is
17 wrong, sir, I apologise, and I can check that in the
18 break.

19 **SIR BRIAN LANGSTAFF:** Well, if one were looking at this as
20 a court case as well, any person who is a secondary
21 victim of an accident or incident would only be
22 compensated if they came within a particular class of
23 those who are -- the classic way of describing it is
24 "nearness, hereness and dearness", within that category.
25 Is it really appropriate, in these circumstances, to

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1 look at that in any other way than a broadbrush way, in
 2 assuming that anyone who does care is within that sort
 3 of class?
 4 **MS JONES:** I agree, sir. I think the current position or
 5 the current state of the law in respect of secondary
 6 victims, so they are people who haven't suffered the
 7 injury themselves but are, as Sir Brian said, nearest,
 8 dearest and --
 9 **SIR BRIAN LANGSTAFF:** Nearness, dearness and hereness -- of
 10 an accident.
 11 **MS JONES:** Yeah.
 12 **SIR BRIAN LANGSTAFF:** The classic case is someone whose
 13 toddler goes round the corner on his pedal bike, there's
 14 the sound of a crash, and they arrive and they don't see
 15 the accident but they see its aftermath, and they may
 16 well suffer shock -- it used to be called psychological
 17 shock -- from witnessing or being within that general
 18 area. And there have been lots of arguments about how
 19 far it extends and whether it extends to the person who
 20 suffers the corrosive impact of being an ever-present at
 21 the hospital bed of someone who is dying.
 22 **MS JONES:** I believe, sir, the Supreme Court is going to be
 23 in exercising itself in a case in the hopefully not too
 24 distant future about those control mechanisms.
 25 **SIR BRIAN LANGSTAFF:** Is this one of yours?

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1 please let me know.
 2 **MS JONES:** I do not disagree. I think that the proposal
 3 that you have set out follow up the fairest and simplest
 4 way forward for everyone that's been infected and
 5 affected by this tragedy.
 6 **SIR BRIAN LANGSTAFF:** Thank you.
 7 **MS JONES:** We consider that the awarding body for the new
 8 compensation scheme should be an independent
 9 arm's length body with rights of appeal. A body that
 10 understands the background of the infected blood scandal
 11 and which seeks to be inclusive rather than exclusive.
 12 There should be a reversal of burden of proof or, at
 13 the very least, a lower standard should be applied, by
 14 which I mean a reasonable degree of likelihood, rather
 15 than blood having been received on the balance of
 16 probabilities, and there must be no insistence upon
 17 medical records as a precondition for eligibility.
 18 Our Core Participants also require meaningful
 19 support and non-financial support which should not be
 20 overlooked or deprioritised in the process of creating
 21 a new compensation scheme. The awarding body should be
 22 aware of applicants' social needs and should be properly
 23 equipped to support applicants to assess comprehensive
 24 welfare services, including housing, income support, and
 25 social care.

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1 **MS JONES:** No. We've got one stayed behind it, so fingers
 2 crossed.
 3 Sir, I think if you were able to recommend the
 4 scheme that didn't impose such narrow restrictions, it
 5 would make it far simpler for applicants and also for
 6 any awarding body to be able to consider the issues and
 7 reach the right level of compensation.
 8 **SIR BRIAN LANGSTAFF:** Well, at the moment, the way that
 9 I tend to regard the principle is it's one of public
 10 policy preventing unlimited liability to an unlimited
 11 class for an unlimited length of time. If that's wrong,
 12 and it's not an act of public policy, then I would
 13 welcome hearing from any of the lawyers, if that's the
 14 case. But I'm not engaged in a court case assessing
 15 compensation; I'm here dealing with what is appropriate
 16 recompense -- assuming that I recommend it --
 17 appropriate recompense for those who have suffered in
 18 their very different and -- in their particular, very
 19 particular way.
 20 **MS JONES:** Yes, sir.
 21 I don't have anything to address you on, sir,
 22 further about the matter of public policy. I don't know
 23 if there's anyone else.
 24 **SIR BRIAN LANGSTAFF:** Well, that's a matter. People can
 25 take their time and think about it and if they disagree,

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1 We invite the Inquiry to recommend that the UK adopt
 2 a model of free services such as that described by Brian
 3 O'Mahony in his evidence to the Inquiry. That includes
 4 free dentistry and optometry services; free hearing
 5 tests and hearing-aids; free physiotherapy; free
 6 complementary therapies, including massage, reflexology,
 7 acupuncture and any other appropriate services;
 8 a Government guarantee to insurers, which will allow the
 9 infected and affected individuals to access life,
 10 mortgage and travel insurance on a level playing field
 11 with other customers.

12 Many of our Core Participants have very substantial
 13 needs for care and support. We invite the Inquiry to
 14 recommend that infected individuals are provided with
 15 free domiciliary support, and social care services as
 16 needed.

17 Once again, applications for such a support must be
 18 viewed sympathetically and on their own merits and, in
 19 order to access these services, sir, we urge the Inquiry
 20 to consider the recommending the introduction of a role
 21 such as the liaison officer in Ireland which Mr O'Mahony
 22 referred to as "crucial".

23 Sir, this is our last chance to make meaningful
 24 redress to the victims of the greatest disaster in NHS
 25 history. Now is the time at long last to compensate and

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support the people who have been rebuffed, excluded and dismissed for decades. The Government response must be swift, generous and unstinting.

The Government's position and failure to issue a response to the Paymaster General at the very least threatens a potentially long and drawn-out period whilst any recommendations that you make, Sir Brian, are implemented, if, in fact, the Government chooses to implement them.

Sir Brian, we urge you to make a further interim recommendation that the Government makes further interim payments to those infected and affected, including those who were excluded from the last interim payments. There is a very real and palpable fear that it could be years before the Government finally has a scheme in place.

Our Core Participants fear that this process is being deliberately drawn out to minimise the compensation to be paid and that they will be dead before any money is received.

We would also urge you to recommend that the Government implementation of your recommendations be scrutinised and reviewed, either by this Inquiry or by an independent body, which includes members of the infected and affected community.

You will be aware, sir, that the Hillsborough

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an apology. Now is the time for a step change from the state and other agencies that have played a role in this tragedy. In our written submissions we invited apologies not only from Government, including the DHSC, but also the UKHCDO, The Haemophilia Society and the pharmaceutical companies.

Sir, you'll recall when we were speaking about discrimination yesterday, I said that I would come back to issues in relation to racial discrimination. Here, sir, I'd like to address you in relation to particular redress and action for minoritised ethnic communities affected by infected blood.

Sir, we have a number of Core Participants who were infected via their treatment for blood disorders. These conditions are likely to require frequent transfusions with blood components of various kinds. Given the significant number of individuals in the UK with sickle cell, sickle cell anaemia or thalassaemia, it is likely that number of these patients would have been infected with HCV and HIV. The statistics expert group was unable to break down the medical reasons for blood transfusions in those who were infected with HCV or HIV, other than to identify than more women than men aged between 20 and 50 required transfusion, and that was probably because of the use of the treatment, by which

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disaster has been in the news again over the past few days because of the anticipated official police response to the report of the Right Reverend James Jones. His report, *The Patronising Disposition of Unaccountable Power*, was a review of the experiences of families affected by Hillsborough and was published in November 2017. It set out 25 points of learning relating to the response of public bodies to state related deaths.

We're now five years on and over five years there has been no formal response from the Government, which the Reverend described as "intolerable for the families".

When asked for comment, the Home Office said that it was committed to responding to the report as soon as practicable, and this is five years on.

We would ask you, sir, to urge the Government not to delay in responding to any recommendations that you might choose to make. The infected and affected to this Inquiry have waited decades for redress and tragically many have died without it. They cannot and should not have to wait any longer.

Sir, another feature of redress is, of course, a meaningful apology. Our clients have waited too long for a recognition of the immense harm and suffering they have experienced. Many have died, waiting for

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I mean blood transfusion, during maternity care.

In response, sir, to a comment put to Dame Sally Davies by CTI that blood-borne viruses were not really on the radar for this group of patients -- by which I mean patients with bleeding disorders -- she referred to the context of health inequalities suffered by her group of patients and the patchy services they received. We submit that the fact that this condition is disproportionately suffered by those from a sub-Saharan, African or Afro-Caribbean ethnic heritage contributed to and compounded these inequalities, and therefore contributed to the lack of spotlight or understanding of the secondary issue of blood-borne viruses, which statistically, we submit, it can be inferred would have affected this group disproportionately.

Professor Davies indicated that during her time at the Middlesex Hospital there was less research being undertaken into sickle cell anaemia than other forms of blood cancers or disorders, and she expressed her concern that this may well have been what she termed as institutional racism. She also identified that the funding for sickle cell patients may have been influenced by their ethnic background, saying:

"I feared it might be, because if you look at the money spent on haemophilia patients and the numbers, the

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1 discrepancy was unfair ... I was concerned about the
2 fairness of it."

3 And, sir, we can get the reference for that
4 transcript for you in the break.

5 The fact that clinicians such as Professor Dame
6 Sally Davies were focusing on the priority of getting
7 decent services in place, and as a starting base for
8 these patients, meant that the issue of blood-borne
9 viruses was overlooked. Sir, we consider that a similar
10 inference can be drawn for patients with thalassaemia,
11 who are disproportionately people of Mediterranean,
12 South Asian, South East Asian and Middle Eastern origin.

13 Sir, we invite the Inquiry to conclude that much
14 like our female Core Participant cohort, existing health
15 inequalities, and in this case arising from ethnic and
16 sociocultural determinants of health, intersected with
17 the general failings outlined above, leading to
18 disproportionately worse outcomes for Core Participants
19 with blood disorders.

20 The Inquiry has also examined the stigma and shame
21 that can be associated with HIV, HCV or HBV, and that
22 there can be a double stigma in some communities. You
23 heard powerful evidence of the fact that some choose to
24 hide their diagnosis for fear of being ostracised by
25 their communities. We would ask, sir, that the Inquiry

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1 Finally, turning to our Core Participants' voices.
2 We must end these submissions by acknowledging the
3 immense harm and suffering experienced by all of our
4 Core Participants as a result of the infected blood
5 scandal. Lives have been lost and lives have been
6 shortened. Debilitating and extreme pain has been many
7 of our Core Participants' daily experience. They have
8 lost parents, children, siblings and partners. Whatever
9 the outcome of this Inquiry, nothing can ever make
10 amends for such devastation.

11 One example is the Core Participant we represent who
12 expressly held consent for her five-year old daughter to
13 receive a blood transfusion where it was not medically
14 necessary. The following day, her daughter's doctor
15 transfused her without her mother's consent. When our
16 Core Participant objected, the doctors laughed at her.
17 Her daughter developed HCV, from which she died at the
18 age of 16. That young woman would have been 36 years
19 old today. Her mother has explained there's not enough
20 words to explain how someone feels when that happens to
21 them.

22 Many of our Core Participants described the stigma
23 of their infection, whether that be HIV, HCV or HBV,
24 being so acute that they felt "dirty", "ashamed",
25 "guilty", "unclean", "like a sewer rat", "poisonous",

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1 recognises this.

2 As we have identified, we consider that this Inquiry
3 is in a position to make recommendations concerning
4 health inequalities, in the context of the evidence that
5 the Inquiry has heard, which could make meaningful
6 change for the future.

7 Sir, as you know, there is now an Office for Health
8 Improvement and Disparities. One of its roles is to
9 gather expert evidence and research, and to identify how
10 to address the issues. We would ask that the Inquiry
11 identify to the Office for Health Improvement the
12 information that the Inquiry has uncovered that poor
13 treatment and outcomes for conditions such as sickle
14 cell and thalassaemia may have masked issues around
15 their infection with HCV, or HIV or HBV.

16 The Government should recognise that those from
17 minoritised backgrounds may well have had double
18 discrimination. The Office for Health Disparities
19 should be asked to examine this in respect of viral
20 hepatitis and HIV and to identify ways to improve their
21 care and treatment.

22 Sir, finally, the Inquiry might wish to consider
23 recommending that the Government should consider
24 initiating a widespread review and/or a public inquiry
25 into health inequalities.

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1 and "like a leper".

2 Our Core Participants have been thrust into
3 a position of living with the constant, unspoken fact of
4 death hanging over them. One Core Participant quotes
5 from their psychologist, who notes:

6 "[X] lives with the fact that hepatitis C is
7 a life-threatening virus. The uncertainty that that
8 generates has a direct affect on his level of anxiety
9 and depression. Also, each time [X] is made aware of
10 someone who, having been well for a number of years, has
11 suddenly become ill from the virus and died even, it is
12 a powerful reminder of the reality of the threat under
13 which he lives."

14 Others describe how the only thing that keeps them
15 going in the face of the fear is not wanting to leave
16 the planet without being sure that there will be
17 adequate compensation for their families.

18 The affected, as you rightly pointed out, sir, have
19 suffered acute, vicarious trauma. As one Core
20 Participant described it:

21 "The most difficult thing is watching somebody you
22 love fall apart day to day. I can only describe it as
23 like watching an old car with bits falling off
24 progressively. It's like there is a paleness or
25 a greyness to every day but you must try to keep your

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1 loved one cheerful and keep them going. All you can do,
2 if you feel overwhelmed is go out into the nearest field
3 and shout."

4 To close, Sir Brian, our clients have found the
5 process of this Inquiry cathartic. But the wrongs of
6 the past 40 years have to be righted. There must be
7 swift, meaningful and comprehensive compensation and
8 unconditional apologies. There needs to be wholesale
9 and systemic change in the way that patients are cared
10 for, and the way that the NHS responds to its own
11 failures. It must become compassionate and open. That
12 would be the greatest and most important legacy of this
13 Inquiry and this whole tragic affair.

14 I wish, as I finish these submissions, to remember
15 the 11 of our Core Participants who have passed away
16 during the course of this Inquiry and all those who are
17 no longer with us. None of them will be forgotten.

18 Each of the Core Participants we represent has
19 a unique story which is uniquely tragic. As a team, we
20 have been honoured to represent them. Further, the way
21 in which all of those infected and affected have
22 conducted themselves during this Inquiry has been
23 humbling. They've acted with dignity, showing respect
24 for each other, and they've acted with compassion and
25 commitment.

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1 **MR WILLIAMS:** Sir, ladies and gentlemen, my name is
2 Lloyd Williams. Together with Mr Christian Howells,
3 Ms Laura Shepherd, and instructed by Watkins & Gunn, we
4 represent 237 individual Core Participants.

5 We also represent Haemophilia Wales, Haemophilia
6 Northern Ireland, Hepatitis B Positive Trust, and CJD
7 Support Network.

8 Sir, it's almost four and a half years ago that
9 I stood up and made our opening remarks. One point
10 I made at that time was how difficult it was to make
11 submissions without hearing any witnesses, not receiving
12 any statements, or being served without any documents --
13 without documents.

14 I rather regret saying that at the time, having
15 received hundreds of statements, tens of thousands of
16 documents. Fortunately, we've had the benefit of
17 Ms Richards and her team, who have guided us through the
18 material as it's emerged. My clients would like to
19 thank Ms Richards, as I think most of them did when
20 they'd finished their evidence.

21 On the morning I made the opening remarks, I was
22 approached by one of our Core Participants. She was
23 upset. She told me, as she subsequently told you, sir,
24 in Cardiff, that she'd been infected with hepatitis C
25 when she received a blood transfusion on the birth of

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1 Sir, they are not group to be dismissed,
2 disempowered and defended against. Instead, they are
3 a group who deserve accountability, acknowledgement and
4 action. Once again, I thank each of them for their
5 courage and resilience in sharing their stories with us.

6 Sir Brian, unless I can be of any further
7 assistance, those are our submissions.

8 **SIR BRIAN LANGSTAFF:** No, thank you very much indeed,
9 Ms Jones, for those submissions. I shall consider them,
10 of course, carefully.

11 **MS JONES:** Thank you, Sir Brian.

12 **SIR BRIAN LANGSTAFF:** Thanks to Ms Morgan as well.

13 Now we'll take a short break, there's no need to
14 leave your seat unless you wish to but, by all means, do
15 if you want, for about five minutes before we hear
16 Mr Williams on behalf of the clients represented by
17 Watkins & Gunn.

18 **(10.38 am)**

(A short break)

20 **(10.44 am)**

21 **SIR BRIAN LANGSTAFF:** Yes, Mr Williams.

22 **Closing Statement by MR WILLIAMS KC**

23 **On behalf of 237 individual core participants, Haemophilia**

24 **Wales, Haemophilia Northern Ireland, The Hepatitis B**

25 **Positive Trust and the CJD Support Network**

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1 her child.

2 She was unaware that she'd received a blood
3 transfusion, and it was some time later that she became
4 aware of the transfusion, and that she'd contracted
5 hepatitis C. Prior to the birth she was a regular
6 attendee at a blood transfusion centre. When she'd
7 recovered from the childbirth she recommenced providing
8 blood.

9 When she was eventually warned that she was
10 infected, she was told she couldn't give blood anymore.
11 She was very upset. She'd been giving blood in the
12 previous years and she'd given blood in the period
13 between the birth of her child and the time when she was
14 eventually warned, some time later, that she'd been
15 infected.

16 I mentioned this when I opened our position four and
17 a half years ago, and I produced her transfusion card.
18 Well, sir, the world keeps on turning and yesterday
19 Mrs Elaine Huxley, who is here somewhere today, produced
20 another document. This was from Velindre, cancer
21 hospital, confirming that she's got terminal cancer.

22 The event confirms, if we need it, the terrible
23 events that we're dealing with. The consequences are
24 not what occurred -- are not just what occurred 10, 15,
25 20 years ago. They're the here and now. And they'll go

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1 on into the future. It's very important to bear in
2 mind, we say -- and our Core Participants would say --
3 that due regard is not just had for those who have
4 suffered in the past, although that's very, very
5 important, but that due regard is had to those who
6 continue to suffer, who continue to be deprived of
7 fathers, children, and who need care and assistance into
8 the future.

9 Sir, we'd like to thank Mr Steven Snowden KC and his
10 junior, Mr Brian Cummins, for the heavy lifting on many
11 of the issues that touch upon all our Core Participants.
12 It makes our task that much easier.

13 In respect of those submissions made by Mr Snowden,
14 that you find persuasive, then we join in on those. Any
15 of his submissions that you don't like, we don't join
16 in.

17 Sir, these submissions will focus on the main issues
18 with which our clients are concerned. Many of our
19 clients have a particular interest in events in
20 Northern Ireland and Wales, and I think Mr Howells will
21 be dealing with that in the second half of these
22 submissions.

23 We don't intend to cover every topic. The Inquiry
24 has an extensive team and detailed knowledge of the
25 evidence. As such, we will, for the most part, not

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1 against which this Inquiry can be measured. We, in our
2 opening remarks, identified three issues that our
3 clients particularly wanted you to address. The first
4 one was that they wanted their stories heard. For 30,
5 40 years, people have spoken on their behalf or not
6 spoken on their behalf. This was the opportunity and we
7 urged you to allow them the opportunity to tell their
8 own stories.

9 Secondly, we raised the issue of they wanted the
10 truth. They didn't want the whitewash. They wanted the
11 truth from the witnesses. Whether we've had the truth
12 remains to be seen.

13 The third issue they wanted us to raise was justice.
14 There's a number of elements to justice. I'll go
15 through them in one moment.

16 Put simply, they want their stories heard. Sir, one
17 should not underestimate the sheer anger felt by the
18 victims. "Victims" was the words we used at the time
19 and for the moment I'll stick with that word. Their
20 feelings are as raw today as they've ever been. The
21 victims feel it's important at this stage that the
22 Inquiry is given the flavour of how their lives have
23 been destroyed.

24 There are a number of themes to be considered and we
25 suggested at that time, sir, that these were the themes:

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1 rehearse evidence, save for references to key documents
2 and excerpts of the oral evidence where necessary.

3 This Inquiry, it's been said many times, should have
4 been held decades ago, when events were fresher,
5 memories sharper, and more key witnesses would have been
6 able to give evidence. Importantly, many infected and
7 affected who are no longer with us, would have been able
8 to bear witness to this Inquiry and the findings which
9 you will make.

10 No adequate explanation has been put forward by any
11 of the ministers or civil servants as to why this
12 Inquiry was not held sooner. The line taken by
13 Government, that patients received the best treatment
14 available given the medical knowledge at the time,
15 became entrenched, notwithstanding that it was wrong.
16 It was done so at the expense of an open-minded review
17 of that position, until now.

18 Before I look at the material that I want to
19 consider, which will cover future compensation, future
20 medical support, and past support, I have to say I've
21 had the thunder taken out of some of my submissions in
22 view of the ones you've heard just now. I'll do my
23 best.

24 I'd just like to look at and consider the opening
25 remarks we made, as it sets out, if you like, a test

26

1 the initial shock of infection; the ill health
2 associated with infection, compounded by the ill health
3 associated with any pre-existing condition; the various
4 forms of treatment they'd undergone, such as liver
5 transplants; combined effect of hepatitis C and HIV, to
6 which we will now add HBV; the stigma attached to those
7 conditions; ostracism from their friends and their local
8 communities; the shock of finding out their infection
9 could have been avoided; the anger, resentment and
10 bitterness they feel towards those whom they trusted and
11 were entitled to trust; the financial devastation that
12 followed infection; the ruined family and private lives
13 of the victims; the guilt that the victims feel about
14 potential infection of their loved ones; and the burden
15 they feel they've brought to their families; and also,
16 a particularly difficult cohort, the guilt that the
17 wholly innocent parents feel for not questioning the
18 treatment that was provided to their children, and in
19 some cases to which they administered to their own
20 children.

21 This not an inquiry simply looking into the past;
22 it's an inquiry, as we've said four and a half years
23 ago, looking into the here and now. Now, four and
24 a half years later, I can say it's for the future from
25 here.

28

1 Sir, the question arises about the material that
 2 they wanted us to tell you about. In respect of that,
 3 we referred to two letters which we read to you. I'm
 4 going to remind you of those letters -- they're going to
 5 become relevant later on as well, but I'm going to
 6 remind those letters I read to you.

7 The first one said this:
 8 "From our experience the UK Government has been
 9 evasive, dishonest and cynical. The Department of
 10 Health has been hostile in its responses to campaigners
 11 and MPs who have debated the matter in Parliament. They
 12 have refused to both fully accept responsibility and to
 13 offer realistic compensation. They have engaged in
 14 political trickery and treated victims with contempt.
 15 The Department of Health clearly has a lot to hide and
 16 has been aggressive in defence of its own interests.
 17 The financial assistance given has been piecemeal and
 18 grudging, the use of contaminated blood and its
 19 consequences is a scandal but the attitude of the
 20 Department of Health to the victims is an even bigger
 21 scandal, provoking great anger, distress and suffering,
 22 adding insult to injury."

23 The second letter is this:
 24 "All widows have been given a life sentence, some
 25 a double life sentence if they've been infected as well,
 29

1 their stories. Have they been allowed to?
 2 That's primarily directed towards you, sir, because
 3 you're the one who has had control of this Inquiry.
 4 Overall the feeling is yes, you've allowed them to
 5 be heard. You've allowed them to have their say,
 6 without constraints. They were allowed to say, within
 7 limits, whatever they wanted to say, and they were
 8 allowed to do it in their words and they were allowed to
 9 do it in their way.

10 Sir, unusually, we had straightforward hearsay
 11 evidence. Some people referring what had happened to
 12 their father, even though they themselves were not alive
 13 at the time and hadn't been born. They appreciate, sir,
 14 fully appreciate, that you're not just going to take
 15 their evidence as it is, that you'd be weighing up other
 16 evidence. You won't deal with individual cases,
 17 individual allegations. You'll look at the matters in
 18 the round. They accept that. But they've finally been
 19 able to speak on behalf of themselves and, for that,
 20 they thank you, sir.

21 The second issue which we looked at was the truth.
 22 The way I put it, then, four and a half years ago, is
 23 they want the truth. When do they want it? 30 years
 24 ago. Well, we can say 34 years ago they'd like the
 25 truth. They'd like the truth. The victims are angry
 31

1 for a crime we did not commit, and we suffer daily from
 2 something we did not do. We have been there when our
 3 husbands have discovered that they've become HIV
 4 positive and/or hepatitis C positive. We have watched
 5 our loved ones become ill. We have often given up our
 6 jobs and careers to nurse and care for them, enduring
 7 hardships in consequence. We have had to endure the
 8 stigma of those illnesses with them. We have suffered
 9 harassment and prejudice. We have often been too
 10 frightened to tell our families about the truth of loved
 11 ones, perhaps lying or keeping secrets. We have had to
 12 tell our children, if we've been able to have them, that
 13 their father was ill and dying, while others have been
 14 denied the chance of ever having children. We have
 15 watched our loved ones slip away, hold their hands as
 16 they do, and see them die horrific deaths, bury them and
 17 afterwards try to rebuild our lives with a constant
 18 background of this travesty in our minds, and with
 19 little support.

20 "Many have been unable to work again. They have
 21 been traumatised, had breakdowns, been left to become
 22 single parents and bring up children who have been left
 23 without fathers. A few widows have become homeless and
 24 some have committed suicide."

25 Well, they wanted to be heard. They wanted to tell
 30

1 that the Government has not faced up to what happened
 2 and hasn't accepted responsibility. During those years,
 3 they've fought tooth and nail for everything, including
 4 treatment and financial support.

5 This is the first and undoubtedly the last
 6 opportunity for the victims to know the truth about why,
 7 for what reasons and in what circumstances they were
 8 exposed to contaminated blood products. It is of the
 9 utmost importance, and they know that it is your
 10 intention, sir, to get to the truth of what has
 11 happened.

12 What do they want the truth about? We asked
 13 ourselves four and a half years ago. In one sense, the
 14 answer to the question is quite simple and
 15 straightforward. They want to know the truth about
 16 everything concerning the desperate situation in which
 17 they have been placed by the actions of others.

18 Taking a slightly more focused approach, they wanted
 19 the truth about each and every item identified in the
 20 terms of reference.

21 Whether they get the truth is up to you, sir. We
 22 know you will consider the evidence very carefully.
 23 You've been assisted throughout by Ms Richards, and
 24 we're satisfied -- those we represent are satisfied
 25 that, if I can put it this way, you'll do your best, and
 32

1 we're sure the best will be very thorough indeed.
 2 Sir, the last thing we wanted is perhaps the most
 3 difficult one. We wanted justice. It's difficult to
 4 know how you can measure justice. In this case,
 5 thousands of people have died, thousands of people still
 6 suffer from very severe ill health and, tragically, as
 7 we just heard, it is likely that in the future more will
 8 discover that they've been infected with hepatitis C and
 9 more people will fall very ill.

10 The victims regard this Inquiry as a search for
 11 justice. There's a general view amongst the victims
 12 that for over 40 years people in the know have kept
 13 their mouths shut, their files closed, and their
 14 shredders busy. All they've received for all the
 15 suffering, was a belated apology from Prime Minister
 16 Cameron in 2015, for what that's worth.

17 Updating things four and a half years later, we have
 18 an apology on behalf of the Department of Health, which
 19 echoed an apology given a couple of days after I made
 20 our original submission. It was at that time
 21 an unreserved apology for what had happened.

22 Quite where we stand on that apology, I don't know,
 23 and at the moment, neither do you, sir, since they
 24 declined to expand upon what they were admitting, which
 25 is an extraordinary position to take.

33

1 of a million.

2 You will know, sir, that's not the case. I would
 3 like to take you to the report of Sir Robert. It's
 4 page 41 of his report. He very helpfully identifies the
 5 rationale for compensation. Page 41, "Terms of
 6 Reference":

7 "To consider the rationale for compensation as
 8 a matter of general principle and in relation to any
 9 particular classes of compensation, recognising that it
 10 is not for the Study to pre-empt the determination by
 11 the Infected Blood Inquiry as to what, if any, rationale
 12 is supported by the evidence it has received ...

13 "Definition of compensation.

14 "What does the term 'compensation' mean? When
 15 participants in our meetings were asked, few were able
 16 to describe clearly what their concept of compensation
 17 was. Therefore, it may be helpful to set out the way in
 18 which it is intended to use the term in this report.

19 "To start with, for the common use of the word, we
 20 can refer to an online dictionary definition:

21 "'something, typically money, awarded to someone in
 22 recognition of loss, suffering or injury'.

23 "Other dictionary definitions include:

24 "'money that is paid to someone in exchange for
 25 something that has been lost or damaged or for some

35

1 Whether or not they were entitled to refuse to
 2 answer your questions is a different matter but it was
 3 contemptuous not Ms Grey of course. I don't blame her
 4 at all.

5 What it was that Mr Snowden said the previous day,
 6 which prompted them to halve their final submissions,
 7 it's difficult to know. Mr Snowden was very persuasive
 8 and the six points he raised were, we thought -- and
 9 respectfully endorsed -- were hardly a surprise to the
 10 Department of Health. They should have foreseen that
 11 coming.

12 Sir, the question of justice includes, we would
 13 say -- and this is a matter I am going to deal with in
 14 more detail -- provision of health services -- I will
 15 just leave that where it is at the moment because I'll
 16 be coming back to it -- and also compensation.

17 I'd just like to look in a little more detail as to
 18 what compensation is. There's a danger that people, the
 19 general public, might misinterpret what compensation is
 20 all about. In fact, the press often misinterpret what
 21 compensation is all about. It is made to seem, in some
 22 people's eyes, as a win on the lottery, so people are
 23 awarded £50,000, £70,000, £1 million, £5 million; it's
 24 seen as a win on the lottery. They put their hand in
 25 the bran tub and they brought out a check for a quarter

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1 problem:

2 "'something that makes you feel better when you have
 3 suffered something bad;

4 "'the act or process of making amends for
 5 something'.

6 "A number of features should be noted --
 7 compensation:

8 "Is not limited to an award of money;

9 "Involves a process;

10 "Recognises that a person has suffered from
 11 an injury or loss;

12 "Is intended to redress that injury or loss."

13 Then jumping over the next paragraph but going to
 14 paragraph 4.6.

15 "For the purpose of this study, I shall adopt the
 16 following definition:

17 "'An award of money or some other remedy to persons
 18 who have suffered injury or loss ... indirectly or from
 19 infected blood or blood products found to be eligible
 20 for such an award to provide them with redress for and
 21 recognition of the adverse experience they have
 22 suffered'."

23 It's compensation for an injury. If the injury is
 24 small, compensation will be small. If the injury is
 25 awful, long lasting or causes death, the damages of

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1 compensation is commensurately higher.
 2 Sir, once again, there is a tendency amongst the
 3 public and the press to regard people who seek
 4 compensation as somehow a form of ambulance chasing, or
 5 people just wanting the money. No doubt that will be
 6 raised in this case. It hasn't been raised at all so
 7 far.

8 The way we would put it is like this, simple and
 9 straightforward: what would you rather have, your son
 10 alive or a large sum of money? If we look at it like
 11 that, it's very straightforward. The compensation is
 12 there to compensate people for injury and in these cases
 13 very, very serious injuries.

14 I just want to compare some people's understanding
 15 of what compensation is about and why it's awarded, that
 16 it's linked to fault, with some former ministers'
 17 appreciation of what compensation is about, and I'd like
 18 now to be played a film of Edwina Currie.

19 *(Video played)*

20 **MR WILLIAMS:** That film was made just a couple of years
 21 after Edwina Currie had to stand down from being
 22 a junior Minister in the Department of Health. Her
 23 comments were crass, unbelievably stupid. She was
 24 supposed to know about the disaster that was then
 25 unfolding. She was supposed to know about how HIV was

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1 of compensation, its structure, and the issue of
 2 eligibility and the calculation of quantum are based
 3 primarily on the evidence of the infected and affected.

4 It's also based on the recommendations and oral
 5 evidence of Sir Robert Francis KC, the evidence the
 6 Inquiry has received concerning the means and systems
 7 providing compensation and support in other countries,
 8 particularly the Republic of Ireland, the present
 9 systems used in the four countries for the support of
 10 the infected and affected, and the existing common law
 11 systems operated in the four countries in the UK.

12 The role of compensation is of the utmost
 13 importance. It represents a clear, unambiguous
 14 acknowledgement and acceptance of responsibility for
 15 this disaster, including HCV, HIV, HBV and uCJD (*sic*)
 16 and acceptance by the UK Government and devolved
 17 governments. The mealy-mouthed words previously used by
 18 them to justify the minimal amounts of money they
 19 provided can be put behind us, we hope. We hope that
 20 responsibility is accepted.

21 Further, the payment of compensation should be seen
 22 as an acknowledgement by them of a continuing obligation
 23 to provide appropriate, fair, and reasonable
 24 compensation and support in the future.

25 The four existing schemes for the provision of

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1 at least said to be caused by the Government. She
 2 equated HIV -- and, by extension, hepatitis C -- to
 3 something that just happens. It didn't just happen. It
 4 happened because of the faults of the Government. She
 5 failed to recognise that. In the position that she'd
 6 formerly held, she would have known about the disputes
 7 that were taking place.

8 If she doesn't know the difference between
 9 compensation and just doling out money, if she doesn't
 10 know the difference between having suffered harm,
 11 someone gets compensation, than someone who hasn't
 12 suffered harm, then how can we blame members of the
 13 public, and perhaps even we can let out the press not
 14 knowing the difference?

15 Her attitude there was appalling. We'll come back
 16 to Edwina Currie later. I can see by the time we're
 17 getting up to 11.15. I don't know whether you want to
 18 stop or just go on. I'm quite happy to go on.

19 **SIR BRIAN LANGSTAFF:** If you're happy to go on, then go on,
 20 and we'll take a break about 11.30, if that would suit.

21 **MR WILLIAMS:** Yes, sir.

22 That was all an introduction to my first point upon
 23 which I'm going to address you, which is compensation
 24 for the infected and affected.

25 What should be done? Our proposals for the scheme
 38

1 financial support for these infected and affected should
 2 be amalgamated into one new system for compensation and
 3 support. Until the new system is set up -- and we
 4 accept it will take a little time -- the running --
 5 sorry.

6 Until the new system is up and running, the amounts
 7 paid to the infected and affected will be given parity
 8 between the four countries, so that under the respective
 9 headings of loss each claimant receives the same amount.

10 The Government should establish a single scheme by
 11 which each of these infected and affected receive fair,
 12 just and equitable compensation for the harm they've
 13 suffered and, in most cases, will continue to suffer for
 14 many years into the future.

15 The compensation paid should be the same wherever
 16 the recipient lives. In order to meet these
 17 requirements, the system should be founded on the
 18 following principles: first, the infected and affected
 19 should have an official unambiguous apology from the
 20 UK Government for the harm caused to the infected and
 21 affected, and an open acceptance by the UK Government
 22 that the need for compensation arises because of their
 23 responsibility for the harm they caused to the infected
 24 and affected.

25 Secondly, the compensation is paid as of right --

40

1 not as a matter of charity, but as of right -- because
 2 of the harm they've suffered.
 3 We adopt those principles set out in Sir Robert's
 4 report at paragraph 4.75. I'm going to go through
 5 those, and that will take a little time, so now might be
 6 time to stop it.

7 **SIR BRIAN LANGSTAFF:** Very well. We will stop now and we
 8 will come back, then, at 11.50. So 11.50.

9 **(11.18 am)**

10 **(A short break)**

11 **(11.49 am)**

12 **SIR BRIAN LANGSTAFF:** Yes.

13 **MR WILLIAMS:** Sir, we were going to look at the principles
 14 as enunciated by Sir Robert. And that's at internal
 15 page 60 of Sir Robert's report.

16 Just to explain the context of this, I was just
 17 going to the principles upon which the system that we
 18 propose, so our system, and setting out those
 19 principles, and the first one we adopted was that set
 20 out at paragraph 4.75 of Sir Robert's. So we're going
 21 to have a look at that:

22 "Principles

23 "Having considered the rationales proposed for
 24 compensation, as opposed to support, I turn to consider
 25 the principles which should underpin a compensation

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1 "Inclusive:

2 "The scheme should recognise the direct impact of
 3 the infection and its consequences on the infected
 4 person, but also the indirect impact of the infection on
 5 those closest to the infected person.

6 "Non-technical:

7 "There should be no bar to eligibility based on
 8 technical issues, such as limitation through the passage
 9 of time since the onset of the infection and its
 10 consequences.

11 "Accessible:

12 "The scheme must be as readily accessible,
 13 understandable and free of complexity and stress to all
 14 potentially eligible persons, as is reasonably possible
 15 with appropriate assistance."

16 Just underlying that, the last two words,
 17 "appropriate assistance", sir, that's a matter which we
 18 will look at in more detail in one moment.

19 It then goes on:

20 "Ease of proof:

21 "Unjust, distressing and disproportionate
 22 requirements of proof and evidence should be avoided.

23 "Broad:

24 "Measures of compensation should be designed, so far
 25 as possible, so that they are either to apply and

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1 scheme."

2 Then next down:

3 "Remedial:

4 "The aim of a compensation scheme is, so far as can
 5 be achieved by provision of money, support and services,
 6 to provide eligible persons who have suffered injury or
 7 loss directly or indirectly from infected blood or
 8 blood, with proportionate redress for, and recognition
 9 of, the adverse experience they have suffered.

10 "Respect for dignity:

11 "The scheme must restore and preserve applicants'
 12 dignity and treat them with respect and confidentiality.

13 "Collaborative:

14 "The scheme should be collaborative with and
 15 supportive of, applicants and, so far as possible, avoid
 16 an adversarial approach to claims: applicants should be
 17 believed unless the contrary is proved.

18 "Choice:

19 "The scheme should respect and enhance the autonomy
 20 of applicants, including offering a choice of how
 21 remedies are delivered.

22 "Individualised:

23 "Awards should reflect, in a proportionate and
 24 consistent manner, the individual circumstances and
 25 experience of applicants.

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1 represent broadly fair, proportionate compensation for
 2 the injury and loss suffered as a result of the
 3 infection, with due consideration of, but without being
 4 bound by, the boundaries of entitlement to damages in
 5 law.

6 "Improving:

7 "No claimant for compensation should be worse off
 8 than they would be entitled without such a scheme, and
 9 an award of compensation should not prevent the pursuit
 10 of any entitlement to bring legal proceedings for the
 11 same subject matter."

12 Then over the page, top of the page.

13 "Complementary:

14 "Continuing payments under the existing support
 15 schemes should be continued, and made more secure
 16 regardless of any claim for, or award of, compensation."

17 I just want to stop there, sir.

18 It's not always easy for people unfamiliar with
 19 litigation or inquiries or compensation to necessarily
 20 follow what we're saying. Lawyers talk one language,
 21 the general public speak their language, and they don't
 22 always cross over very well.

23 I know this is a matter of great concern to many of
 24 our Core Participants, but they fear that if they have
 25 an award of compensation they will lose the regular

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1 payments they're receiving at the moment, and it is
 2 crucial to many people that the regular payments they
 3 receive at the moment continues into the future. And
 4 it's clear from Sir Robert's principles there that he
 5 agrees. with our clients.
 6 So, sir, that's a particularly important matter.
 7 They don't want to forgo regular payments for
 8 compensation, they want both.
 9 Continuing:
 10 "Holistic:
 11 "Compensation is not just about money, but should
 12 also include consideration of material means to
 13 compensate for what has been lost."
 14 So that's Sir Robert's recommendations.
 15 We've drawn up our own list of recommendations. To
 16 an extent it mirrors what Sir Robert has said, or maybe
 17 a slightly different way than Sir Robert has said, but,
 18 sir, we thought it would be appropriate to set out
 19 certain additions.
 20 So, firstly, the purpose of the scheme is to ensure
 21 that everyone who is entitled to compensation receives
 22 compensation.
 23 The scheme, we say, should be judge-led.
 24 The scheme must be wholly independent of government,
 25 whether UK-wide or devolved.

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1 respect of those that have not received an interim
 2 payment, to have an interim payment in the very near
 3 future. That would allow some recompense, some
 4 compensation to those who need it -- and they all need
 5 this money, sir -- but also allow a balanced view to be
 6 taken about the scheme to be set up and how the
 7 compensation is to be calculated.
 8 I continue. Those recruited to run the scheme must
 9 be provided with appropriate training in all aspects of
 10 their respective roles.
 11 Contrary to the position by Sir Robert, those who we
 12 represent would wish to have the opportunity to be
 13 legally represented going through this process, paid for
 14 by the UK Government, so that the Core Participants, or
 15 those seeking an award, can receive appropriate advice
 16 and reassurance regarding the process of seeking an
 17 award of compensation, advice regarding the various
 18 types of compensation, and support and full explanation
 19 of any decision they may have to make in respect of
 20 eligibility and quantum.
 21 It would be wholly inappropriate for the infected
 22 and affected to have to rely on the guidance and support
 23 of employees of an institution which is financed by the
 24 body paying their compensation. There's an obvious room
 25 for conflict of interest, we say, sir.

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1 We say there must be a dynamic, vigorous, and
 2 proactive approach to identifying those entitled to
 3 compensation. There should be a search for them, and
 4 all possible methods must be used.
 5 Although there may in some claims be disagreement
 6 concerning the entitlement of compensation or the amount
 7 of compensation, the process of making a claim and
 8 resolving the amount of compensation must, so far as
 9 possible, be dealt with in a non-adversarial way.
 10 The purpose of the process is one where the infected
 11 and affected are to receive the appropriate amount of
 12 compensation, not one where pressure is applied, direct
 13 or indirect, or to accept less than the claim is worth.
 14 A person seeking compensation should not be required
 15 to waive their rights to pursue litigation.
 16 The issues as to whom should receive compensation
 17 and the amount that should be paid should be resolved as
 18 soon as is reasonably practicable. However, this has to
 19 be balanced against the understandable desire of the
 20 infected and affected to have careful consideration
 21 given to their own individual case.
 22 Sir, if I can just stop there for one moment. The
 23 tension between those two things can be met to an
 24 extent, of course, by another interim payment to those
 25 who have received an interim payment already. And in

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1 People don't have to have a lawyer, but if they want
 2 one to help them, to give them advice, particularly on
 3 the compensation to be calculated, the quantum of it,
 4 then it may well assist them if they have a lawyer.
 5 Given their previous experience of the trusts and
 6 schemes, where they were treated with disdain, contempt
 7 and distrust, dealt with as beggars seeking charity, not
 8 as a person who had a right to compensation, and where
 9 those who were acquiescent in this regime might be
 10 treated more generously than those who tried to stand up
 11 for their rights, waiting for the relationship of trust
 12 to develop between those infected and affected and those
 13 seeking to administer the scheme will take a long time.
 14 In order to make sure that process of assessing the
 15 amount of compensation to be awarded proceeds as
 16 smoothly and as quickly as possible, the UK Government
 17 should finance the provision of Legal Aid and
 18 representation of the applicant.
 19 We say there are further advantages in having legal
 20 representation. Firstly, the application for
 21 compensation will necessarily require detailed
 22 consideration of the applicant's medical records, which
 23 sometimes will extend to a number of lever-arch files.
 24 This is likely to be a traumatic and upsetting process
 25 for the claimant as they are reminded of the many

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1 painful events which have occurred and which, in many
 2 cases, will continue into the future.
 3 This may be less traumatic if they are able to rely
 4 on legal representatives who already know the background
 5 to the scheme and the issues that may need to be
 6 explored in any individual case.
 7 Secondly, their medical records are likely to
 8 contain private and confidential information, unrelated
 9 to becoming infected, which should not be shared with
 10 strangers.
 11 Three, their present solicitors will have access to
 12 the medical records and they will know the issues likely
 13 to arise, and so will therefore be able to start
 14 processing their application for compensation
 15 immediately. Those who don't wish to be instructed by
 16 their present solicitors, then of course they are at
 17 liberty to instruct another solicitor.
 18 Insofar as may be necessary, the UK Government shall
 19 fund the instruction of such independent medical experts
 20 as the person claiming compensation may reasonably
 21 require. Those who receive compensation should be
 22 entitled to an annual amount -- sorry -- to an annual
 23 sum to pay a financial adviser to help them invest the
 24 compensation and to manage their financial affairs.
 25 The new scheme shall be funded by the UK Government.

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1 lower level should make initial decisions on eligibility
 2 and quantum. The adjudicators should be of such calibre
 3 as to engender in those making an application,
 4 confidence and trust in their independence and ability.
 5 Those making decisions affecting eligibility and quantum
 6 should be experienced in the assessment of damages for
 7 personal injury claims, and the assessment of relevant
 8 medical matters. They should receive training in the
 9 possible effects of the relevant diseases. They should
 10 be provided with information concerning why this
 11 disaster occurred and the devastating effect it has had
 12 and continues to have on individuals and families.
 13 They should be told of the way the infected and
 14 affected have had to fight for justice for many decades
 15 against intransigent, uncaring and defensive
 16 governments. The rules and procedures should be clear,
 17 straightforward and well publicised.
 18 Each tribunal of first instance shall be presided
 19 over by a circuit judge.
 20 **SIR BRIAN LANGSTAFF:** Why do you say that?
 21 **MR WILLIAMS:** Because --
 22 **SIR BRIAN LANGSTAFF:** The -- go ahead.
 23 **MR WILLIAMS:** For this reason. First of all, the amount of
 24 money that will be considered by the judge will be
 25 considerable, in some cases very large sums of money.

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1 The amount of money required to fund the scheme shall be
 2 provided by the UK Government on an annual basis. There
 3 will be no more reserves maintained by the body
 4 administering the scheme.
 5 The new scheme will be capable of being accessed
 6 locally to ensure that, so far as possible, a trusting
 7 relationship eventually develops over time between those
 8 administering the scheme and those receiving
 9 compensation. The scheme should be co-designed by
 10 a committee which should include representatives of the
 11 infected and affected, so as to ensure that appropriate
 12 weight is given to their interests and concerns.
 13 There should be a representative of those infected
 14 and affected on any group, subcommittee or panel
 15 involved in setting up the scheme or continuing to run
 16 it thereafter.
 17 The infected and affected should be invited to play
 18 an active and collaborative approach in the continuing
 19 development of the scheme. Every effort should be made
 20 to ensure that the infected and affected are not cut
 21 adrift or simply drift away from the tribunal or the
 22 scheme.
 23 The framework of the scheme. There should be
 24 established a judicial body known as -- this is our
 25 suggestion, sir -- the Infected Blood Tribunal. The

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1 The claimants must have confidence in the person
 2 they appear before, that they know what they're dealing
 3 with.
 4 **SIR BRIAN LANGSTAFF:** Well, that was why I asked, actually.
 5 You're proposing a tribunal. There is, in HMCTS -- the
 6 key is the "T" -- a parity, as it were, between courts
 7 and tribunals. Tribunals have the advantage, it may be
 8 said, of being less formal in their procedure, of
 9 tending to be quick and to have rules of procedure which
 10 are rather simpler than the rules of civil procedure,
 11 which as you know are quite complex and complicated.
 12 It also involves people who are dedicated to doing
 13 the particular task that they do, whereas circuit judges
 14 are either, and generally, dealing with crime in most of
 15 their career or, to some extent, in some cases, dealing
 16 with civil. There isn't an awful lot of civil
 17 litigation currently conducted, I think, in the County
 18 Courts.
 19 So it might be -- I'm just asking, really, for your
 20 reaction to this -- that if the proposal is that there
 21 be a tribunal with an appeal tribunal beyond, why
 22 shouldn't it be a tribunal judge within the Tribunal
 23 Service having the support of the senior president of
 24 tribunals, ultimately, who, as you know, is on a par to
 25 the -- almost on a par to the Lord Chief Justice?

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1 **MR WILLIAMS:** Well, sir, there are number of reasons. First
 2 of all, from a practical point of view, as the scheme
 3 develops over the years, there will be less and less
 4 hearings. There will be less and less call on circuit
 5 judges. So whilst they may be kept very busy and be on
 6 their feet in the initial few years, eventually the
 7 amount of work will diminish. So the needs of the
 8 schemes can be, we say, met by the existing circuit
 9 judges.

10 We also say this is a very important tribunal. It
 11 will be seen as such, as very important. It's very
 12 important that the Core Participants have confidence in
 13 the people they appear before. Circuit judges, their
 14 status is well known. District judges sounds somewhat
 15 less important than a circuit judge. It's a matter of
 16 appearance. It's a matter of regular knowledge and
 17 working with large personal injury claims.

18 The position seems to be at the time -- at the
 19 moment that, even though district judges do have the
 20 ability to deal with compensation --

21 **SIR BRIAN LANGSTAFF:** I wasn't really thinking of district
 22 judges who do, as you are implicitly accepting, the bulk
 23 of the civil work in County Courts; I was thinking of
 24 tribunal judges -- a special tribunal -- you're
 25 proposing a separate tribunal, a tribunal devoted

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1 matters I've raised already about knowledge of the
 2 matter they are dealing with, and the background to
 3 these claims, and it will enable them to get through
 4 this work. We believe.

5 **SIR BRIAN LANGSTAFF:** Yes, I see.

6 **MR WILLIAMS:** I'm coming to deal with High Court judges in
 7 a moment, so I wonder what comment you'll have about
 8 that but we'll see when we come to them.

9 In light of the behaviour of the trusts and schemes
 10 that previously controlled the systems for support, the
 11 hearings should be non-adversarial. Applicants should
 12 be allowed -- I'm sorry -- applications should be
 13 allowed unless there is overwhelming evidence to the
 14 contrary.

15 In respect of every decision, the tribunal must be
 16 given a judgment. All meetings should be fully minuted,
 17 all hearings should be conducted in private but be fully
 18 recorded. All correspondence, documents and minutes
 19 should be retained. The respondent, who will be allowed
 20 to have the same documents as that provided to the
 21 adjudicator, shall not be permitted to ask questions of
 22 the applicant. Many of those who have sought support in
 23 the past have been treated in a hostile, dismissive or
 24 disbelieving manner. They should not be exposed to such
 25 behaviour again.

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1 infected blood, in which case you might expect there to
 2 be judges who would be expert in that subject.

3 **MR WILLIAMS:** Well, sir, we wish to avoid what appears to
 4 have happened in the past, which is the scheme,
 5 tribunal, getting into a certain way of thinking as to
 6 how compensation should be awarded. We believe that
 7 judges coming in fresh to -- running the tribunal and
 8 then going back to their regular work will bring
 9 a breath of fresh air every time they're brought in. We
 10 don't want this to be seen simply as the same old, same
 11 old, where it's the same judges dealing with it day
 12 after day.

13 **SIR BRIAN LANGSTAFF:** So you want, as it were, a rotating
 14 panel of circuit judges?

15 **MR WILLIAMS:** Yes. So they can sit in this tribunal and
 16 then go back to their regular --

17 **SIR BRIAN LANGSTAFF:** How many weeks in a year would you
 18 expect them to be sitting?

19 **MR WILLIAMS:** Well, I won't condescend to the details of how
 20 often we should get judges to work.

21 **SIR BRIAN LANGSTAFF:** The reason I ask is because to sit
 22 meaningfully, you might have to sit for a longish
 23 period, might you not?

24 **MR WILLIAMS:** Yes, we were thinking somewhere in the order
 25 of six months. That will allow some training in the

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1 The applicant may appeal on matters of principle and
 2 quantum to a high level, where the adjudicator shall be
 3 a High Court judge.

4 It is often said, sir, that there isn't much work
 5 for High Court judges, much civil work. Well, there
 6 will be now, at least for a few years.

7 **SIR BRIAN LANGSTAFF:** Well, there is quite a lot of civil
 8 work but it's not necessarily personal injury work.

9 **MR WILLIAMS:** No.

10 **SIR BRIAN LANGSTAFF:** I think High Court judges, in my
 11 experience, have been pretty busy.

12 **MR WILLIAMS:** Well, you'd know more about that than I do,
 13 sir. If there aren't any High Court judges then we
 14 could have senior circuit judges, of course.

15 **SIR BRIAN LANGSTAFF:** Well, I think -- I shan't enter into
 16 a debate on relative merit of senior circuit judges and
 17 High Court judges for understandable reasons.

18 **MR WILLIAMS:** Well, sir, it's all about having status. The
 19 status of the judges who give --

20 **SIR BRIAN LANGSTAFF:** I understand the point.

21 **MR WILLIAMS:** Sir. There will be a positive obligation on
 22 all tribunals to complete an application within
 23 a reasonable time limit. There will be an annual audit
 24 assessing, amongst other things, the applications made,
 25 applications concluded, applications outstanding,

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1 amounts awarded.
2 Until an application is fully resolved, compensation
3 would be paid on the basis of the existing schemes,
4 however all applicants should receive a highest amount
5 currently paid to any registrant under the existing four
6 schemes.

7 How should the scheme be run? When the scheme is
8 established, all those presently registered on the four
9 existing schemes will automatically be transferred to
10 the new scheme. The scheme shall then be responsible
11 for compensation and the ongoing regular financial
12 support for payments. All new registrants shall
13 automatically be registered with the new scheme.

14 All applicants shall have the right to file
15 a statement, setting out their history, why they are
16 entitled to compensation, the extent to which they have
17 or will suffer harm and all past and future financial
18 loss together, if possible, with a schedule and list of
19 sums of sort. In addition, they will be entitled to
20 file such further lay evidence as they think fit.

21 An IBI statement should be sufficient as long as it
22 contains all or part of the relevant information sought.
23 They can file reports from such experts as they think
24 fit; the respondent can file just a brief reply.

25 It will be a matter entirely for the applicant as to

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1 "or
2 "b) a collaborative process [in respect of those not
3 yet registered] in which ..."

4 And then it sets out various things that the scheme
5 should do to help the applicant.

6 **SIR BRIAN LANGSTAFF:** The "or" there really means "and",
7 doesn't it?

8 **MR WILLIAMS:** Yes.

9 **SIR BRIAN LANGSTAFF:** Because they're not alternatives
10 really.

11 **MR WILLIAMS:** No, they're not alternatives, sir.

12 So we say that those who are registered now don't
13 have to prove anything. They're automatically
14 transferred, things carry on as they are, they apply as
15 they no doubt would once they've considered their
16 position for compensation. Those who are not yet
17 registered have to make an application.

18 If we can leave up Sir Robert's report, eligibility.

19 "Those infected and affected with HBV should be
20 awarded compensation on the same basis as though who are
21 infected and affected by HCV and/or HIV without the
22 necessity to establish that it is a serious case of
23 HBV."

24 The reference to serious cases found in
25 Recommendation 2, if we could go back a page, we say

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1 whether they give oral evidence and no adverse inference
2 can be drawn from their decision not to. It will be
3 a matter entirely for the applicant as to whether they
4 call oral evidence from any other lay witnesses or from
5 their expert witnesses.

6 We adopt Sir Robert's Recommendation 4 but with some
7 additions. So if we could just look at Sir Robert's
8 report. These start at page 33, internal numbering.

9 Sir, if we just look very briefly at 1 and 2, they
10 are matters I'm going to come back to, sir, I'd just
11 like to deal with this as a preliminary matter.
12 Recommendation 3 we'll come back to, but
13 Recommendation 4, over the page, he says this:

14 "I recommend that the scheme should, so far as
15 possible, avoid legalistic and adversarial concepts of
16 the burden and standard of proof: establishing
17 eligibility under the scheme should be either:

18 "a) automatic in the case of infected persons
19 already accepted for eligibility under the support
20 schemes."

21 We would add to that "and affected", so it would
22 then read:

23 "automatic in the case of infected or affected
24 persons already accepted for eligibility in the support
25 schemes."

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1 that -- sorry. He says that he recommends:

2 "... that the scheme should offer redress to those
3 infected with HCV and/or HIV, and defined serious cases
4 of HBV ..."

5 We invite you to say that the recommendation
6 concerning "defined serious cases of HBV" be deleted,
7 and there's simply a reference to HBV.

8 I'm not going to go through all the reasons why HBV
9 should be incorporated into this. It's been touched
10 upon in some detail yesterday by Leigh Day, and it may
11 be touched upon this afternoon by Mr Howells.

12 Next, subject to amending subparagraph (b) by
13 allowing claims for HBV as set out in Recommendation 2,
14 we say should be in Recommendation 2, by deleting
15 subparagraph (c), we adopt Sir Robert's
16 Recommendation 3. I'm sorry if that's a bit convoluted,
17 sir, but that's the way we go around these matters.

18 In light of the evidence received by the Inquiry,
19 including date of knowledge, self-sufficiency and
20 a caution that should have been exercised regarding the
21 use of blood products, given its known potential for
22 transferring viruses, the application date is
23 unnecessary. So the starting position should be dates
24 of exposure are irrelevant so long as there has been
25 exposure and so long as they've developed one of the

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1 relevant conditions.
2 If after the legal teams have met and the doctors
3 have met there's further consideration required about
4 dates, then it can be given at that time, and the
5 question of dates then become relevant. But the
6 starting position is dates are not relevant.

7 We recommend that those infected but self-cleared
8 shall be entitled to register with the new scheme.
9 Appropriate bands should be created to allow claims to
10 be made for any harm suffered, in particular any shock
11 or distress experienced on being informed that they may
12 have been exposed to contaminated blood.

13 Save that the references to age at subparagraphs
14 (b), (c) and (d) be deleted, we adopt Sir Robert's
15 Recommendation 5.

16 If we can just look at that. He recommended:
17 "... that the following relevant indirectly affected
18 persons should be admitted to the scheme ..."

19 So we have spouses, et cetera.

20 "b) children of an eligible infected person ...

21 "c) parents of eligible infected persons whose
22 eligible started in childhood;

23 "d) siblings living, while under the age of 18, as
24 a family with an eligible infected person."

25 We say that those references to age, either directly
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1 expert, states that the relevant medical procedure may
2 have involved the use of blood or blood transfusion,
3 there should be a presumption in favour of the
4 applicant. The burden [and we say it should be a heavy
5 burden] should be on the respondent to rebut that
6 presumption."

7 We now turn to the assessment of quantum of damages.

8 Sir, there are many different methods by which
9 compensation could be calculated but, ultimately, there
10 seem to be two main methods, namely a system based on
11 the common law calculations of damage -- Sir Robert
12 calls this a bespoke method -- or (2) a system based on
13 set tariffs or bands of damages in respect of most types
14 of loss.

15 Sir Robert's report analyses the pros and cons of
16 each method of compensation and they'll be well known to
17 you, sir, and it's considered various types of
18 compensation schemes in the UK and abroad.

19 Sir Robert's report adopts a more nuanced approach
20 which is primarily tariff or band based but coupled with
21 significant elements of common law principles,
22 especially in respect of the calculation of future loss
23 of earnings and future care. In addition, even in those
24 areas where compensation is banded, Sir Robert seems to
25 have allowed some wiggle room in respect of those that

1 or implicitly, should be taken out.

2 The matter people are going to be compensated for,
3 if they are compensated, is something that struck not
4 just individuals but families. It doesn't matter
5 whether you were 18 at the time or whether you're
6 a brother or a sister, were younger or older, siblings
7 will have suffered terrible hurt and shock and upset at
8 what took place. The same will be in respect of
9 parents. The same will obviously be in respect of
10 children.

11 This doesn't give a blanket of compensation to every
12 single person, but it makes it available to those who
13 have suffered harm without recourse to age limits.

14 We endorse the proposal made by Sir Robert at
15 page 132 that:

16 "... the approach of the scheme to the assessment of
17 eligibility, starting with the demands made on
18 applicants for information, should be to offer all the
19 best chance possible of establishing an entitlement,
20 rather than to be searching energetically for reasons to
21 exclude them."

22 We then continue:

23 "Where there is an absence of medical records and
24 the applicant asserts that they did receive blood
25 products or a blood transfusion, and/or a medical

1 identify a greater loss than might normally be expected.

2 Some of our clients are attracted by the idea of
3 a common law approach, individually assessed
4 compensation, a bespoke method of calculation. It
5 appears that there is a belief that, because it is
6 a bespoke approach, it is more likely to be accurate and
7 therefore must be a more generous approach than that
8 provided by the banded approach.

9 Those experienced in the common law approach to
10 compensation may think that these beliefs may be
11 misconceived. To a greater or lesser extent, the amount
12 awarded on a common law approach will be based on
13 a considerable amount of guesswork, which, in the long
14 term, probably renders it no more accurate or generous
15 than a banded approach.

16 The main problem -- so far as this scheme is
17 concerned, the main problem with the common law
18 approach, is the inevitable delay that occurs in the
19 preparation of such a case, which is likely to defer
20 considerably from every other case in nearly every
21 respect. Applying some knowledge of personal injury
22 claims, and considering the experience of the Republic
23 of Ireland, it seems to us to be inevitable that even
24 a partial resolution of these claims for compensation
25 will take a considerable time.

1 That would be intolerable to the vast majority of
2 the people that we represent and, we suspect, to
3 everyone else.
4 At recent conferences, many of our clients agreed
5 that they wished the assessment of compensation to be
6 carried out as fast and as quickly as possible. They
7 much prepared a banded approach. Having been deprived
8 of proper, appropriate or any meaningful compensation
9 and indeed, in some cases, of any compensation for many
10 decades, it would be unacceptable to introduce a further
11 delay.

12 The following remarks, sir, are primarily directed
13 to the assessment of compensation as that advanced in
14 Sir Robert's report, the banded approach.

15 If we can have the report of Sir Robert back up, and
16 once again it's internal numbering 35. So, Sir Robert's
17 recommendation:

18 "... that infections eligible for compensation
19 should be classified in the following manner:
20 "there should be defined categories for each type of
21 eligible infection, and the stages through which it
22 progresses, and for each category defined degrees of
23 severity to which a range of possible awards for the
24 impact of the disease can be applied ..."

25 The first one is that:

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1 aggravated and exemplary damages and it's a somewhat
2 specialised area. We can leave that to one side. With
3 the assistance of their lawyers, as we heard -- their
4 lawyers, you can be taken to that to see if there is any
5 merit in making such a claim.

6 We adopt Recommendation 8. That's the separate
7 awards that are made to those eligible infected. I'm
8 just going to read out the titles of the categories, but
9 no more. So he recommends an injury impact award; he
10 recommends a social impact award; he recommends a care
11 award; an autonomy award; a financial loss award.

12 Recommendation 8 is adopted.

13 So far as Recommendation 9, save for paragraph (e),
14 we also recommend paragraph 9.

15 9(e) deals with a bereavement award. That has
16 a fairly specialised meaning in common law claims. It's
17 an award given to a limited number of people and it's
18 one award which is then, as you know, sir, spread out
19 amongst the various groups. In other words, if one
20 starts with 15,000 people, and there's 15 people who
21 come in to the various categories -- unlikely to be 15,
22 but one never knows -- that's £1,000 each.

23 It's often been thought that a claim for bereavement
24 under the Fatal Accidents Act -- it's often been thought
25 that the awards are derisory and often excludes those

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1 "the stages and degrees of severity for each disease
2 should be defined by an independent clinical expert
3 advisory board, by reference to a clinical professional
4 consensus."

5 We say that the infected and affected should also
6 have representatives sat on that panel. It's
7 intolerable that for the last 40 years they've been
8 spoken about as exhibits or something to be considered
9 at a distance. It's imperative that they have some --
10 are able to provide some feedback into that committee.

11 The same in respect of (c):

12 "the range of potential awards for the impact should
13 be determined by an independent legal expert advisory
14 panel, to be consistent with what would be awarded in
15 common law personal injury litigation."

16 There, too, they should be represented.

17 It's important that all participants, all claimants,
18 feel confident that the various panels should have input
19 from, if you like, their own side, and they're entitled
20 to think of it as their own side because, for the last
21 40 years, it has been them and nearly everyone else.
22 They've fought for the right to have this award of
23 compensation; they should be represented.

24 Subject to that, we adopt Recommendation 6.

25 We adopt Recommendation 7. That deals with

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1 who most need help. Here, such an award would offer
2 very little to those who have suffered such grievous
3 loss and would be grossly insulting. As we mentioned
4 already, the outstanding feature of these claims for
5 compensation is the way in which the disease has
6 destroyed families. The effects of the diseases ran
7 through families and they still do.

8 We contend that, in respect of three categories
9 which we're going to identify, there should be a sum
10 awarded to each claimant in those categories. So not
11 15,000 divided by 15, but 15,000 -- if that's the sum,
12 and I'm not suggesting it should be for one moment --
13 then 15,000 to each claimant.

14 In fact, for obvious reasons, we say it should be
15 considerably more than £15,000 to acknowledge the very
16 great hurt -- loss of these people.

17 So we say this: we believe that a suitable sum
18 should be awarded to mark the appalling loss suffered by
19 parents, children and siblings. We recommend that each
20 parent alive at the time of the child's death,
21 regardless of the child's age, should be entitled to
22 receive a fair and equitable amount. We recommend that
23 each child should receive a similar amount in respect of
24 the death of a parent, no matter what age the child was
25 at the date of death. We recommend that each sibling

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1 should receive a similar amount, irrespective of the age
 2 of the deceased or sibling at the time of death.
 3 For the avoidance of doubt, these awards should be
 4 paid in addition to any other sum to be paid under any
 5 other head of loss.
 6 Sir, we adopt Recommendations 10, 11, 12, 13, and
 7 15. I'm not going to read them out otherwise we really
 8 will be here all day, but we adopt those recommendations
 9 as well.
 10 We also say that insurers, financial companies, must
 11 provide financial products and mortgages to those
 12 infected and affected, and any difference in premium to
 13 those who would not be infected or affected should be
 14 underwritten by the Government.
 15 We recommend that in its report, the Inquiry
 16 emphasises the need for appropriate compensation to be
 17 awarded in the following circumstances. We know that
 18 some of these categories are already dealt with by
 19 Sir Robert, but these are particular ones that concern
 20 our clients, and so we put them before you as stand
 21 alone recommendations, if you will.
 22 So first of all, where couples were warned that they
 23 should not have a child due to the risk that one or the
 24 other might be infected with one of the relevant
 25 diseases, as a result thereof they lost the opportunity

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1 adopt Recommendations 16 to 19.
 2 I just want to deal with some additional matters
 3 with future compensation. We say that once the Inquiry
 4 has reported, it is likely there will be a flurry of
 5 activity until the new scheme is up and running.
 6 Following that, it is likely that the public, press and
 7 Government's interest in the blood scandal will diminish
 8 until it becomes, I'm afraid, sir, a distant memory. We
 9 contend that, as well as an appropriate scheme of
 10 compensation, radical improvements in their healthcare
 11 and appropriate findings concerning wrongdoing, the
 12 infected and affected have the right to expect that the
 13 continued health and wellbeing of the infected and
 14 affected is supported, advanced and protected by some
 15 independent person or body to be established as soon as
 16 possible.
 17 These people who have suffered for so long should
 18 not be forgotten or cut adrift. We have invented the
 19 title of "Infected Blood Victim Commissioner" but we're
 20 open to any more manageable title than that, sir.
 21 We say the infected and affected should play a part
 22 in setting up the scheme and, thereafter, their views
 23 should be sought at regular intervals. The Commissioner
 24 should be fully funded but wholly independent from the
 25 Government, both UK and devolved. It is important that

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1 of having children, there should be an award. Where
 2 couples were warned not to continue with a pregnancy
 3 because of the risk that one or another might be
 4 infected with one of the relevant diseases and that, as
 5 a result the pregnancy was terminated, there should be
 6 an award.
 7 Where couples were warned after their child was born
 8 of the risk that one or other might have been infected
 9 with one of the relevant diseases, then whether or not
 10 the child was infected -- on second thought, I should
 11 just alter that to even where the child was not
 12 infected -- they should have an award for any shock,
 13 distress.
 14 A separate category. Women carriers of haemophilia
 15 who, in the late 1970s and early 1980s, sought advice
 16 from clinicians as to the risk of having a child and
 17 were not warned of the risk of their child developing
 18 hepatitis and/or HIV if they went ahead and had a child,
 19 and subsequently it transpired that there had been
 20 a significant risk -- and we do know there was
 21 a significant risk -- then even though the child was not
 22 infected, both parents and child could suffer
 23 significant shock, anxiety and upset, and if they did,
 24 they should be entitled to claim compensation.
 25 Sir, to the extent we've not argued otherwise, we

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1 the Commissioner is established at the outset, in order
 2 to play a constructive role in the establishing of
 3 a scheme.
 4 Sir, when we make this recommendation, we don't seek
 5 to replicate the established position of Victim
 6 Commissioner, which covers all manner of issues
 7 connected with the criminal law. Rather, we invite the
 8 Inquiry to give consideration to the role of the
 9 Commissioner of Survivors of Institutional Childhood
 10 Abuse, an independent organisation established by the
 11 Government to assist the victims and survivors following
 12 the report of the Historical Institutional Abuse Inquiry
 13 in Northern Ireland, which reported in 2017.
 14 The role of the Commissioner -- presently, we
 15 believe, Fiona Ryan -- is to empower victims and
 16 survivors to exercise their rights. The Commissioner
 17 has various statutory powers given to her, including
 18 powers to undertake or commission research, to compile
 19 information, to provide advice or information, to
 20 publish anything concerning their interests and to make
 21 representations or recommendations to any person or body
 22 concerning the interests of the victims and survivors.
 23 We recommend that a similar commissioner should be
 24 set up as soon as possible to represent the interests
 25 and to protect the wellbeing of the infected person.

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1 The Commissioner should be given a very wide discretion
2 as to how they carry out their duties, thus the
3 Commissioner should be allowed to campaign on behalf of
4 the infected and affected, should be allowed to seek
5 higher awards of compensation and should be allowed to
6 make recommendations to central or devolved governments
7 regarding all matters affecting the lives and wellbeing
8 of the infected and affected.

9 Sir, that's all we have to say about compensation.

10 I now want to turn to the issue of healthcare.

11 **SIR BRIAN LANGSTAFF:** Just a question, if I may, about
12 compensation. The principle which Sir Robert sets out
13 is that whatever scheme there may be, the monetary side
14 of it won't be out of step with what he calls common law
15 damages. He recognises that he is an expert in the law
16 of England and Wales. Now, you are here representing --
17 you're not representing Scotland, where the legal system
18 is a little different and the Inquiry has taken advice
19 on what the Scottish position on damages is. But can
20 you help me with Northern Ireland at all? You may not
21 be able to. If you can't, then please by all means, add
22 this later.

23 But am I right or wrong in thinking that the
24 guidelines for the assessment of personal damages which
25 apply to England and Wales, may not apply with the same

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1 detail. I'm not going to go through all of them but
2 I just want to go through some of the major ones which
3 will directly affect our clients.

4 So, healthcare.

5 In the UK and devolved governments, must establish
6 multidisciplinary centres of excellence for the
7 treatment of persons infected by the treatment of blood
8 and blood products. Such centres should provide access
9 to all medical advice, including consultant haematology,
10 consultant neurology, they can receive treatment for
11 dentistry and also specialist social work support that
12 is commonly required by those who have been infected
13 with HIV or hepatitis, with routine consideration being
14 given to whether any referral should be prioritised.

15 Further, the Department of Work and Pensions should
16 undertake assessments for the purpose of applications
17 for personal independence payments at such centres, and
18 be provided with bespoke training to the assessors who
19 will be carrying out such assessments, drawing upon
20 advice from the practitioners who operate from
21 specialist centres.

22 Second, a scheme for or rapid transfer to
23 multidisciplinary centres should be arranged from other
24 outlying hospitals. It's been drawn to our attention
25 that in Northern Ireland this is a particular problem.

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1 force in Northern Ireland?

2 **MR WILLIAMS:** Well, sir, I have some knowledge, and with
3 Mr Howells, and your experience is the same as ours.
4 They're not the same as the damages awarded in England
5 and Ireland, the amounts suggested are not as cast in
6 stone as they are here and, more interestingly to our
7 clients, they tend to be more generous than they are in
8 England and Wales.

9 As far as that is concerned, that's as far as I can
10 take it. We will, of course, if you wish, file further
11 written submissions about the differences between
12 Northern Ireland and Wales.

13 **SIR BRIAN LANGSTAFF:** The expression "common law" would
14 apply to England, to Wales and probably to Northern
15 Ireland, but it wouldn't necessarily apply to Scotland,
16 would it?

17 **MR WILLIAMS:** I don't know, sir. Tomorrow you have before
18 you the --

19 **SIR BRIAN LANGSTAFF:** Well, I can ask Mr Dawson.

20 **MR WILLIAMS:** I think that's the best thing.

21 **SIR BRIAN LANGSTAFF:** Yes.

22 **MR WILLIAMS:** Now, as I said, I'd like to look at
23 recommendations for healthcare. We have set out quite
24 a lot of them. They go from page 93 of our written
25 submissions, and they're set out in some considerable

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1 There is the main hospital, which under the scheme would
2 be roughly in Belfast. It is slightly skewed because it
3 is far to the right and there are many people who are
4 far to the left, and so some scheme has to be developed
5 for rapid movement in serious cases or in those where
6 it's thought it might develop into a serious case.

7 The UK and devolved Government should make available
8 specialist mental health services to persons infected by
9 blood and blood products and those affected by such
10 infections at trust or health board independent of the
11 trust or health board who treated the infected person
12 when they became infected. That's not mandatory, sir,
13 it's a matter for the person who seeks treatment as to
14 whether they wish to go to a new hospital or whether
15 they attempt to go to the hospital where they were
16 treated.

17 They must also establish a UK-wide system of
18 counselling for those infected and affected by blood and
19 blood products. The system should be accessible
20 throughout the UK, whenever and wherever the person may
21 require it. The UK and devolved governments should
22 design and implement a scheme which will confirm that
23 a person has been infected by blood or blood products.
24 This should be done in two ways. These are not
25 alternatives. It should be done in both.

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1 First of all, a health card would be issued to every
2 person affected by blood or blood products. Its
3 appearance will be similar to that of a credit card.
4 The production of this card will alert a healthcare
5 employee that the holder of the card has been infected
6 with infected blood. To maintain confidentiality, there
7 will be nothing on it to indicate the purpose of this
8 card. This card will be sufficient for a person to
9 require priority treatment.

10 Secondly, the UK and devolved governments should
11 design and implement a health passport for persons
12 infected by blood and blood products, so that upon
13 presentation, a healthcare employee can see: (i) the
14 statement of the fact that the person was infected by
15 blood or blood products; (ii) the current status of the
16 person's infection, presently infected, cleared or
17 suppressed, et cetera; (iii) the person's illnesses,
18 symptoms and treatment side effects; (iv) the person's
19 treatment regime; (v) medicines that should not be
20 prescribed; (vi) if applicable the severity of the
21 person's haemophilia or whatever existing disease he
22 has, or she has, and its complications; and (vii) the
23 necessary destination for ambulatory services, so
24 paramedics will be provided with information and
25 training in relation to the health passport.

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1 and brain disease, including but not limited to
2 cognitive impairment, strokes and dementia.

3 As an adjunct to this is recommendation, clear
4 guidance should be published by the Royal College of
5 Pathologists on the decision to perform and conduct an
6 autopsy of the brain for the purposes of such research.

7 The UK Health Department should ensure that
8 treatment for HIV is available at a place other than
9 a GUM clinic for those who are infected through blood
10 and blood products.

11 The UK Health Department should ensure that a person
12 infected with hepatitis C through blood or blood
13 products is offered an appointment with a hepatologist
14 and routine FibroScans every six to 12 months as
15 appropriate.

16 Blood transfusion practice. Where a clinician or
17 health professional has administered or authorised
18 a blood transfusion in contravention of the guidance
19 contained within JPAC's transfusion handbook, this
20 should be prima facie evidence for any GMC/NMC referral.

21 The implementation of SHOT and SaBTO's
22 recommendations by NHS Trusts and local health boards
23 should be monitored by the Health Department, with
24 a failure to comply being prima facie evidence of the
25 Trust or health board needing to go into special

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1 The health passport would require regular updating
2 by the treating clinicians and should appear in
3 a prominent way when the person's records are accessed
4 digitally. It can also be provided in hard copy to the
5 infected person. The digital passport should work
6 across all the UK health departments so that a person
7 usually resident in one part of the UK is not
8 disadvantaged if they need to access health care
9 provision in another part of the UK.

10 The UK health departments should adapt the criteria
11 for organ transplants so that: (i) persons infected by
12 blood or blood products are able to receive a liver
13 transplant after the age of 70; (ii) prioritisation
14 criteria which disproportionately affect persons
15 infected by blood and blood products should be
16 identified, or disapplied in their cases; (iii) the fact
17 that a person was infected by blood or blood products
18 should be a criterion which is adopted so that it leads
19 to a greater prioritisation, bearing in mind that liver
20 failure depends more -- sorry, liver failure develops
21 more quickly in persons affected with hepatitis C than
22 other causes, and they may have been infected for
23 decades.

24 The Medical Research Council should establish and
25 fund research into the association between hepatitis C

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1 measures.

2 The UK Health Department should fund the
3 implementation of a standalone electronic system which
4 provides: the integration of GP and hospital systems;
5 the integration of systems between health boards and
6 trusts; allows data to be collected by the UKHSA, SaBTO,
7 JPAC and SHOT; and allows a single reporting portal for
8 serious adverse events, serious adverse reactions,
9 near misses, TTIs, and any other relevant information
10 concerning transfusions.

11 Medical schools should be required to cover
12 haemovigilance as part of the curriculum and GMC should
13 be able to veto curricula developed by medical schools
14 in order to provide recommendations for improvement.

15 Where any health care practitioner administering
16 a blood transfusion fails to: (i) ensure the patient
17 consents to the transfusion -- and by that we mean
18 proper, full and informed consent; (ii) fails to record
19 the patient's consent; (iii) fails to record the
20 transfusion is compatible with a patient; and (iv)
21 record the justification for the transfusion, this
22 should be prima facie evidence for a GMC and/or NMC
23 referral.

24 The UK Health Departments should ensure that
25 hospital transfusion committees: (i) complete annual

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1 audits to determine which blood products are being used,
2 in what quantity, and by which departments; (ii) record
3 the number of transfusion reactions, transfusion
4 incompatibility incidents, bacterial infection, viral
5 infections, and such other adverse reactions as a result
6 of the provision of blood or blood products, however
7 long after the transfusion they present; and report the
8 same to SHOT.

9 The UK Health Departments should adopt into guidance
10 the recommendations contained within SHOT and SaBTO's
11 annual reports. That should be automatic, it shouldn't
12 require further legislation.

13 Sir, I think that's as far as I can take the
14 recommendations in respect of future medical treatment.
15 There are others, as you know, but I'm not convinced
16 that it would take the matter very much further this
17 morning.

18 Sir, I see the time. We are a little early this
19 time, but I'm just about to go on to past care and
20 I believe that might take me some time.

21 **SIR BRIAN LANGSTAFF:** Yes. Well, let us take a break now
22 then, shall we. Now, would 1.50 suit you?

23 **MR WILLIAMS:** Any time would be suitable. I think everyone
24 here, and I'm sure the listeners, would like to get on
25 with this sooner rather than later, so I'm quite happy

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1 misconduct. Before I go specifically to the trusts and
2 schemes, I just want to open that bracket a bit wider,
3 because the trusts and schemes, or at least these
4 particular ones, took their lead from the Department of
5 Health, and so it's important to know the type of person
6 who would be in charge of the Department of Health.

7 So we're going to return to Edwina Currie. She was
8 in the junior ministry. The excerpt of a letter that
9 we're going to look at was, I think, written before she
10 resigned, or was sacked, and you'll see what she says.

11 So this is to Ms -- "Dear Mrs Grindley -- can I just
12 say, sir, we have Mrs Grindley here -- over there --
13 a stalwart campaigner on behalf of the haemophilia
14 cohort, husband died as a result of infection. And
15 she's been a regular correspondent with the Inquiry,
16 putting good questions and good issues which she wanted
17 raised.

18 So, 23 March 1987.

19 "Dear Mrs Grindley,

20 "Mrs Currie has asked me to thank you for your
21 letter of 13 February about her remarks on 12 February
22 about AIDS. She has asked me to reply.

23 "I am sorry that you do not agree with what she
24 said. We are very concerned about the dangers of AIDS.
25 There is no cure or vaccine, no prospect that either

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1 if we start again at 1.30.

2 **SIR BRIAN LANGSTAFF:** Well, I think that may be a little
3 early. People have to have their lunch and, if
4 necessary, stretch their legs. Yes, I've seen people
5 nodding in agreement with you, sir.

6 So we'll go with the public.

7 **SIR BRIAN LANGSTAFF:** So I think we'll stick with 1.50,
8 shall we?

9 **MR WILLIAMS:** Very well, sir.

10 (12.52 pm)

11 (The Luncheon Adjournment)

12 (1.50 pm)

13 **SIR BRIAN LANGSTAFF:** Yes.

14 **MR WILLIAMS:** Sir, I was told two things over the luncheon
15 adjournment. One is, some of my clients can't hear me
16 because I'm talking too quietly, which I find a little
17 surprising but there we are. The other is that
18 Mr Howells would like me to hurry up because he wants to
19 make his part of the submissions. I'll leave it to you
20 to decide which was predictable and which wasn't.

21 **SIR BRIAN LANGSTAFF:** Juniors always were like that!

22 **MR WILLIAMS:** Not in my experience, they weren't, sir.
23 Anyway.

24 The heading on the next and final item is previous
25 trusts and schemes, which is about their conduct, or

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1 will be developed for some years. The government is
2 supporting research and funding a wide-ranging public
3 education campaign to bring home the threat that AIDS
4 poses to us all. It is essential that the message is
5 put across clearly, at every opportunity, that the only
6 way to stop AIDS spreading is for all our people to
7 behave responsibly."

8 "Mrs Currie has asked me to thank you for your
9 letter of 13 February about her remarks of 12th February
10 about AIDS."

11 Sorry, I'm repeating myself.

12 It goes down to the last but one paragraph:

13 "I understand that you take particular exception to
14 Mrs Currie's reminder about good Christian people not
15 catching the disease. She had in mind merely that, for
16 most people, a responsible and caring way of life should
17 protect them and their loved ones from the threat of
18 AIDS in the future.

19 "Thank you for taking the time to write about this
20 important matter."

21 That's an astonishing letter for a minister in the
22 Health Department to write. It's grossly insulting to
23 many groups. One gets a hint of homophobia there. It's
24 insulting to people who don't lead a "good Christian
25 life". It suggests that if you have HIV that maybe you

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1 don't lead a good Christian life. It suggests that --
2 this sounds positively medieval -- but if you are a good
3 Christian, that will stop you getting HIV.

4 There's not an awful lot more for me to say about
5 that letter. It speaks for itself and what it says is
6 dreadful.

7 So put that to one side and let's go back if we may
8 to the previous trusts and schemes. Thank you,
9 Lawrence.

10 So this section will comment upon the purposes for
11 which the trusts and schemes were set up, whether they
12 supported the infected and affected, the manner in which
13 the trusts and schemes treated them, and the extent to
14 which they operated in an open and fair manner.

15 They operated along similar lines, often using the
16 same staff, especially at a senior manager level. For
17 the most part we did not intend to consider each scheme
18 separately, rather we will take an overview of the
19 schemes. Given the time that has elapsed since the
20 closure of the old schemes, the setting up of the
21 present schemes and with the prospect that a wholly new
22 compensation scheme will be devised, we have no
23 recommendations to make on the issues arising under this
24 particular heading.

25 I should perhaps have added a sentence, "But please
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1 the activities of the schemes. The schemes operated as
2 if they were an extension of the DoH, whilst keeping the
3 registrants at arms-length. They did not seek to
4 protect the beneficiaries, rather, they sought to
5 protect the Department of Health.

6 We then set out some examples.

7 In any dispute regarding the beneficiaries and the
8 Department of Health, the schemes took the side of the
9 Department of Health.

10 The schemes were not accountable to the
11 beneficiaries, or at least they acted as if they
12 weren't. Rather, they appear to have decided that they
13 were accountable only to the Department of Health.

14 They declined to raise issues which might have
15 caused embarrassment to the Department of Health. They
16 appear to have decided that they would not rock the
17 boat.

18 They refused to promote or advertise the schemes,
19 preferring any potential applicants to find them.

20 They refused to campaign for the infected and
21 affected, in particular for more money from the
22 Department of Health or seek any public contributions.

23 They refused to campaign for greater social and
24 health support for the infected or affected.

25 Those who controlled the schemes, the chair, the
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1 make sure that no one ever behaves as badly as these
2 people did."

3 We have extracted from the evidence of the infected
4 and affected their comments about their dealings with
5 the schemes. We also have relied upon the evidence of
6 employees of the schemes. I'll just name them so you
7 can see we've taken a fairly widespread view, Ann Lloyd,
8 Nick Fish, Mark Mildred, Russell Mischon, Susan Daniels,
9 Ann Hithersay and Jude Cohen, although there are others
10 as well.

11 We do, however, invite the Inquiry to make the
12 following findings -- so no recommendations but
13 findings:

14 That the purpose of creating these schemes was not
15 to provide meaningful and appropriate support for the
16 infected and affected, rather, they were used by the
17 UK Government as a means of avoiding any investigation
18 into this medical disaster, whilst at the same time
19 appearing to provide some support to certain categories
20 of those infected and affected.

21 That the schemes were used as a smokescreen to cover
22 up the lack of any meaningful, financial or other
23 support.

24 That the use of arm's-length bodies was a device by
25 which the UK Government could cover up their control of
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1 deputy chair, the trustees, took their lead from the
2 Department of Health, and from the civil servants that
3 sat on the boards.

4 They followed what they regard as the Department of
5 Health's line. So, by way of an example, they built up
6 reserves of money when told, they reduced the Reserves
7 of money when told, and they didn't object when told
8 transfer the remaining funds to the Terence Higgins
9 Trust, even though the beneficiaries of those schemes
10 wanted the funds to be distributed to them.

11 They didn't seek to empower the infected and
12 affected.

13 The agonisingly slow speed at which the various
14 schemes developed illustrates the uncaring attitude of
15 the UK Government.

16 We say the schemes were run in an *ad hoc*, careless,
17 inefficient, bizarre and illogical manner. So by way of
18 example, they employed people who for the most part had
19 no previous experience of medical matters, let alone any
20 knowledge of HIV or hepatitis. They employed people who
21 for the most part had no previous experience of
22 exercising any sort of discretion to decide whether or
23 not an applicant should receive support or not.

24 They employed such people without providing any
25 induction into their roles. They appear to have been
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1 expected to learn what they were supposed to do as they
2 carried out their tasks.

3 Most had little experience of financial matters.
4 They were expected to decide whether a beneficiary
5 should be supported by helping the person to buy their
6 own home on a mortgage. And if so, would it be by
7 making a grant, by a loan, or taking a mortgage on the
8 property or by some other means?

9 In finance, they don't seem to have had any fixed
10 policy as to whether -- where it was financed by a loan
11 or mortgage, whether it was transferable. They made
12 their decisions on the hoof.

13 The beneficiaries were expected to get two
14 quotations for every item or piece of work which they
15 needed to be paid for, no matter how small. The schemes
16 could refuse the request, might require lower quotations
17 to be obtained, or allow part of the request but require
18 the beneficiary to pay the balance. This process, which
19 was not required under the terms of the Trust, could
20 cause, and would cause, maximum delay, maximum
21 frustration, distress and upset.

22 There was no attempt to identify and reach out to
23 the infected and affected to alert them that they and
24 their family might be entitled to support.

25 The evidence that the Inquiry has received in

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1 Just stopping there for one moment. They seem to
2 have broken nearly every rule that you'd use to create
3 a court, a tribunal, something to be heard and where
4 a judicial type of decision should be made. Excluded
5 every possible avenue of contact.

6 The receipt of blood had to be confirmed by an
7 applicant's medical notes. It was not sufficient that
8 the applicant or their doctor confirmed that blood was
9 or was likely to have been used.

10 No record was kept of the consideration of the
11 claim.

12 If a medical opinion was sought, then it was done on
13 an *ad hoc*, informal and unreported basis.

14 For the most part there was no one who could advise
15 them on benefits.

16 There were no regional support workers.

17 There was no long-term plan as to how the schemes
18 could be developed to provide support for the infected
19 and affected.

20 The amount of money paid was very low. The amounts
21 paid were inconsistent between one registrant and
22 another, notwithstanding they wanted the same item.

23 The registrants were expected to apply for support
24 from other sources before applying to the schemes. This
25 wasn't a requirement in the documents setting up the

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1 respect of widows is that they made no attempt to
2 contact the widows because they thought that they would
3 have known about the various schemes by keeping in
4 contact with the haemophiliac centres after the death of
5 their husbands. This is an absurd approach to keep in
6 contact with the infected or affected. These are women
7 whose husbands were -- I was going to use the emotive
8 term "killed", but that -- I'll use a lesser term -- who
9 were responsible for the deaths of their husbands, and
10 they seem to have thought that they would remain in
11 contact with the hospital. It's preposterous.

12 There were no fixed criteria to be used to decide
13 whether an application for support should be granted.

14 There were no secretarial resources.

15 The applicant couldn't support their application
16 with a statement or photograph.

17 The applicant could not support their application
18 with medical evidence.

19 Often, there was no forum on the schemes' websites,
20 or if there had been one it was shut down when people
21 became too critical of the schemes.

22 The applicant was not entitled to attend the meeting
23 when their application was considered.

24 The applicant was not entitled to give oral
25 evidence.

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1 schemes; it's just a rule they decided to impose. The
2 net effect of this was that, once again the application
3 of schemes was unnecessarily delayed.

4 The applicant was not informed as to why their
5 application had failed.

6 The applicant was not informed what additional
7 document, if it had been provided, would have allowed
8 the application to be successful.

9 Whether deliberately or otherwise, those in charge
10 of the schemes didn't try to develop or encourage
11 a meaningful, constructive relationship with the
12 infected or affected. On occasions, those in charge of
13 the schemes would act in a deliberately awkward and
14 obstructive manner, and we will come to examples of that
15 shortly.

16 The schemes made no attempt to contact or in any
17 constructive way communicate with the registrants. The
18 schemes refused to publish any information or guidance
19 regarding the discretionary items that could be claimed
20 or the amount that would be allowed. They seem to have
21 thought that the registrants could not be trusted, that
22 such was their character that they would make a claim
23 for everything they could and for the maximum amount
24 available.

25 They were concerned that if they published such

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1 a list, the "great unwashed", as these people were
2 described, would use it as a shopping list. What
3 an appalling attitude to bring to the distribution of
4 funds, even the minimum money that was available, in
5 dealing with these applications, and these badly hurt
6 people.

7 The approach about the question of shopping lists is
8 somewhat ironic, given the fact that the only evidence
9 of dishonesty is that of Foster, an employee of the
10 schemes, who carried out a wholly unsophisticated fraud
11 by paying cheques to the value of £400,000 to himself.
12 Despite the absence of any evidence or indeed allegation
13 of dishonesty on the part of the infected or affected,
14 it appears to be them who were made subject to more
15 stringent conditions.

16 The registrants were not invited to take part in any
17 important meetings with the trustees or representatives
18 of the Department of Health. There was, for the most
19 part, no newsletter, no partnership group. Their
20 address -- and you'll remember the evidence of
21 Mr Peter Stevens, who we'll come to in one moment in
22 more detail -- their address was kept a secret because
23 they didn't want unwanted callers.

24 That's you they didn't want.

25 **SIR BRIAN LANGSTAFF:** (unclear) -- there was, for a while,
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1 Eileen Trust is an odd body on these trusts and schemes.
2 There seemed to have been an element of class -- that
3 would be the next point I was going to make any way --
4 an element of class, because the people going to the
5 Eileen Trust would have been perhaps middle class,
6 perhaps working class.

7 Those going to the other trusts and schemes would
8 often be working class people. They'd often not have
9 very much money because they'd been affected by
10 haemophilia for many years or they would be seeking
11 support from the trusts and not receive them.

12 **SIR BRIAN LANGSTAFF:** I follow that they may have been lower
13 income but is it not the case that the diseases hit
14 without reference to the class of the recipient, but
15 across the board. It may have resulted in those who
16 were given the infections losing a source of income
17 which they previously enjoyed but the actual infection
18 didn't discriminate on a class basis, did it?

19 **MR WILLIAMS:** Well, there are some hints that it might have
20 been. So if I can just go on for one moment. It's the
21 next point.

22 It is noted -- noticeable that employees comment on
23 the fact that a number of chairs, trustees and board
24 members were middle-class men, well off, from
25 a professional background, such as finance, or from the

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1 a partnership group.

2 **MR WILLIAMS:** There was, which is why --

3 **SIR BRIAN LANGSTAFF:** (unclear) -- in any case.

4 **MR WILLIAMS:** I'm terribly sorry for interrupting you.

5 There was, at various stages, which I think is why
6 I prefaced, I hope, my remarks about, "for the most
7 part" or "for most of the time".

8 **SIR BRIAN LANGSTAFF:** I wasn't sure whether that most of the
9 time covered the partnership group --

10 **MR WILLIAMS:** Yes.

11 **SIR BRIAN LANGSTAFF:** -- because in your written submissions
12 it doesn't.

13 **MR WILLIAMS:** Yes.

14 **SIR BRIAN LANGSTAFF:** But I understand the point that there
15 wasn't one for most of the time.

16 **MR WILLIAMS:** Yes.

17 **SIR BRIAN LANGSTAFF:** In the same vein, you say that the
18 schemes made no attempt to contact or in any
19 constructive way communicate with the registrants.
20 There's some evidence, is there not, that the Macfarlane
21 Trust did have away days or weekends, at least early on,
22 with those who were members of the scheme, and that the
23 Eileen Trust did too.

24 **MR WILLIAMS:** Yes, there is evidence about the Macfarlane
25 Trust about that, although that soon petered out. The

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1 military. Cohen, one of the witnesses, suggests that
2 they liked the feeling of power. A number of employees
3 commented on their lack of empathy and sympathy because
4 the people they were dealing with came from a different
5 class.

6 Make of that as you will, sir, but there's certainly
7 more than a hint that the difference in classes between
8 professional, middle-class men who were running the
9 schemes dealt with working-class men, in particular,
10 very badly.

11 **SIR BRIAN LANGSTAFF:** I understand the point about the
12 constitution of the Trust board or the company board,
13 whichever it was. That I do understand.

14 **MR WILLIAMS:** Yes.

15 **SIR BRIAN LANGSTAFF:** They may not have found it as easy to
16 deal with people who did not share their background.
17 That I also understand.

18 **MR WILLIAMS:** In which case, they shouldn't have been there.
19 If they can't deal with the people --

20 **SIR BRIAN LANGSTAFF:** Yes, that's fair. I am going to stop
21 interrupting. My apologies.

22 **MR WILLIAMS:** Yes.

23 Well, there we are, sir. It's a matter which is
24 bought to our attention.

25 **SIR BRIAN LANGSTAFF:** Well, I have the submission that the

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1 board should have been more representative.
 2 **MR WILLIAMS:** Yes, or just behaved themselves, behaved
 3 accordingly.
 4 **SIR BRIAN LANGSTAFF:** I understand that point too, very
 5 well.
 6 **MR WILLIAMS:** So, sir, I'd just like to, as a last point,
 7 deal with a particular family. It's the Lewis family
 8 from Cardiff. So perhaps we can have the photo of Mr
 9 and Mrs Lewis up, please. There we are.
 10 Ladies and gentlemen, this photograph has been
 11 produced before. That's Haydn Lewis with his wife.
 12 There's also a picture which we don't need to turn to,
 13 of Gareth Lewis. Gareth was Haydn's brother. They
 14 lived in Cardiff. Haydn and Gareth developed HIV and
 15 hepatitis C.
 16 They had received that whilst being treated by
 17 Dr Bloom at the University Hospital. Haydn wasn't
 18 immediately told that he had HIV, as a result of which
 19 he infected his wife, that's Gaynor Lewis. They had two
 20 children. Fortunately, the children survive and so does
 21 Mrs Lewis.
 22 At a very early stage, particularly Haydn but also
 23 Gareth, became involved in campaigning for the rights of
 24 the infected and affected. The prompt for that seems to
 25 have been the result of the death of a young boy in the
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1 more -- sorry. That makes his behaviour that much more
 2 surprising.
 3 I want to deal with the cross-examination of Gaynor.
 4 So this is the transcript, sir, 26 July 2019, of
 5 Gaynor Lewis. She deals with a number of things. As we
 6 will see.
 7 So the question -- I think it was Ms Richards who
 8 was conducting the questioning:
 9 "I just want to ask you, as the last area of
 10 questioning that I have for you, about the Macfarlane
 11 Trust.
 12 "Mmm.
 13 "Haydn had a lot of dealings over the years with the
 14 Macfarlane Trust. You've described them in your
 15 statement from your own perspective as terrible to deal
 16 with?
 17 "Mmm.
 18 "An uphill battle with obstacles in the way and
 19 Haydn was particularly concerned that they weren't
 20 providing enough financial help and support.
 21 "That's right and there was one time when we moved
 22 to the house we're now in, there was work being done,
 23 a downstairs bathroom. We called them adaptations but
 24 the Macfarlane Trust would see it as renovations and the
 25 council would pay so much towards the work but there was
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1 clinic. We've had his name, Colin. Such was the
 2 distress they felt was they thought they should do
 3 something about it. So the two of them set up the
 4 Birchgrove Group, in the Birchgrove pub, and that went
 5 on to be the Birchgrove organisation more generally, and
 6 then I think became Tainted Blood.
 7 Although, from the descriptions we've had, Gareth
 8 was a somewhat fiery individual, Haydn was less so.
 9 Haydn has been described as a thoughtful, polite,
 10 hardworking young man. Unfortunately, because he was
 11 a campaigner, he seems to have fallen foul of
 12 Mr Peter Stevens. Mr Stevens -- a degree from Oxford
 13 University, obviously very clever -- became a financial
 14 analyst during the course of his professional career,
 15 became a trustee of the Macfarlane Trust in -- if I can
 16 read my writing -- '87. He then sat on nearly every
 17 board that was dealing with compensation -- well,
 18 dealing with support, and he ended up a director of the
 19 Skipton Fund.
 20 For reasons which are inexplicable, Mr Stevens,
 21 treated Mr Haydn Lewis in a terrible manner.
 22 In making these remarks, I bear in mind that
 23 Mr Stevens also suffered grievous loss in this medical
 24 disaster, with at least one son infected and one son
 25 infected who died. That makes his behaviour even
 98

1 5,000 needed and we asked or Haydn asked for the money
 2 and this was bouncing back and forth for a couple of
 3 months, I think. And Fran rang one day and said, 'We've
 4 had a meeting and I'm sorry you can't have it' [the
 5 money]. I burst into tears because I could see the work
 6 being done, it was boosting him and giving him something
 7 to get up for, you know.
 8 "So I burst into tears and she said 'I'll phone you
 9 back, hang on', they changed their mind just like that.
 10 What if I hadn't burst into tears? What about all those
 11 other people that just accept it? No, they were awful."
 12 So we say that was appalling behaviour. There
 13 either is a rule that they apply, and guidance that they
 14 apply, or there isn't. But they're persuaded to go one
 15 way not the other because of whatever reasons they had
 16 for not advancing the money to Mr Haydn Lewis, and then
 17 they changed because a woman cries. As she herself
 18 says, what if she hadn't cried? They wouldn't have got
 19 the money, they'd have had a building half finished.
 20 Then Ms Richards goes on:
 21 "We're going to look first of all at a letter and
 22 then at some emails.
 23 "The letter is 2368009, please ...
 24 "This a letter dated 30 April 1996, from the
 25 Macfarlane Trust. It's addressed to Dr Dasani and it
 100

1 says this ..."

2 I should explain, Dr Dasani was one of the main

3 people in charge of the haemophilic --

4 Only two more days then you can have your phone on

5 whenever you like!

6 Dr Dasani was one of the doctors in charge at the

7 Cardiff haemophilia centre. It says:

8 "Dr Dasani, your patient shown above has made

9 a request to the Trust for the financial assistance,

10 which will be considered by our trustees at their

11 meeting in three weeks' time. Since on present policy

12 single payments are almost invariably health related the

13 trustees have decided that the anonymous case summaries

14 which they receive in advance of their meetings should

15 contain up-to-date health information gathered in

16 a consistent fashion. To meet this aim where the health

17 information held on a particular patient is older than

18 six months a doctor's report will be requested.'

19 "Then there's reference to how often doctors might

20 be asked to provide information. Then it says this:

21 "All the information contained in the completed

22 report will be treated as given in confidence to the

23 Trust and will not be shared with the patient

24 concerned."

25 Gaynor: "It doesn't surprise me.

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1 witnesses an infected intimate?

2 "Yeah, nice.

3 "We see -- thank you for explaining the context. We

4 see what the email is."

5 So a quotation:

6 "Martin, what's with these people?

7 "Funnily enough, when you set it out as you have

8 done it makes one wonder why infected intimates are

9 treated exactly as registrants, since they do not have

10 haemophilia to worry about. We might see if we can

11 review that when we get round to looking at regpay

12 [which I'm reliably informed were the regular payments

13 that were made] at the NSSC (that would be a way of

14 pissing off the Lewis contingent)."

15 Unbelievable, sir, that someone could write about

16 that with one brother infected with HIV, hepatitis B,

17 the other brother also infected, and he knew that Gaynor

18 also had HIV.

19 "The second email we're going to look at is the

20 second page, please ... We'll just look at the top,

21 first of all. The context here is an email here from

22 Haydn referred to a meeting he'd attended where he had

23 lost his temper and it's an email in which he says he

24 was so angry and frustrated with the meeting, he was

25 unable to make his point and get any sensible answers,

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1 "Were you aware the Macfarlane Trust was asking for

2 confidential medical reports --

3 "No.

4 "-- the contents of which wouldn't be shared with

5 you?

6 "No."

7 Once again, sir, it hardly needs saying, what

8 appalling conduct. They're getting secret reports from

9 a patient and getting a doctor to conspire in that by

10 not telling their client -- sorry, their patient -- what

11 they're doing. Then it says:

12 "Could we have up on the screen, please ... 2368016.

13 "We're going to look at some details between Martin

14 Harvey, Chief Executive of the Macfarlane Trust, and

15 Peter Stevens, Chair of ..."

16 Then Gaynor intervenes:

17 "Can I just say that before -- well, before we read

18 this, the context of this is that Haydn -- I didn't --

19 kept the £20,000 when the first payment and my boys

20 didn't get the Category G payment either so Haydn was

21 talking to the Trust. He didn't want a penny more or

22 a penny less, only what we deserved and this is the

23 outcome."

24 Ms Richards: "You were what the Trust termed and the

25 Inquiry has heard the phrase before in relation to other

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1 and he lost his temper and he says in the email at the

2 top:

3 "I would like to apologise to all present at the

4 meeting."

5 That's Haydn apologising.

6 "Then he says this:

7 "I ended the matter with a statement of never

8 writing to either the Chairman or the [Chief Executive]

9 again which is a sad conclusion to the whole matter.

10 What I am even sadder about is that the Chairman and CE

11 don't even seem to care that one registrant has now lost

12 all faith in the honesty and integrity of those involved

13 and I'm left with no way of contacting the Trust with

14 any belief of what they will tell me is true.'

15 "Then further on he adds that you will now be

16 dealing with the Trust on behalf of both of them."

17 So, that's Gaynor will be dealing with them.

18 "Then if we go down to the bottom email, please

19 [then Ms Richards reads it out]. It's from Peter

20 Stevens to Martin Harvey:

21 "Martin, as I prepare to go to bed I recall

22 that I shall never have a private email from Haydn Lewis

23 again. Oh happy day! (Indeed, Calloo! Callay! but

24 I have not yet discovered whether you, too, nurse

25 a Lewis Carroll streak).

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1 "Otherwise, what a monumental waste of time -- not
2 just this afternoon, but all the previous hours spent
3 nurturing that lot of moaners. As [and then there is
4 a reference to an individual] said, there are some
5 people who want to get on with their lives. However,
6 I guess we just have to persevere. Peter.'

7 "The third email that you have provided to the
8 Inquiry, Gaynor, is the fifth page, please ...

9 "We can see again the context here is an email from
10 Haydn to Peter Stevens. I should say that these emails
11 are all from 2004 and it's an email in which Haydn sets
12 out number of matters that he is asking to be
13 considered. We might go through the detail of that. We
14 can see the context from the email itself. We can go to
15 the bottom of the page, please, from Peter Stevens to
16 Martin Harvey:

17 "'Martin, notwithstanding the heading' -- the
18 heading being 'Private letter chairman MFT' --
19 'I thought you'd love to join me in starting the week
20 with an insight into the thoughts of Haydn Lewis.

21 "I shall try to compose a reply in the course of
22 the day. I shall point out to him that I am unable to
23 provide him with information about expenses without
24 asking you.

25 "'It's irritating that someboyd [sic] so thick can
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1 exchanges. It's not specifically directed at any issues
2 relating to Haydn, but it just says this:
3 "Nobody will argue with the sentiment that whatever
4 the amount of money available, registrants do not get
5 sufficient financial support (to recompense for what has
6 happened to them) and that each and every one of them
7 would swap their MFT involvement for a clean bill of
8 health'."

9 That was true, but why were they writing to each
10 other those disgusting letters and emails? Was Haydn
11 a bad man? Was he uncouth? Was he rude to them?

12 Many of you will remember him. If not, we have
13 evidence about the sort of character he was. In
14 a moment we're going to see an interview that was
15 conducted with Haydn shortly before he died.

16 When you look at it, sir, we invite you to give some
17 thought -- and I'm sure you have already -- as to
18 whether Haydn merits all the disgusting things that were
19 said about him. We respectfully suggest he came over as
20 a thoughtful man, a driven man, a man who wanted to put
21 forward what was best for him, his family, and the wider
22 family that's been affected in the way that they have.
23 In any event, we'll have the film now, please.

24 *(Video played)*

25 **MR WILLIAMS:** Did you recognise yourself at the end, sir?

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1 come up with such meddlesome suggestions.'

2 "He spelt 'somebody' wrong!

3 "Yes, spelt incorrectly."

4 Of course, sir, there is always the possibility that
5 he was going to say "some boyo", we don't know. You
6 seem puzzled at that suggestion, at that word.

7 **SIR BRIAN LANGSTAFF:** He was going to say somebody, wasn't
8 he?

9 **MR WILLIAMS:** Well, it may be. It could just be an "O" on
10 the end that you require, take the "D" off, and you've
11 got "some boyo".

12 **SIR BRIAN LANGSTAFF:** Well, "some boyo" or "somebody so
13 thick".

14 **MR WILLIAMS:** Yes.

15 **SIR BRIAN LANGSTAFF:** It doesn't alter the flavour of it at
16 all.

17 **MR WILLIAMS:** No.

18 Then Ms Richards continues:

19 "Those are three of the emails you shared with the
20 Inquiry.

21 "Sorry, Paul, can we go back to the document. There
22 is just one further email I want to put up, and it is
23 the third page. It is an email from Martin Harvey.
24 It's maybe an email to Haydn; it's not clear because
25 I don't think we have the full consecutive email

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1 **SIR BRIAN LANGSTAFF:** Yes.

2 **MR WILLIAMS:** There we are, sir. Those are my submissions.

3 **SIR BRIAN LANGSTAFF:** In my younger days!

4 **MR WILLIAMS:** Those are the end of my submissions, and
5 Mr Howells is now going to follow on.

6 **Closing Statement by MR HOWELLS**

7 **MR HOWELLS:** Sir, I intend to make submissions on three main
8 issues. Firstly, the unlawfulness of the disparity that
9 emerged in the support schemes in the four nations.
10 Secondly, the failure of the Wales Office and the
11 Northern Ireland Office to achieve self-sufficiency in
12 their respective nations. And thirdly, the conflicts of
13 interest that impacted upon decision making and the
14 implementation of those decisions.

15 Turning first of all to the unlawfulness of the
16 disparity in the support schemes, may I preface this
17 section with three points. Firstly, this really matters
18 to our clients, and so it is important that I address
19 you in relation to it fully.

20 Secondly, some level of technicality is unavoidable,
21 but I shall try to minimise that technicality.

22 Thirdly, the ultimate point is that there should
23 never have been different financial provision in the
24 four nations, and that should never happen again.

25 It is well known in this Inquiry that when the

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UK Government announced an uplift to the payments in the English Infected Blood Support Scheme, which I shall call EIBSS, on 30 April 2019, there were no equivalent uplifts made to the payments for the support schemes in Wales and Northern Ireland. The difference in payments was not insignificant.

That position was allowed to continue until 25 March 2021, when finally the four nations reached agreement on what parity meant across the four schemes, and Her Majesty's Treasury provided funding to the governments of Wales and Northern Ireland so that the payments made by their schemes were increased.

So for a period of almost two years the UK Government allowed a position to continue whereby the infected and affected who lived in Wales and Northern Ireland were treated differently to those who lived in England. For two years, during the currency of this Inquiry, the UK Government exacerbated the resentment and mistrust felt by many, if not all, of our clients who reside in those countries.

This was at a time when the healing process bought about by this Inquiry should have been taking place.

Let it not be thought that the only real effect on our clients was financial disadvantage. No. The utterly inexplicable difference in treatment caused an

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parity is a highly sensitive reminder that again such people are targeted as 'less than' causing secondary psychological injury.

"The inequality provokes reactivation and reliving of past traumatic experiences and can be perceived as confirmation that fairness is not required due to the 'second class citizen' status. Equality and fairness would help to interrupt the trauma cycle and the associated symptoms providing a platform for the complex journey towards adjustment and acceptance of situations of harm and injustice.

"Achieving parity would demonstrate the importance of recognising the need for fairness and justice.

I have been struck by the resourcefulness and resilience shown by the beneficiaries of the scheme and surprised by the desire to 'move forward' from such painful experience. Realistically the associated traumas will never be resolved but it is psychologically damaging and limiting progress if aspects of inequality, in particular the lack of financial parity across the four devolved schemes are not currently addressed."

The disparity in payments should never have been allowed to happen. The suggestion that the schemes were established by each of the four nations to respect the devolution settlements is, we say, a fallacy. The truth

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increased sense of injustice and a feeling that not only did the UK Government not care about them in the 1970s and the 1980s, but that it did not care about them now. Lawrence, please can I ask for WITN4506014.

This is a letter from Dr Coffey, who is a consultant clinical psychologist based at the Wales Infected Blood Support Scheme, which I shall call WIBSS, and it's to the Welsh Government dated 11 March 2021.

If I could start with the second paragraph, please.

Dr Coffey says this:

"It is crucial that the context and impact of the decisions of a higher powered organisation are seen as relevant and need consideration. There are similarities between the decisions of the governments now, and the NHS then, which is a reminder of the harm not help that was inflicted upon the beneficiaries.

"Understandably, people report entrenched feelings of anger and injustice, alongside damaged identities related to feeling like 'a second-class citizen', as unworthy and undeserving due to a growing awareness that harm was knowingly inflicted on an 'unimportant' group of people. The extent of the psychological injury is unquestionable. The acceptance and normalisation of the harm caused is only more recently being exposed and challenged but the current legitimisation of the lack of

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of the matter is that they are the unfortunate consequence of flawed and opportunistic decision making by the UK Government.

The original plan in 2016, when the UK Government first started drawing up consultation plans, was that there would be a UK-wide scheme.

The reference for that, sir, is WITN4688013.

We now know that as a result of the Scottish Government making a unilateral decision to establish its own scheme, the UK Government reacted by establishing EIBSS, without further discussion with the Governments of Wales and Northern Ireland. I will invite you, sir, to see, in particular, the evidence of William Vineall, a senior civil servant in the DHSC, who gave evidence alongside Matt Hancock at page 108 of the transcript, and also document WITN0066007 at pages 3 and 4.

That this was the situation was confirmed by Vaughan Gething, who was then the Minister for Health and Social Services, who admitted that the Welsh Government reacted to the decision of the UK Government and set up WIBSS out of necessity. I would invite you to see pages 8 and 9 of the transcript of his evidence.

So the schemes in the four nations were not the result of a conscious decision, but that is what devolution demanded.

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1 The result is a curious dichotomy in the approach to
2 those infected with HIV and to those infected with
3 hepatitis C. The UK Government has always accepted its
4 responsibility to fund HIV payments, and it continued to
5 do so by way of a budget transfer to the governments of
6 Wales and Northern Ireland. The references for that are
7 WITN4065004 at paragraph 12, and DHSC0003814_090 at
8 paragraph 37.

9 But the UK Government takes the view that the
10 Governments of Wales and Northern Ireland are
11 financially responsible for hepatitis C payments because
12 these were established after devolution. That is to say
13 that the first devolution settlement took place in 1998
14 and the Skipton Fund was established in 2004.

15 It is incongruous that there should be a difference
16 in the identity of the government with financial
17 responsibility for payments for each of HIV and
18 hepatitis C when both viruses were transmitted in blood
19 and blood products at a time long before the devolved
20 governments were established. It is frankly illogical
21 to say that the devolved governments have competence to
22 make hepatitis C payments but do not have competence to
23 make HIV payments.

24 WIBSS was given statutory powers to make payments to
25 eligible persons by the Wales Infected Blood Support

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1 persons infected with Hepatitis C, as a result of
2 treatment by the NHS in Scotland, would be within
3 devolved competence."

4 So that's the Law Officers saying Scotland can set
5 up the scheme if they want to.

6 Then, Lawrence, can we go to paragraph 3 on page 2.

7 At paragraph 3 the Law Officers set out the features
8 of the scheme proposed by the Scottish Government and,
9 sir, I would draw your attention to the last bullet
10 point, that what was being proposed was that:

11 "No payments are to be made to dependants of
12 infected patients."

13 Now, I say that's important to understand the advice
14 going forward.

15 Then, Lawrence, paragraph 16, page 4.

16 Ultimately this is the reasoning given by the Law
17 Officers as to why it was within the competence of the
18 Scottish Government.

19 "In this instance, the Law Officers consider that
20 sufficient additional factors exist to indicate that
21 what has been proposed by the Scottish Executive differs
22 in purpose from a scheme for financial assistance for
23 social security purposes. The Scottish Executive has
24 the stated purpose of providing compensation to
25 a particular class of individuals who suffered injury

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1 Scheme (No. 2) Directions 2017. Those directions were
2 made under the National Health Service (Wales) Act 2006,
3 which is an Act of the UK Parliament. If that Act gave
4 the Welsh Ministers a power to make payments to infected
5 persons through WIBSS, there is no proper basis for
6 saying that it did so only in relation to hepatitis C
7 and not HIV.

8 That is because the exercise of the power under that
9 Act was not conditioned by devolved competence. It was
10 a statutory function given to the Welsh Ministers by an
11 Act of the UK Parliament.

12 The Inquiry has heard evidence that in 2002
13 a dispute arose between the UK Government and the
14 Scottish Government about whether the Scottish
15 Government can make payments for hepatitis C. The
16 reference for the email raising the dispute is
17 DHSC0042275_129. That was an internal email to
18 Charles Lister in November.

19 That resulted in a joint advice from the UK and
20 Scottish Law Officers. So may I bring that on screen.

21 Lawrence, it's DHSC0042275_012.

22 If I could just have the summary to begin.

23 Sir, the summary says:

24 "In summary the Law Officers consider that the
25 Scottish Executive's proposed scheme for payments to

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1 through a particular source. These people are to
2 qualify for payment not on the basis of being sufferers
3 of Hepatitis C, but rather where it can be shown that
4 they have been infected by that virus and this has been
5 caused by NHS treatment in Scotland, an agency of the
6 State for which the Scottish Executive is responsible.
7 That infection, so caused, is proposed to be treated as
8 an injury for which compensation should be paid, on
9 a no-fault basis. It is understood that the concept and
10 function of compensation in this context would be
11 broader than that of damages, the latter being more
12 calculated to respond to the degree of loss sustained in
13 any particular instance."

14 That's the reasoning.

15 Then, Lawrence, paragraph 22 on page 5, please.

16 The Law Officers were obviously aware of the HIV
17 payments, and this is what they say about it:

18 "At the same time, the Law Officers recognised that
19 there will be a need to maintain a consistent and
20 coherent approach to other payment schemes in the
21 assessment of whether they fall within devolved or
22 reserved competence. For instance, the Law Officers are
23 aware that schemes for the payment of those infected
24 with the HIV virus through treatment by the NHS have
25 been dealt with as schemes for social security

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1 purposes."

2 I pause there to interject that that would therefore
3 mean it is not within devolved competence.

4 "It is understood that the trusts which operate
5 those schemes have been paid entirely from funds from
6 the UK Government, including in the period after
7 devolution. Yet if the driving purpose behind these
8 schemes has also been the provision of compensation to
9 persons who have been injured through HIV infection
10 caused by the NHS (ie not simply to sufferers of HIV),
11 there may be nothing to distinguish that purpose from
12 what is proposed by the Scottish Executive in relation
13 to Hepatitis C. The Law Officers do not attempt to
14 resolve this particular issue, but see that it raises
15 questions of this kind. They observe that it might also
16 be possible to distinguish such a scheme from that
17 applicable to those infected with [vCJD], if the basis
18 of payment to such sufferers is simply infection of that
19 illness, from whatever source. But [they] express no
20 view ..."

21 That leads to this submission, sir: that it may be
22 that the UK Government formed the view in 2004, which is
23 a view they still hold, that it was not responsible for
24 hepatitis C payments across the UK based on this advice.
25 If so, if they took that view, then it is wrong for

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1 submissions that we make. Firstly, the UK Government,
2 from the moment it unilaterally decided to increase
3 payments made by EIBSS, without providing funding to the
4 other support schemes, acted in a way that discriminated
5 on the grounds of nationality. It always accepted that
6 it was responsible for making HIV payments, but it paid
7 more to those who lived in England than the rest of the
8 United Kingdom. That was a wholly unjustifiable
9 difference in treatment.

10 Secondly, the UK Government acted in an underhanded
11 way in making the announcement it did in 2019 without
12 giving any notice to the Governments of Wales and
13 Northern Ireland, in much the same way it did in 2017
14 when the schemes were established.

15 It acted in an underhanded way by stating that the
16 increase was to be funded from the existing DHSC budget,
17 so that there would be no consequential funding for the
18 devolved governments. As Vaughan Gething put it, it
19 essentially found the money down the back of the
20 departmental sofa. It failed to do the right thing and
21 resolve the disparity in payments for almost two years.

22 As it was put by Vaughan Gething in a letter to the
23 UK Minister for Care on 9 October 2019, and the
24 reference is WITN5665004, he said this:

25 "This was very disappointing, given that this

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1 three reasons.

2 Firstly, the Law Officers were specifically advising
3 about a compensation payment to an injured person which
4 did not involve payments to dependants. The
5 Skipton Fund, conversely, did make payments to
6 dependants and contained discretionary elements based on
7 need.

8 Secondly, the Law Officers specifically identify
9 that HIV payments are to be treated as relating to
10 social security, and it was hard to distinguish between
11 the two.

12 Thirdly, this advice related to the Scotland Act
13 1998, which, from the outset of devolution, empowered
14 the Scottish Parliament to legislate on all matters save
15 for reserved matters.

16 That was different to the form of devolution that
17 existed in Wales at that time, and so the advice could
18 not be read across to Wales.

19 We have provided the Inquiry with a note on the
20 phases of devolution in Wales to assist with an
21 understanding of that difference. Jane Hutt, the first
22 Welsh Minister for Health and Social Services, between
23 1999 and 2005, confirms as much in her witness statement
24 at paragraph 35. The reference is WITN7293001.

25 To conclude in this segment, sir, there are two

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1 problem pre-dates devolution. And the letter of 23 July
2 gave reassurance that there would be creation of an
3 equitable share in funding to provide parity across the
4 four UK support schemes."

5 Jeremy Hunt, the now Chancellor of the Exchequer,
6 stated that there should not have been a difference in
7 payments across the United Kingdom, but that the
8 UK Government did not have the ability to impose
9 a single scheme across the United Kingdom.

10 It's our submission that he was mistaken in saying
11 that. Even if the support schemes were a devolved
12 matter -- and you'll be delighted to know, sir, I'm not
13 going to go into that thorny question, but even if they
14 were a devolved matter, the UK Government could seek
15 consent of the devolved governments to establish
16 a UK-wide scheme in two ways. Firstly, the ability of
17 the UK Parliament to legislate in devolved areas is
18 unfettered, although it would not normally do so without
19 the consent of the Senedd -- so that's all that's
20 required -- or the Scottish Parliament, or in relation
21 to Northern Ireland. And that's -- in respect of Wales,
22 that's section 107(5) of the Government of Wales Act
23 2006.

24 Secondly, the Governments of Wales and Northern
25 Ireland are able to delegate their functions to the

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1 UK Government, and the power to do so is in section 83
2 of the Government of Wales Act 2006, section 93 of the
3 Scotland Act 1998, and section 28 of the
4 Northern Ireland Act 1998.

5 Thus, our firm submission is that both the
6 compensation framework and the continued support schemes
7 should be established on a UK-wide basis. There is
8 power to do so even if it's a devolved matter. It would
9 be for the four nations to decide whether it is in fact
10 a devolved matter or not, and what budgetary
11 consequences that has.

12 It follows that we take issue with the submission
13 made by David Johnston KC on behalf of the Scottish
14 Government that the support scheme should remain on
15 a four nation basis just to retain flexibility to make
16 different payments. That difference in treatment should
17 never be allowed to happen again.

18 Further, our clients from Northern Ireland are
19 particularly concerned in relation to the continuation
20 of the scheme in Northern Ireland, because of the
21 interruption to government there.

22 Sir, that concludes my submissions in relation to
23 the first issue.

24 Moving now to the second issue, which is the failure
25 of the devolved health systems in Wales and

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1 There was all sorts of available monies from
2 pharmaceutical companies.

3 "... it's unfortunate, because I think even now
4 things haven't changed that much, although now they
5 would have to declare it. And some things would be
6 unacceptable now ... if the gifts went above a certain
7 level ... it wouldn't be acceptable at all. But at that
8 time, it was accepted practice. It was normal practice.

9 "... some of them were the same directors who were
10 advising the Government ... there were reference
11 directors who were in committees that were ...
12 recommending.

13 "I mean, we wanted honest advice, and ... it sort of
14 made us think: ... is this purely unbiased or not?
15 I think it was unbiased ... I think we got very good
16 guidelines from UKHCDO but it wasn't pleasant visibly to
17 see people not declaring their interest, which they
18 would have to now. They wouldn't be allowed to do it.
19 It would be scandalous.

20 "But at that time it seemed acceptable practice to
21 be a Reference Centre Director to be on committees that
22 recommended the use of Factor VIII, and they would be
23 the advisers to Government, and these are people who are
24 paid by the National Health Service, employed by the
25 National Health Service.

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1 Northern Ireland to achieve self-sufficiency.

2 I should begin this segment with a quotation from
3 the evidence of Professor Parapia to this Inquiry.
4 I will fairly read it out in summary form, otherwise the
5 transcript will be punctuated with questions.

6 We say this piece of evidence puts the decision
7 making of clinicians and regulators in context.

8 He said this:

9 "When we went to conferences, meetings and so on ...
10 directors that were most closely associated with
11 companies would stay in the conference hotels and have
12 five-star, et cetera, et cetera, and you could see that
13 they were -- then there were gradations and you could
14 see that as you went lower down the usage of Factor VIII
15 in numbers or type of centre you were, then you may have
16 to go into three-star or four-star hotels, and you could
17 see the dinners, et cetera, et cetera. There was quite
18 a big difference on hospitality that people got ...

19 "The bigger -- the centres that were more -- were
20 nearer working with pharmaceutical companies and so on,
21 people who used more of the product had a lot of support
22 for their departments. And there were individuals being
23 employed as consultants. I know at least one who is
24 still working as a consultant to one of the
25 pharmaceutical companies. There were research grants.

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1 "I felt sad for BPL that they were not able to
2 compete on an equal footing with multinational
3 companies."

4 So may I firstly deal with the attempts to achieve
5 self-sufficiency or rather the adoption of the policy of
6 self-sufficiency on a UK-wide basis. I will do so at
7 a pace, if I may.

8 In March 1973, the Chief Medical Officer wrote to
9 all senior medical officers stating that planning was
10 required to achieve more domestic production of
11 concentrate to avoid very significant expenditure for
12 amounts bought in excess of immediate needs. That's
13 DHSC0100005_033.

14 Then in December 1974, Lord Owen, the Minister for
15 Health, invested £500,000 in BPL and PFL. In March 1975
16 the following year, the Regional Transfusion Directors
17 were seeking to persuade clinicians to accept a steadily
18 increasing supply of domestically produced concentrate.

19 It was noted that Regional Transfusion Directors did
20 not always see eye to eye with Haemophilia Centre
21 Directors over the treatment of haemophiliacs, as HCDs
22 wanted to implement home prophylaxis and treatment
23 programmes, whereas the present proposals were based
24 upon home treatment when a bleed occurs.

25 The reference for that, sir, is LDOW0000018.

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1 So it's clear that, even as of 1975, the battle
2 lines were drawn between the RTDs and HCDs as to what
3 self-sufficiency meant.

4 Dr Foster confirmed in his evidence that PFC could
5 have fractionated plasma from England and Wales and
6 could have fractionated around a third of the plasma
7 from England and Wales. He disputed Dr Lane's
8 contention that the capacity of PFC was exaggerated.
9 Dr Robert Perry told the Inquiry that there may have
10 been some merit in a joint approach for the development,
11 production and supply of plasma products on a UK-wide
12 basis.

13 In the event, BPL fractionated about 90 per cent of
14 plasma for the UK, and PFC about 10 per cent, whereas it
15 should have been in the order of 50/50.

16 Thus, in our submission, by the end of 1975 the
17 position was: firstly, the DHSS had adopted a policy of
18 self-sufficiency in concentrates, based on the known
19 risk of non-A, non-B transmission associated with
20 imported concentrate.

21 Secondly, the CMO had set up a working party to
22 address the issue and the DHSS had invested £500,000 in
23 PFC and appreciated that the health economics indicated
24 that it was financially prudent to invest more money in
25 achieving self-sufficiency rather than purchasing

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1 taxpayer."

2 So the problem is there to be seen in 1981.

3 Then in 1982, the DHSS decided to invest in BPL and
4 to have the PFC focus on Scotland and Northern Ireland.
5 The reference for that is DHSC0001674. Of course by
6 then Northern Ireland had entered into an agreement with
7 the Scottish Home and Health Department for the
8 fractionation of plasma from Northern Ireland, which
9 I will return to shortly, thereby entrenching the
10 artificial division in fractionation to the disadvantage
11 of patients.

12 May I now move on to look at the devolution
13 dimension in respect of self-sufficiency, but the
14 UK-wide decisions provide the context.

15 Now, in respect of Cardiff Regional Transfusion
16 Centre, there is no evidence that any steps were taken
17 by the Welsh Office to enter into arrangements with PFC
18 for the fractionation of Welsh blood to remove the
19 expenditure of the Cardiff RTC on imported concentrate
20 and there is no evidence that the Chief Medical Officer
21 for Wales took any steps to reduce the growing level of
22 demand for imported concentrates.

23 Dr Tony Napier, the Regional Transfusion Director
24 for Cardiff from 1977, agreed that it was open to him to
25 take his own action and that he tried to work with other

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1 expensive imports.

2 Thirdly, the DHSS and the CMO appreciated that the
3 freedom of clinicians to purchase imported concentrates
4 for home treatment programmes needed to be managed,
5 whilst fractionation capacity at BPL was increased and
6 arrangements with PFC were put in place, hence the
7 reference to seeking to persuade clinicians to accept
8 a gradually increasing amount.

9 Then, fourthly, notwithstanding that knowledge, no
10 additional money was invested to achieve
11 self-sufficiency. No arrangements were put in place at
12 PFC and no steps were taken to suppress the increasing
13 demand by clinicians for imported concentrates.

14 In January 1981, Mr Meakins from the School of
15 Pharmacy and Pharmacology at the University of Bath
16 wrote in The Times about the fact that PFC was not being
17 used by the DHSS. That's CBLA0001229.

18 He stated that the insufficiency of blood products
19 in the UK was largely self-imposed by bureaucracy and
20 that because the Health Departments for England, Wales
21 and Scotland are independent, blood is not sent north
22 across the border, and he stated:

23 "In my view this state of affairs is nothing less
24 than scandalous on the current efficiency situation,
25 which is disadvantageous to both patients and the

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1 RTDs. He stated that the issue of self-sufficiency was
2 not a matter of great debate locally. He admitted that
3 he was aware of the possibility of sending plasma to PFC
4 but that he didn't consider it. Had he been aware that
5 there was a cap on the amount of Welsh plasma that BPL
6 could fractionate, he would have considered sending
7 plasma to PFC.

8 Ultimately, he accepted that he did not discuss
9 self-sufficiency with the Welsh Office. He stated that
10 had Cardiff RTC been resourced to produce the requisite
11 amount of plasma, then it could have been
12 self-sufficient and, in that event, it was likely that
13 the worst of the HIV transmission could have been
14 avoided in Wales -- in South Wales, because South Wales
15 was supplied by Cardiff.

16 We are grateful to counsel to the Inquiry for their
17 recent presentation on decision making in Wales. What
18 it demonstrates, in our submission, in particular by
19 reference to the evidence of Lord Barry Jones, who was
20 Parliamentary Under-Secretary of State in the Welsh
21 Office between 1974 and 1979, is that, insofar as the
22 DHSS took major responsibility, then the detail of
23 blood, blood products, haemophilia, other bleeding
24 disorders and hepatitis would have been within the
25 purview of senior civil servants in Cardiff.

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1 However, he did not recollect making any decisions
2 on blood policy. He also explained that it was
3 a principal necessity for the Chief Medical Officer for
4 Wales to inform either the Minister's officials, or
5 possibly the Minister directly, about the risks
6 associated with blood and blood products and that the
7 Chief Medical Officer certainly had responsibility for
8 issuing guidance, advice or instructions to clinicians.

9 I will come shortly to a meeting with the Welsh
10 Office and Professor Bloom where that didn't happen.
11 But before I do, I'd like to turn to Northern Ireland.

12 Dr Morris McClelland, the RTD for Belfast,
13 consciously formulated a plan for self-sufficiency in
14 relation to Factor VIII. He accepted that the purpose
15 of the arrangements at PFC was to achieve
16 self-sufficiency in Northern Ireland. The reference is
17 RHSC0000076, at page 34. The Health Board, that's the
18 Eastern Health and Social Services Board, became
19 involved on the issue of self-sufficiency and blood
20 products. He had regular meetings with Dr Mayne because
21 of the rising costs of concentrate. The Health Board
22 wanted to understand how the costs may be contained and
23 they played a coordinating role between supply and
24 demand. He tried to discourage Dr Mayne from purchasing
25 imported concentrates. He failed.

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1 exerted over Dr Mayne's purchase of increasing amounts
2 of commercial concentrate because, as explained by
3 Dr McClelland, blood products were procured and supplied
4 directly to the Haemophilia Centre. But the cost came
5 out of the NIBTS budget.

6 We're also grateful to Counsel to the Inquiry for
7 the recent presentation on decision making in Northern
8 Ireland. It demonstrates, in our submission, that
9 Sir Richard Needham, the Health Minister with
10 responsibility for blood from 1985 until 1989, had no
11 recollection of dealing with blood during his time at
12 the Health Minister. He blamed this on the Troubles and
13 his far reaching portfolio.

14 Lord King, who was the Secretary of State for
15 Northern Ireland, also denied any recollection of
16 dealing with blood. The gist of their evidence is that
17 Northern Ireland followed the policy lead of the UK
18 Government on health. However, that is problematic
19 because we know that the Department of Health and Social
20 Services in Northern Ireland reached an agreement to
21 send plasma to Scotland for fractionation, and the fact
22 that the Department was involved is shown by
23 CBLA0001388.

24 It may have been the position that Dr Mayne was the
25 main protagonist, and that the Health Board played

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1 An agreement in principle was reached with the
2 Scottish National Blood Transfusion Centre in
3 February 1981. That's CBLA0001388. But due to delays
4 caused by the capacity of the Belfast RTC to carry out
5 the required testing, the agreement was not implemented
6 until April 1982, that's CBLA0001572. Dr McClelland
7 wrote to Dr Bridges in 1984, NIBS0001719. In that
8 letter he stated that PFC was fractionating all the
9 fresh frozen plasma sent by Northern Ireland so that
10 they were self-sufficient in Factor VIII. It seems that
11 the only product they were not self-sufficient in was
12 albumin.

13 The letter does note, however, that the demand at
14 the Royal Victoria Hospital had doubled -- doubled -- in
15 1983 from 1982. In evidence, Dr McClelland confirmed
16 that they were not using 100 per cent PFC Factor VIII
17 because demand was increasing rapidly.

18 Thus, in distinction to the position in Cardiff RTC,
19 the story of Belfast RTC is that they did have an RTD
20 and a Health Board with the foresight and desire to
21 achieve self-sufficiency in 1981, but the plan was
22 poorly executed in two ways. Firstly, a lack of
23 investment meant that Belfast RTC could not carry out
24 the required screening, which delayed the implementation
25 of the agreement and, secondly, no adequate control was

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1 a coordinating role. But the Department was involved.

2 It was not following the policy lead of the UK
3 Government.

4 At paragraph 17(b) of the presentation, it refers to
5 Jack Scott not being altogether happy at Dr Mayne's
6 treatment policy in relation to SNBTS Factor VIII. He
7 wasn't happy that it was being given preferentially to
8 those already on treatment with it, with the rest being
9 treated by commercial concentrate. However, it does not
10 seem, from the available material, that Mr Scott ever
11 acted upon his displeasure at Dr Mayne continuing to use
12 commercial concentrate.

13 Lord John Patten, the Parliamentary Under-Secretary
14 in the Northern Ireland Office between January 1981 and
15 June 1983, told the Inquiry that when he was in Northern
16 Ireland, at a crucial time for the purposes of this
17 Inquiry, he did not recall seeing a single submission on
18 blood and blood products, even though he was responsible
19 for Health and Social Services.

20 Thus the evidence in Northern Ireland seems to be
21 that those with responsibility for decision making
22 didn't make any decisions, save to the extent that the
23 agreement was reached with Scotland. There was nobody
24 providing direction at a crucial time in Northern
25 Ireland.

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1 Sir, may I make a brief comment on an element
2 contained in the oral submissions of Mr Aldworth, King's
3 Counsel, to the effect that the document retrieval
4 exercise in Northern Ireland had been, in his words,
5 "successful". We say that's a rather odd way of putting
6 it. There is still a marked dearth of evidence in
7 relation to Northern Ireland, as the concluding remarks
8 of counsel to the Inquiry's presentation allude to.

9 The remark that no evidence of document destruction
10 had been found also faces the difficulty that any
11 evidence of ill-motivated document destruction is also
12 likely to have been destroyed.

13 There was a meeting between the DHSS, the Scottish
14 Home and Health Department, the Welsh Office and the
15 Northern Ireland Office to discuss self-sufficiency in
16 February 1981, and that's DHSC0000064. I won't bring it
17 on screen for reasons of time and I will summarise it.

18 It was agreed that, although BPL were currently
19 supplying England, Wales and Northern Ireland, PFC could
20 play a role in meeting the needs of the United Kingdom.
21 It was identified that PFC had the potential to meet
22 around 50 per cent of the UK's requirements for blood
23 products. At paragraph 11 it was suggested that BPL
24 fractionated Welsh plasma and would presumably continue
25 to do so. So it was not revisited; it was presumed that

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1 nations and that was normally left to administrators.
2 He said that the exchange of information was also
3 done by the administrators. He confirmed that there was
4 no system or process in place by which medical advice
5 was shared across the four nations. Often, it occurred
6 to the DHS late to notify the four nations of
7 developments. He confirmed that the health departments
8 of the four nations were smaller, so that the medical
9 officers in those departments had a much wider role than
10 haematology, so that they relied on the work done by the
11 DHSS, and the policy decisions would come from the DHSS.

12 In our submission, there are three problems with
13 that evidence. Firstly, the exchange of information
14 could only be done on the administrative side in respect
15 of matters with which this Inquiry is concerned, if the
16 medical officers told the administrators what
17 information to exchange. Secondly, it can be seen from
18 the limited documents available in respect of the Welsh
19 Office and the Northern Ireland Office that they did not
20 take policy instruction from Whitehall but made their
21 own policy decisions which would be unreasonable, if not
22 based on all relevant information, and that was
23 dependent on the medical officers in the UK Government
24 sharing all relevant information with the medical
25 officers in the Welsh Office and the Northern Ireland

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1 that arrangement would continue.

2 It may be appropriate for the Welsh Office to
3 contribute towards the redevelopment of BPL and,
4 similarly, if PFC fractionated Northern Ireland plasma,
5 it may be appropriate for the Northern Ireland Office to
6 contribute towards the costs of running PFC.

7 Thus, in our submission, the possibility of
8 different countries having their plasma fractionated at
9 either BPL or PFC was expressly considered at this
10 meeting, but what does not appear to have been
11 considered on any evidence available to this Inquiry is
12 the possibility of Welsh plasma being fractionated at
13 PFC at any point up until BPL was finally redeveloped in
14 the late 1980s, by which point it was too late to
15 mitigate the effects of HIV or hepatitis C on
16 haemophiliacs in Wales.

17 In terms of the UK Government's attitude towards the
18 NHS in Wales and Northern Ireland, Lord Kenneth Clarke
19 told the Inquiry he did not remember any meetings with
20 the Welsh Office or the Northern Ireland Office.

21 David Mellor told the Inquiry that there was no time
22 to discuss decisions with his counterparts in the four
23 nations and liaison was left to permanent secretaries
24 and civil servants. Dr Rejman stated that he did not
25 have regular meetings with officials from the four

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1 Office.

2 Thirdly the safe production of blood products in the
3 UK is something that should have been considered on
4 a four nations basis, given that the Welsh Office, the
5 Northern Ireland Office and the Secretary of State for
6 the Home Department -- the Scottish Home and Health
7 Department, sorry -- were responsible for blood in their
8 respective countries.

9 So what you effectively had was an administrative
10 devolution of responsibility for policy making and
11 implementation, but an overreliance on information being
12 given by the medical officers in the UK Government, but
13 then the medical officers on Dr Rejman's evidence were
14 not meeting regularly with the medical officers in
15 Scotland, Wales and Northern Ireland.

16 So the system was topsy-turvy.

17 Rather, it seems to be the position that it was
18 assumed that the Welsh Office and the Northern Ireland
19 Office would follow suit. But that was inappropriate
20 because they had the advantages of being smaller and of
21 self-sufficiency being a more realistic prospect.
22 Indeed, Northern Ireland did not follow England's lead
23 and decided to pursue a policy of self-sufficiency of
24 its own. In Wales, the issue was simply not addressed
25 by those with the power to take decisions and the

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1 responsibility to do so.
 2 The Public Health Administration Expert Group made
 3 it clear that the Secretary of State for Health and
 4 Social Services was not responsible for health in Wales,
 5 Northern Ireland or Scotland. They identified
 6 a complication in that Wales and England were integrated
 7 for the purpose of some legislation and high level
 8 policy. They commented that the lack of documentation
 9 in relation to decisions being made in Wales and
 10 Northern Ireland on blood policy may be attributable to
 11 the fact that the Secretary of State for Wales and the
 12 Secretary of State for Northern Ireland were not
 13 dedicated to health but had a wider policy portfolio.
 14 They were unsurprised by the evidence of the
 15 ministers in the Department of Health and Social
 16 Services that they had little dialogue with their
 17 counterparts in the four nations, as this was
 18 a reflection of the Anglo-centric approach of the
 19 Department of Health and Social Services.
 20 They identified that the missed opportunity was not
 21 creating a National Blood Transfusion Service that made
 22 the most of both BPL and PFC. The devolution problem,
 23 it seems, compounded matters as there was a failure to
 24 recognise that there were different systems in place.
 25 I move now to address the exponential increase in
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1 address you in relation to the exponential increase of
 2 the use of imported concentrates, save to say that they
 3 were a combination of two factors in our submission:
 4 firstly, the development of prophylaxis treatment; and,
 5 secondly, the refusal of Haemophilia Centre Directors to
 6 relinquish control of the purchase and stock of imported
 7 concentrates. They were very keen and felt very
 8 strongly about the fact that that should be retained
 9 within the centres.
 10 Sir, I will also not address you generally in
 11 relation to knowledge of risk in relation to
 12 non-A, non-B and HIV, but I do wish to make some
 13 specific points relating to Dr Dempsey and
 14 Professor Bloom.
 15 Firstly in relation to non-A, non-B, Dr Dempsey gave
 16 evidence that when he arrived at the children's hospital
 17 in Belfast, cryoprecipitate was exclusively used. He
 18 stated that Dr Mayne and Dr Bridges discussed with him
 19 the risk of non-A, non-B and its association with liver
 20 disease in 1978 or 1979. However, in 1981 Dr Dempsey
 21 started using commercial concentrates on children, and
 22 he did so until July 1983, when he stopped in response
 23 to the emerging information in relation to AIDS.
 24 So, on his evidence, he started using commercial
 25 concentrates on children when the seriousness of the
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1 the use of imported concentrates and how this impacted
 2 upon the policy of self-sufficiency.
 3 Sir, I note the time, it is 3.15. Would you like to
 4 take a break or would you like me to continue?
 5 **SIR BRIAN LANGSTAFF:** Well, how much longer do you have to
 6 go, do you reckon?
 7 **MR HOWELLS:** Sir, that rather depends on how long you're
 8 willing to give me.
 9 **SIR BRIAN LANGSTAFF:** Well, being as short as you can
 10 reasonably be, within your allotted timespan -- you
 11 mustn't take a disproportionate amount of time compared
 12 to others -- how much longer do you think it might be?
 13 Otherwise, we'll take a break now.
 14 **MR HOWELLS:** Yes, I would ask for at least another
 15 30 minutes.
 16 **SIR BRIAN LANGSTAFF:** Well, let's take a break now, shall
 17 we?
 18 **MR HOWELLS:** Thank you, sir.
 19 **SIR BRIAN LANGSTAFF:** Come back at 3.45.
 20 (3.17 pm)
 21 (A short break)
 22 (3.45 pm)
 23 **SIR BRIAN LANGSTAFF:** Yes.
 24 **MR HOWELLS:** Sir, having addressed you in relation to the
 25 adoption of policies for self-sufficiency I won't now
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1 risk of non-A, non-B should have been known to him.
 2 His justification was twofold. Firstly, that his
 3 confidence in cryoprecipitate was shaken due to one
 4 incident when it didn't stop an internal bleed in 1981.
 5 And secondly, Armour and Hemofil were keen to assuage
 6 any concerns that he had in relation to the safety of
 7 their products.
 8 Dr Mayne states in paragraph 14.3 of her witness
 9 statement that Dr Dempsey was more enthusiastic about
 10 only using cryoprecipitate on children than she was.
 11 That is plainly incorrect.
 12 Dr Mayne accepts at paragraph 22.3 that between the
 13 late 1970s and the mid-1980s, there was growing evidence
 14 that non-A, non-B was not benign. She also states at
 15 paragraph 33.5 and 43.1 that, in response to the
 16 emerging evidence about AIDS, patients were offered
 17 a return to cryoprecipitate but rejected it. That is
 18 not a version of the truth that our clients recognise.
 19 Mr Aldworth KC made a submission that Dr Mayne
 20 followed the 1983 guidance from the UKHCDO. Even if
 21 that is correct, it carries little weight in light of
 22 the fact that Dr Dempsey had been treating children with
 23 commercial concentrate for the previous two years or so.
 24 Dr Dempsey, moving on to HIV, accepted that he was
 25 in no major doubt from the end of 1982 that AIDS was
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1 transmissible by blood and blood products, as the other
2 theories did not hold water. However, he stated that
3 the haemophilia community were not prepared to commit
4 themselves to the idea that AIDS was related to blood
5 and blood products. And, of course, he continued to use
6 imported concentrates on children he treated after the
7 end of 1982.

8 So too did Dr Mayne. In fact -- in respect of her
9 patients that is. In fact, she was content to swap
10 Scottish SNBTS Factor VIII for imported concentrate.

11 And Dr Morris McClelland stated in evidence that he
12 discussed the MMWR report with Dr Mayne in 1982.

13 So the effect of Dr Dempsey's evidence is that
14 notwithstanding that he knew about the seriousness of
15 non-A, non-B, notwithstanding that he knew that AIDS was
16 caused by an agent transmissible in blood, he continued
17 treating children with imported concentrate, having
18 reversed a policy of exclusive cryoprecipitate in 1981.

19 Of course, in January 1983, as is well known, there
20 was the Heathrow meeting, which was chaired by
21 Professor Bloom, at which those in attendance were told
22 that AIDS was transmissible by blood and blood products,
23 that it had an incubation period of six months to
24 two years, and that it had a 45 per cent mortality rate.

25 Then on 7 March 1983 Professor Bloom received
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1 received the report from Professor Bloom of probable
2 AIDS on 26 April 1983; and a representative from the
3 Health Authority, Dr Napier and Professor Bloom.

4 Lawrence, can we go to page 2, please.

5 At the top of page 2 we can see Professor Bloom:

6 "However in a discussion which followed
7 [Professor Bloom] admitted that a case had been treated
8 in Cardiff which showed some of the features of a mild
9 possible AIDS."

10 Then we can see in the next paragraph that there was
11 pressure from the press in the days leading up to the
12 meeting. Then in the middle of this page, where it says
13 "Guardian Reports", there's a suggestion -- well, I'll
14 read it:

15 "'Guardian Reports' of the 4 May 1983 -- The Andrew
16 Vatch column attempts to place matters in perspective.
17 However the Richard Boston feature aided by Reg Bird of
18 the ASTMS implies that with foresight and the
19 expenditure of an unspecified sum we could have avoided
20 the consequent consequences of reliance upon imported
21 blood products is based on a false premise."

22 Then, Lawrence, top of page 3, please.

23 We see here the remark that:

24 "It was important to keep the problem in
25 perspective."

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1 a letter from Dr Evatt at the CDC, that's
2 BPLL0001351_021, in which he pointed out that in 1982,
3 based on preliminary data, AIDS was the second highest
4 cause of deaths in haemophiliacs in the USA.

5 Then, on 16 March 1983, Professor Bloom received
6 a letter from Alpha UK, CBLA0000060_067, enclosing
7 a press release issued by Armour's parent company on
8 7 January 1983, which accepted that:

9 "The evidence suggests, although it does not
10 absolutely prove, that a virus or other disease agent
11 was transmitted to haemophilia patients with AIDS in
12 Factor VIII concentrate."

13 So Professor Bloom had all of that knowledge in
14 January and March.

15 The Welsh Office convened a meeting on 4 May 1983,
16 so a couple of months further on, to discuss the
17 implications arising from the reported case of AIDS in
18 Cardiff.

19 Lawrence, please can we have this on the screen.
20 It's HSSG0010055_001.

21 Thank you.

22 We can see there that present were the Chief Medical
23 Officer for Wales, Dr Gareth Crompton, three medical
24 officers from the Welsh Office, Dr McEvoy from the CDSC,
25 which is the same organisation as Dr Craske, who

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1 And it goes on to say two things. Firstly, that an
2 increase in the use of blood -- that the problem in the
3 USA was due to an increase in the use of blood and blood
4 products. But secondly, prevailing homosexuality and
5 drug use in the USA which was dissimilar to the United
6 Kingdom.

7 Then at the bottom half of page 3, please, Lawrence,
8 under the heading "What would be the effect of a ban of
9 American Factor 8?" Thank you. It says:

10 "The effects would be far reaching. Instead of the
11 ready access to 60 million units of factor 8 now
12 available any 30 million units would be accessible
13 exactly half current requirements. Blood product
14 laboratories in the UK are presently working to
15 capacity. If we were in Wales to attempt locally to
16 make good our own deficit it would require a great deal
17 of extra facility within the NBTS at Rhydlafer. It
18 follows that a ban on imported factor 8 would
19 necessitate:

20 "a. a reduction in patients treated;

21 "b. the modification of the home treatment facility
22 (with the associated consequences of lost jobs with
23 implications for social services as well as for the
24 health service)."

25 Then can we go to the top of page 4, please,

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1 Lawrence.
2 The heading is "Can we go on using factor 8?"
3 It says that:
4 "The asserted greater risk arising from the use of
5 purchased blood as opposed to voluntary donated blood is
6 less than hitherto with the greater awareness of the
7 AIDS problem."

8 It goes on to say in the next paragraph that:
9 "There is no justification on the basis of facts so
10 far established to ban the importation of factor 8
11 though it was thought preferable in the case of children
12 to restrict treatment to the BPL concentrate produced in
13 Britain."

14 Our submission is that this advice given to the
15 Welsh Office was materially misleading for the following
16 reasons: firstly, as discussed by the DHSS and the Chief
17 Medical Officer as early as 1974, it was foreseen that
18 blood products carried a risk to health and, with
19 sufficient expenditure and/or arrangements with PFC,
20 self-sufficiency could have been achieved. And so the
21 foresight argument put forward in The Guardian was not
22 based on a false premise.

23 Secondly, blood laboratories in the UK were not
24 working to capacity. This statement, misleadingly,
25 omits the fact that PFC did have potential to

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1 have the home treatment available, they would go into
2 hospital and place further demands than existing on the
3 hospital services, which would imply a greater need for
4 jobs. So I don't quite understand what that suggestion
5 is. Can you help at all?

6 **MR HOWELLS:** Sir, I respectfully adopt your circumspection
7 about what is said but the way I read it is that (a) and
8 (b) are related. So if there was a reduction in the
9 number of patients put on home treatment, there would be
10 less demand for the home treatment facility and
11 therefore there would be, in effect, redundancies. But
12 that, as I have already said, is a fallacy, because the
13 number of treatment -- the number of patients would stay
14 the same. It's the amount of treatment that would be
15 reduced.

16 **SIR BRIAN LANGSTAFF:** Yes.

17 **MR HOWELLS:** So it's misleading.

18 **SIR BRIAN LANGSTAFF:** Just while we're on this document can
19 we go to the next page and see if you can help me with
20 another part of it, which I noticed -- I should have
21 noticed this before when we first looked at it, but it
22 says, "The asserted" -- the top of the page:

23 "The asserted greater risk arising from the use of
24 purchased blood as opposed to voluntary donated blood in
25 [should be 'is', I think] less than hitherto with

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1 fractionate Welsh plasma.

2 Thirdly, a ban on imported concentrate would not
3 have led to a reduction in the number of patients
4 treated; rather, it would have led to a reduction in the
5 amount of home treatment or prophylaxis.

6 Fourthly, the loss of jobs, the home treatment
7 facility and consequences for Social Services and the
8 Health Service could hardly overwrite the risk of deaths
9 to patients treated with --

10 **SIR BRIAN LANGSTAFF:** I don't quite understand what that
11 suggestion implies.

12 Could we can just go back to the page 4, please,
13 Lawrence. Thank you. And down to the bit "the
14 modification of the home treatment facility". It's at
15 the bottom of the screen at the moment.

16 Can we scroll down? Thank you.

17 (b), to modify a home treatment facility.

18 Now, home treatment, the theory would be you give
19 the patient or his parents a quantity of Factor VIII
20 concentrate to keep in the fridge to use if the occasion
21 should arise. That doesn't involve anybody else. It
22 involves the parents, it involves the child -- assuming
23 it's a child. Or the adult if it's an adult.

24 Where do the lost jobs come in, when one might have
25 thought that if somebody had a bleed at home and didn't

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1 a greater awareness of the AIDS problem."

2 I don't understand that. The more we know about
3 AIDS, presumably from the United States, the less the
4 risk appears to be?

5 **MR HOWELLS:** Sir, this was my next submission. This was (f)
6 in the list I have. But it's plainly wrong to suggest
7 that the risk presented by imported products, as
8 compared to domestic products, was less. Presumably
9 this was based on the fact that the Cardiff patient used
10 NHS concentrate between 1981 and the onset of
11 symptoms --

12 **SIR BRIAN LANGSTAFF:** But he also had commercial
13 concentrate.

14 **MR HOWELLS:** -- in December 1982. But Professor Bloom had
15 been told by Immuno Limited that the incubation period
16 was between -- up to two years.

17 So Professor Bloom's attempts in those days to try
18 to attribute the transmission of the virus causing AIDS
19 to the NHS product was again misleading because he knew,
20 because he'd been told in January and March, about the
21 incubation period, so could very well, and was more
22 likely to be, the imported concentrate, and Professor
23 Bloom was trying to pull the wool over everyone's eyes
24 and blame it on the NHS product.

25 **SIR BRIAN LANGSTAFF:** Yes.

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1 Well, I -- it's not altogether clear to me at the
 2 moment what it's trying to say.
 3 **MR HOWELLS:** Well, if we --
 4 **SIR BRIAN LANGSTAFF:** It's obviously saying something which
 5 avoids those who were at the meeting doing anything
 6 about it.
 7 **MR HOWELLS:** Perhaps the answer lies back on page 1, from
 8 recollection. So if we go to the "Background History".
 9 **SIR BRIAN LANGSTAFF:** Yes.
 10 **MR HOWELLS:** You can see in the first paragraph the
 11 reference to the fact that he had British Factor VIII.
 12 **SIR BRIAN LANGSTAFF:** Yes.
 13 **MR HOWELLS:** So there was an attempt by Professor Bloom to
 14 blame the British product rather than imported
 15 concentrate.
 16 **SIR BRIAN LANGSTAFF:** Thank you very much.
 17 **MR HOWELLS:** The other document that is relevant to this
 18 point, sir, is the briefing, the Q&A briefing, which
 19 is -- I won't bring it on screen but it's
 20 HSSG0010056_035.
 21 Finally, on this document, the submission is that
 22 the statement that there was no justification to ban
 23 imported concentrates was unreasonable. Five days
 24 later, Dr Galbraith wrote to Dr Field at the DHSS
 25 suggesting exactly that. The then incidence of AIDS
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1 Firstly, it's stated that there is no proven connection
 2 between the Cardiff case and the use of imported
 3 Factor VIII, even though, for the reasons I've already
 4 explained, a link could not be excluded and it was more
 5 likely that the transmission was from the USA products
 6 rather than the UK product, given the high prevalence of
 7 AIDS in the USA at that time. Secondly, it's stated
 8 that the level of risk created by imported blood
 9 products was very small and there was no cause for
 10 precipitate action.
 11 There was no proper basis for Professor Bloom to
 12 describe the risk as "very small".
 13 We note from the presentation by Counsel to the
 14 Inquiry on Wales that Professor Stephen Palmer was the
 15 PHLS CDSC's first medical consultant epidemiologist for
 16 Wales. He took up his post shortly after this meeting
 17 in May 1983. Prior to taking up his role, he spent time
 18 in Atlanta on a secondment from the CDC from late 1982.
 19 His role included supporting the office of the Chief
 20 Medical Officer for Wales. The greater part of his
 21 time, he says, was devoted to supporting the NHS and
 22 local authorities in Wales by developing epidemiological
 23 surveillance of communicable diseases, undertaking field
 24 investigations, giving advice on the management and
 25 control of incidents, and supervising training in field
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1 amongst haemophiliacs in the UK did not represent the
 2 risk and Professor Bloom knew that, given what he was
 3 told in January and March.
 4 So this was a missed opportunity for the Welsh
 5 Office to discuss putting in place arrangements for PFC
 6 to fractionate plasma from Wales. There seems to be no
 7 discussion or collaboration with the counterparts in
 8 Scotland or Northern Ireland, otherwise PFC would surely
 9 have been discussed at this meeting. It is regrettable
 10 that the Chief Medical Officer for Wales was not in
 11 a position to advise on the points identified that I've
 12 made a moment ago, and the Inquiry has received no
 13 evidence as to whether the Welsh Medical Officers
 14 liaised with the counterparts in the other four nations.
 15 In other words, it may well have been that the Chief
 16 Medical Officer for Wales was entirely reliant on
 17 Professor Bloom for accurate advice, and this is in fact
 18 what Professor Stephen Palmer suggests, and I'll come
 19 back to his evidence in a moment. Professor Bloom, as
 20 we know, was also on the subcommittee of the CSM(B) that
 21 provided the advice that they did, that the ban was not
 22 justifiable at that time.
 23 The advice that went to the Minister following that
 24 meeting is contained at HSSG0010055_002. I won't bring
 25 it up but it is misleading in two additional ways.
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1 epidemiology.
 2 He states in his witness statement, a draft witness
 3 statement, that the risk groups became evident quickly,
 4 including reports of patients with haemophilia
 5 developing AIDS. Though the cause of AIDS was not
 6 known, the most likely scenario was transmission
 7 following a hepatitis B model.
 8 So he agreed with Professor Tuddenham that it had
 9 all the hallmarks of hepatitis B and should have been
 10 treated that way, and he picked that up in Atlanta.
 11 Notwithstanding his role and his experience with the
 12 AIDS outbreak in the USA, the presentation summarises
 13 his evidence on his involvement with AIDS in the UK this
 14 way, and I'm referring to the presentation because still
 15 the statement is not yet available on Relativity. The
 16 presentation says:
 17 "Professor Palmer does not recall being party to
 18 decisions about blood and blood products, although he
 19 would have discussed the probable sources of infection
 20 of AIDS with Dr Crompton and his colleagues. The Welsh
 21 Office looked at Professor Bloom as director of the
 22 haemophilia centre in Cardiff and to Dr Napier as the
 23 director of the Regional Transfusion Centre, for
 24 specialist advice. As well as the Department of Health,
 25 Professor Palmer did not have a direct working
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relationship with Professor Bloom or Dr Napier. He does not have any recollection of discussions with Dr Galbraith in relation to the latter's proposal in May 1983 that there should be withdrawal from blood products from the USA."

Our submission is that whilst that evidence, that summary of the evidence, tends to show that the Welsh Office and the Chief Medical Officer for Wales were entirely dependent upon Professor Bloom for advice in relation to blood and blood products, as Dr Napier did not second-guess Professor Bloom's treatment decisions, it also shows that Professor Palmer failed in his role as an epidemiologist to offer impartial advice that contradicted that of Professor Bloom.

It is a reasonable inference that he had available to him the minutes of the Welsh Office meeting of 4 May that we've all seen, and so could and should have made himself aware of the advice provided at that meeting in relation to AIDS.

He accepts that he did discuss AIDS with the Chief Medical Officer in other respects.

At this point, because I've moved over the section, there is one correction I wish to make to our written submissions, and I wish to withdraw paragraph 140 of the written submissions. It contains an obvious error in

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death posed by imported concentrates. It could have been interpreted as an as-required basis.

Professor Bloom acknowledged in his litigation report written in 1990, that a reversion to cryoprecipitate would have resulted in a curtailment of home therapy. That would have been perfectly acceptable in response to the risk.

By February 1985, Professor Bloom had found his conscience, it seems, and wrote in The Lancet -- and it's PRSE0001758 -- that it was time to review the ever increasing use of factor concentrates. He said -- and we wouldn't know whether he said it with a straight face:

"A hierarchical assignment of risks from single-donor cryoprecipitate and various heat-treated concentrates, together with different patient characteristics such as age, previous treatment and HTLV-III serology should be made before each lesion is treated. The use of coagulation factor concentrates in the UK is still increasing by arithmetic progression. It may be wise now to take stock of the situation so that treatment intensity at least levels out until the possible risks can be more rationally assessed."

Sir, you, may think that a wise person could and should have done precisely that at the turn of at least

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drafting. It conflates two medical officers in respect of two different advisory committees, seven years apart, for which we apologise.

So I have apologised and I have explained what I'm apologising for.

SIR BRIAN LANGSTAFF: That's when you blame Dr Rejman, is it?

MR HOWELLS: Sir, yes.

SIR BRIAN LANGSTAFF: For something he did when he wasn't even there?

MR HOWELLS: Sir, yes.

Against the background that I've set out, it is astonishing that on 13 July 1983 Professor Bloom continued to advise the CSM(B) against taking action about the treatment, the use of imported concentrates. He justified his conclusion, his advice to that subcommittee that USA concentrates should not be withdrawn on the basis that: (i) it would be impossible to meet needs; (ii) even if needs could be met it would involve a major rethink of UK policy; and (iii) the perceived level of risk did not justify the response.

We say the fundamental flaw with this analysis is that need is based on usage, including home treatment, and prophylaxis, whereas need could have been interpreted more narrowly in response to the risk of

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1980. It was not wise to say --

SIR BRIAN LANGSTAFF: 1985?

MR HOWELLS: At least 1980. It was not wise to say in 1985, and apparently to seek credit for it, something that he fought against for at least five years previously.

That brings me to a submission made by number of public bodies, that you should be careful about judging actions at the time with the benefit of the knowledge of the outcome. We say hindsight is irrelevant.

The evidence shows that the relevant decision-makers had foresight but that's precisely why self-sufficiency was an aim. They knew that there were risks. Insofar as you find that individuals made material non-disclosures which I have invited you to find, again hindsight is irrelevant.

The whole point of having safety systems in place is to identify risks and mitigate them. The Government cannot say that they didn't know what was going to happen until it happened. That is not the point.

Sir, in the final five minutes, I want to say something briefly about the conflicts of interest. Although it's certainly correct to say that there was a failure to apply the precautionary principle to decision making about blood and blood products, that failure is beside the point. The real failure is the

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failure to act upon the knowledge that existed as of at least 1979/1980 that blood products were dangerous.

The point that we develop in our written submissions is that this failure occurred because of conflicts of interest, and a failure to act in the best interests of the patients. It was not, in truth, a failure to apply the precautionary principle, but something more egregious.

The precautionary principle is more relevant to the decisions being taken in the mid-1970s, when it was known that imported concentrates carried a higher risk of non-A, non-B hepatitis but the long term consequences were less understood.

The alternative to a conflict of interest is that all haemophilia clinicians were collectively negligent in the same way. That, we say, is too much of a coincidence. They minimised the risk they knew or ought to have known about, and the real question is why they did that. We say, in order to understand why Professor Bloom and others favoured clinical freedom over taking reasonable measures to mitigate the risk of death, it is necessary to understand the conflict of interest that existed.

I've read to you, pretty early on in my submissions, the evidence of Professor Parapia. It's a pretty good

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Professor Bloom.

His approach between January 1983 and July 1983 demonstrates that he acted unreasonably, and was likely to be unduly influenced by pharmaceutical companies.

This also explains his approach prior to 1983, and his role in the failure to achieve self-sufficiency, in that he was instrumental in the increasing demand for imported concentrates, both to enable home treatment programmes and his treatment of inhibitor patients, an approach that was also adopted by Dr Mayne. And those on behalf of the Health Service in Northern Ireland accept that Dr Mayne seemed to have a high number of inhibitor patients.

One tangible example of Professor Bloom advocating on behalf of pharmaceutical companies is January 1983 when he encouraged HCDs to use hepatitis-reduced products on patients previously unexposed to factor concentrates to find out the extent of infectivity, even though this was resisted by Dr Lane, who opposed the random exploitation of the haemophilia service by commercial organisations for the study of hepatitis-safe products. And he told Dr Bloom and Dr Rizza to inform other HCDs of the proper basis for this action. And that is addressed in the presentation on Professor Bloom at paragraphs 85 and 99-100.

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encapsulation of what the issues were. But also

Professor Tuddenham accepted that the commercial incentive overwhelmed safety issues. The money being spent by commercial companies on lavish entertainment created subconscious bias. Professor Tuddenham was a consultant at Speywood Laboratories and purchased their products for use at his hospital.

In respect of Professor Bloom, paragraph 279 of presentation by Counsel to the Inquiry states that:

"While at the Atlanta conference, Bloom met with a Cutter representative. The representative's internal memo provides further insight into the nature of Bloom's relationship with pharmaceutical manufacturers. The memo recorded that Bloom had asked if he could visit with Cutter the week following the San Diego meeting and that he would need room reservations in the city for Saturday, Sunday and Monday, plane reservations from San Diego, and that he would be accompanied by his wife. Bloom was said to be most interested in talking about testing for heat-treated Factor VIII to determine the levels of virus kill and infectivity following heat treatment. He also raised the issue of Cutter supply problems in the United Kingdom."

That's a pretty extraordinary extravagance that the pharmaceutical company seem to have afforded

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In summary, we say that the inappropriate

relationships between pharmaceutical companies and clinicians were the pervasive rot that led to the collapse of good clinical decision making in haemophilia care and impartial advice to Government.

The conflict of interest extended to the Committee on Safety of Medicines. Sir Michael Rawlins confirmed that members of the CSM did not have to declare conflicts of interest in the past. He opined that colleagues were put under pressure by payments received from pharmaceutical companies. He stated that he was concerned about the sponsorship that pharmaceutical companies provided for clinicians to attend conferences. He wrote an article entitled *Bribery*, which was published in the Sunday People in March 1981, and that's in JEVA0000125. Sir Michael stated that there was a certain amount of covert bribery. He referred to pharmaceutical companies paying expenses for foreign conferences and stated that he had also been invited.

He also stated that:

"The companies are not idiots. They would not do it if it was not worthwhile ... education gets mixed up with financial rewards or other substitutes."

Sir, those are the submissions that I intend to make. I have gone over the allotted time. I would have

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1 made reference to the Baroness Cumberledge review where
 2 she also touches upon her concerns about conflicts of
 3 interest. You have had the evidence of Dame Raine and
 4 from the MHRA about the actions they've taken in
 5 response to that review, and we invite you to consider
 6 whether that is sufficient. And we invite you to
 7 consider why it's only in response to the review in 2022
 8 that the MHRA is carrying out a consultation on its
 9 conflicts of interest policy and why it didn't identify
 10 it itself at an earlier point.

11 Finally, sir, I want to say something about
 12 apologies. As I understand it, Ms Grey KC does not
 13 represent the Secretaries of State for Wales and
 14 Northern Ireland. Mr Aldworth KC repeated the hollow
 15 apology made by the DHSC. That is, no apology at all.
 16 In fact, our clients were insulted that he chose to do
 17 that knowing how it had been received by you, sir, but
 18 also the infected and affected.

19 Our clients think they were weasel words. The
 20 apology was not explained but was followed by
 21 exculpatory submissions both in writing and orally. The
 22 Welsh Government has chosen not to make oral submissions
 23 or indeed written submissions of any substance. When
 24 they are compared to the NHS in Scotland, they fall far
 25 short.

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1 consequence of a reduction of home treatment would lead
 2 to haemophiliacs losing jobs because they would no
 3 longer be in receipt of home treatment. They would have
 4 to go to hospital for their treatment and then they
 5 would become, in turn, more reliant on Social Services.
 6 That, I think, is the correct reading. Whether it is
 7 a valid point a matter for you to consider.

8 **SIR BRIAN LANGSTAFF:** I was puzzling over it, as you can
 9 see, and I think your explanation makes sense.

10 **MS RICHARDS:** Sir, then, that leaves only tomorrow, when we
 11 have the submissions of Mr Dawson KC on behalf of the
 12 Core Participants represented by Thompsons Solicitors.

13 **SIR BRIAN LANGSTAFF:** So, tomorrow, 10.00, Mr Dawson.

14 (4.21 pm)

15 (The hearing adjourned until 10.00 am the following day)
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1 They've all fallen short of the duty of candour that
 2 Mr Bowie, King's Counsel, accepted applied to public
 3 bodies in Scotland. They've fallen short of reasonable
 4 expectations as to how Government and Health Authorities
 5 should conduct themselves even now.

6 Finally, the psychosocial expert group report at
 7 paragraph 13.4.6 stresses the importance of proper
 8 apologies. Failure to initiate open disclosure as soon
 9 as possible, and to apologise, is damaging to
 10 individuals in many ways. It does not permit people to
 11 move on. They get stuck with their anger. That said,
 12 it is never too late to try to partially rectify, as
 13 might happen with this Inquiry.

14 We adopt the submissions made by Leigh Day in
 15 relation to hepatitis B and the exclusion of people
 16 infected with hepatitis B from the support schemes.

17 Unless I can be of any further assistance.

18 **SIR BRIAN LANGSTAFF:** No, you've been already a lot of
 19 assistance. Thank you very much, and thank you both you
 20 and Mr Williams.

21 **MR HOWELLS:** Thank you, sir.

22 **MS RICHARDS:** Sir, whilst it's fresh in my mind, the note of
 23 4 May 1983, the Welsh Office meeting that you and
 24 Mr Howells were debating, as I read it, the reference to
 25 lost jobs is a reference to the suggestion that the

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