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

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.

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

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.

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

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

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

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

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

MS JONES: Yes.

SIR BRIAN LANGSTAFF: Is that broadly right?

MS JONES: That is broadly right. Actual financial loss. But, sir, also if, for example, an infected person has received care from their loved one or a family member, then that is known as gratuitous care, and the costs of gratuitous care should also be included within --

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

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

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

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

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

the gratuitous care but cannot recover loss of earnings.

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

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

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

SIR BRIAN LANGSTAFF: Well, if one were looking at this as a court case as well, any person who is a secondary victim of an accident or incident would only be compensated if they came within a particular class of those who are -- the classic way of describing it is "nearness, hereness and dearness", within that category. Is it really appropriate, in these circumstances, to look at that in any other way than a broadbrush way, in assuming that anyone who does care is within that sort of class?

MS JONES: I agree, sir. I think the current position or the current state of the law in respect of secondary victims, so they are people who haven't suffered the injury themselves but are, as Sir Brian said, nearest, dearest and --

SIR BRIAN LANGSTAFF: Nearness, dearness and hereness -- of an accident.

MS JONES: Yeah.

SIR BRIAN LANGSTAFF: The classic case is someone whose toddler goes round the corner on his pedal bike, there's the sound of a crash, and they arrive and they don't see the accident but they see its aftermath, and they may well suffer shock -- it used to be called psychological shock -- from witnessing or being within that general area. And there have been lots of arguments about how far it extends and whether it extends to the person who suffers the corrosive impact of being an ever-present at the hospital bed of someone who is dying.

MS JONES: I believe, sir, the Supreme Court is going to be in exercising itself in a case in the hopefully not too distant future about those control mechanisms.

SIR BRIAN LANGSTAFF: Is this one of yours?

MS JONES: No. We've got one stayed behind it, so fingers crossed.

Sir, I think if you were able to recommend the scheme that didn't impose such narrow restrictions, it would make it far simpler for applicants and also for any awarding body to be able to consider the issues and reach the right level of compensation.

SIR BRIAN LANGSTAFF: Well, at the moment, the way that I tend to regard the principle is it's one of public policy preventing unlimited liability to an unlimited class for an unlimited length of time. If that's wrong, and it's not an act of public policy, then I would welcome hearing from any of the lawyers, if that's the case. But I'm not engaged in a court case assessing compensation; I'm here dealing with what is appropriate recompense -- assuming that I recommend it -- appropriate recompense for those who have suffered in their very different and -- in their particular, very particular way.

MS JONES: Yes, sir.

I don't have anything to address you on, sir, further about the matter of public policy. I don't know if there's anyone else.

SIR BRIAN LANGSTAFF: Well, that's a matter. People can take their time and think about it and if they disagree,

please let me know.

MS JONES: I do not disagree. I think that the proposal that you have set out follow up the fairest and simplest way forward for everyone that's been infected and affected by this tragedy.

SIR BRIAN LANGSTAFF: Thank you.

MS JONES: We consider that the awarding body for the new compensation scheme should be an independent arm's length body with rights of appeal. A body that understands the background of the infected blood scandal and which seeks to be inclusive rather than exclusive.

There should be a reversal of burden of proof or, at the very least, a lower standard should be applied, by which I mean a reasonable degree of likelihood, rather than blood having been received on the balance of probabilities, and there must be no insistence upon medical records as a precondition for eligibility.

Our Core Participants also require meaningful support and non-financial support which should not be overlooked or deprioritised in the process of creating a new compensation scheme. The awarding body should be aware of applicants' social needs and should be properly equipped to support applicants to assess comprehensive welfare services, including housing, income support, and social care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"The most difficult thing is watching somebody you love fall apart day to day. I can only describe it as like watching an old car with bits falling off progressively. It's like there is a paleness or a greyness to every day but you must try to keep your loved one cheerful and keep them going. All you can do, if you feel overwhelmed is go out into the nearest field and shout."

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

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

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

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

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

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

MS JONES: Thank you, Sir Brian.

SIR BRIAN LANGSTAFF: Thanks to Ms Morgan as well.

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

(10.38 am)

(A short break)

(10.44 am)

SIR BRIAN LANGSTAFF: Yes, Mr Williams.

Closing Statement by MR WILLIAMS KC

On behalf of 237 individual core participants, Haemophilia Wales, Haemophilia Northern Ireland, The Hepatitis B Positive Trust and the CJD Support Network

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

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

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

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

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

her child.

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

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

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

The event confirms, if we need it, the terrible events that we're dealing with. The consequences are not what occurred -- are not just what occurred 10, 15, 20 years ago. They're the here and now. And they'll go on into the future. It's very important to bear in mind, we say -- and our Core Participants would say -- that due regard is not just had for those who have suffered in the past, although that's very, very important, but that due regard is had to those who continue to suffer, who continue to be deprived of fathers, children, and who need care and assistance into the future.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The first one said this:

"From our experience the UK Government has been evasive, dishonest and cynical. The Department of Health has been hostile in its responses to campaigners and MPs who have debated the matter in Parliament. They have refused to both fully accept responsibility and to offer realistic compensation. They have engaged in political trickery and treated victims with contempt. The Department of Health clearly has a lot to hide and has been aggressive in defence of its own interests. The financial assistance given has been piecemeal and grudging, the use of contaminated blood and its consequences is a scandal but the attitude of the Department of Health to the victims is an even bigger scandal, provoking great anger, distress and suffering, adding insult to injury."

The second letter is this:

"All widows have been given a life sentence, some a double life sentence if they've been infected as well,

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

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

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

their stories. Have they been allowed to?

That's primarily directed towards you, sir, because you're the one who has had control of this Inquiry.

Overall the feeling is yes, you've allowed them to be heard. You've allowed them to have their say, without constraints. They were allowed to say, within limits, whatever they wanted to say, and they were allowed to do it in their words and they were allowed to do it in their way.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Definition of compensation.

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

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

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

"Other dictionary definitions include:

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

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

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

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

"Is not limited to an award of money;

"Involves a process;

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

"Is intended to redress that injury or loss."

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

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

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

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

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

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

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

(Video played)

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

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

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

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

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

MR WILLIAMS: Yes, sir.

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

What should be done? Our proposals for the scheme

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

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

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

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

The four existing schemes for the provision of

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

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

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

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

Secondly, the compensation is paid as of right --

not as a matter of charity, but as of right -- because of the harm they've suffered.

We adopt those principles set out in Sir Robert's report at paragraph 4.75. I'm going to go through those, and that will take a little time, so now might be time to stop it.

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

(11.18 am)

(A short break)

(11.49 am)

SIR BRIAN LANGSTAFF: Yes.

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

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

"Principles

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

scheme."

Then next down:

"Remedial:

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

"Respect for dignity:

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

"Collaborative:

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

"Choice:

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

"Individualised:

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

"Inclusive:

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

"Non-technical:

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

"Accessible:

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

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

It then goes on:

"Ease of proof:

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

"Broad:

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

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

"Improving:

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

Then over the page, top of the page.

"Complementary:

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

I just want to stop there, sir.

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

I know this is a matter of great concern to many of our Core Participants, but they fear that if they have an award of compensation they will lose the regular payments they're receiving at the moment, and it is crucial to many people that the regular payments they receive at the moment continues into the future. And it's clear from Sir Robert's principles there that he agrees. with our clients.

So, sir, that's a particularly important matter. They don't want to forgo regular payments for compensation, they want both.

Continuing:

"Holistic:

"Compensation is not just about money, but should also include consideration of material means to compensate for what has been lost."

So that's Sir Robert's recommendations.

We've drawn up our own list of recommendations. To an extent it mirrors what Sir Robert has said, or maybe a slightly different way than Sir Robert has said, but, sir, we thought it would be appropriate to set out certain additions.

So, firstly, the purpose of the scheme is to ensure that everyone who is entitled to compensation receives compensation.

The scheme, we say, should be judge-led.

The scheme must be wholly independent of government, whether UK-wide or devolved.

We say there must be a dynamic, vigorous, and proactive approach to identifying those entitled to compensation. There should be a search for them, and all possible methods must be used.

Although there may in some claims be disagreement concerning the entitlement of compensation or the amount of compensation, the process of making a claim and resolving the amount of compensation must, so far as possible, be dealt with in a non-adversarial way.

The purpose of the process is one where the infected and affected are to receive the appropriate amount of compensation, not one where pressure is applied, direct or indirect, or to accept less than the claim is worth.

A person seeking compensation should not be required to waive their rights to pursue litigation.

The issues as to whom should receive compensation and the amount that should be paid should be resolved as soon as is reasonably practicable. However, this has to be balanced against the understandable desire of the infected and affected to have careful consideration given to their own individual case.

Sir, if I can just stop there for one moment. The tension between those two things can be met to an extent, of course, by another interim payment to those who have received an interim payment already. And in

respect of those that have not received an interim payment, to have an interim payment in the very near future. That would allow some recompense, some compensation to those who need it -- and they all need this money, sir -- but also allow a balanced view to be taken about the scheme to be set up and how the compensation is to be calculated.

I continue. Those recruited to run the scheme must be provided with appropriate training in all aspects of their respective roles.

Contrary to the position by Sir Robert, those who we represent would wish to have the opportunity to be legally represented going through this process, paid for by the UK Government, so that the Core Participants, or those seeking an award, can receive appropriate advice and reassurance regarding the process of seeking an award of compensation, advice regarding the various types of compensation, and support and full explanation of any decision they may have to make in respect of eligibility and quantum.

It would be wholly inappropriate for the infected and affected to have to rely on the guidance and support of employees of an institution which is financed by the body paying their compensation. There's an obvious room for conflict of interest, we say, sir.

People don't have to have a lawyer, but if they want one to help them, to give them advice, particularly on the compensation to be calculated, the quantum of it, then it may well assist them if they have a lawyer.

Given their previous experience of the trusts and schemes, where they were treated with disdain, contempt and distrust, dealt with as beggars seeking charity, not as a person who had a right to compensation, and where those who were acquiescent in this regime might be treated more generously than those who tried to stand up for their rights, waiting for the relationship of trust to develop between those infected and affected and those seeking to administer the scheme will take a long time.

In order to make sure that process of assessing the amount of compensation to be awarded proceeds as smoothly and as quickly as possible, the UK Government should finance the provision of Legal Aid and representation of the applicant.

We say there are further advantages in having legal representation. Firstly, the application for compensation will necessarily require detailed consideration of the applicant's medical records, which sometimes will extend to a number of lever-arch files. This is likely to be a traumatic and upsetting process for the claimant as they are reminded of the many painful events which have occurred and which, in many cases, will continue into the future.

This may be less traumatic if they are able to rely on legal representatives who already know the background to the scheme and the issues that may need to be explored in any individual case.

Secondly, their medical records are likely to contain private and confidential information, unrelated to becoming infected, which should not be shared with strangers.

Three, their present solicitors will have access to the medical records and they will know the issues likely to arise, and so will therefore be able to start processing their application for compensation immediately. Those who don't wish to be instructed by their present solicitors, then of course they are at liberty to instruct another solicitor.

Insofar as may be necessary, the UK Government shall fund the instruction of such independent medical experts as the person claiming compensation may reasonably require. Those who receive compensation should be entitled to an annual amount -- sorry -- to an annual sum to pay a financial adviser to help them invest the compensation and to manage their financial affairs.

The new scheme shall be funded by the UK Government.

The amount of money required to fund the scheme shall be provided by the UK Government on an annual basis. There will be no more reserves maintained by the body administering the scheme.

The new scheme will be capable of being accessed locally to ensure that, so far as possible, a trusting relationship eventually develops over time between those administering the scheme and those receiving compensation. The scheme should be co-designed by a committee which should include representatives of the infected and affected, so as to ensure that appropriate weight is given to their interests and concerns.

There should be a representative of those infected and affected on any group, subcommittee or panel involved in setting up the scheme or continuing to run it thereafter.

The infected and affected should be invited to play an active and collaborative approach in the continuing development of the scheme. Every effort should be made to ensure that the infected and affected are not cut adrift or simply drift away from the tribunal or the scheme.

The framework of the scheme. There should be established a judicial body known as -- this is our suggestion, sir -- the Infected Blood Tribunal. The

lower level should make initial decisions on eligibility and quantum. The adjudicators should be of such calibre as to engender in those making an application, confidence and trust in their independence and ability. Those making decisions affecting eligibility and quantum should be experienced in the assessment of damages for personal injury claims, and the assessment of relevant medical matters. They should receive training in the possible effects of the relevant diseases. They should be provided with information concerning why this disaster occurred and the devastating effect it has had and continues to have on individuals and families.

They should be told of the way the infected and affected have had to fight for justice for many decades against intransigent, uncaring and defensive governments. The rules and procedures should be clear, straightforward and well publicised.

Each tribunal of first instance shall be presided over by a circuit judge.

SIR BRIAN LANGSTAFF: Why do you say that?

MR WILLIAMS: Because --

SIR BRIAN LANGSTAFF: The -- go ahead.

MR WILLIAMS: For this reason. First of all, the amount of money that will be considered by the judge will be considerable, in some cases very large sums of money.

The claimants must have confidence in the person they appear before, that they know what they're dealing with.

SIR BRIAN LANGSTAFF: Well, that was why I asked, actually. You're proposing a tribunal. There is, in HMCTS -- the key is the "T" -- a parity, as it were, between courts and tribunals. Tribunals have the advantage, it may be said, of being less formal in their procedure, of tending to be quick and to have rules of procedure which are rather simpler than the rules of civil procedure, which as you know are quite complex and complicated.

It also involves people who are dedicated to doing the particular task that they do, whereas circuit judges are either, and generally, dealing with crime in most of their career or, to some extent, in some cases, dealing with civil. There isn't an awful lot of civil litigation currently conducted, I think, in the County Courts.

So it might be -- I'm just asking, really, for your reaction to this -- that if the proposal is that there be a tribunal with an appeal tribunal beyond, why shouldn't it be a tribunal judge within the Tribunal Service having the support of the senior president of tribunals, ultimately, who, as you know, is on a par to the -- almost on a par to the Lord Chief Justice?

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

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

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

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

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

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

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

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

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

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

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

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

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

SIR BRIAN LANGSTAFF: Yes, I see.

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

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

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

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

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

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

MR WILLIAMS: No.

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

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

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

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

SIR BRIAN LANGSTAFF: I understand the point.

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

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

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

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

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

It will be a matter entirely for the applicant as to

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

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

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

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

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

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

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

"or

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

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

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

MR WILLIAMS: Yes.

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

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

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

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

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

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

that -- sorry. He says that he recommends:

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

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

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

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

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

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

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

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

If we can just look at that. He recommended:

"... that the following relevant indirectly affected persons should be admitted to the scheme ..."

So we have spouses, et cetera.

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

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

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

We say that those references to age, either directly

or implicitly, should be taken out.

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

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

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

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

We then continue:

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

expert, states that the relevant medical procedure may have involved the use of blood or blood transfusion, there should be a presumption in favour of the applicant. The burden [and we say it should be a heavy burden] should be on the respondent to rebut that presumption."

We now turn to the assessment of quantum of damages.

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

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

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

identify a greater loss than might normally be expected.

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

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

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

That would be intolerable to the vast majority of the people that we represent and, we suspect, to everyone else.

At recent conferences, many of our clients agreed that they wished the assessment of compensation to be carried out as fast and as quickly as possible. They much prepared a banded approach. Having been deprived of proper, appropriate or any meaningful compensation and indeed, in some cases, of any compensation for many decades, it would be unacceptable to introduce a further delay.

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

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

"... that infections eligible for compensation should be classified in the following manner:

"there should be defined categories for each type of eligible infection, and the stages through which it progresses, and for each category defined degrees of severity to which a range of possible awards for the impact of the disease can be applied ..."

The first one is that:

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

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

The same in respect of (c):

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

There, too, they should be represented.

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

Subject to that, we adopt Recommendation 6.

We adopt Recommendation 7. That deals with

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

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

Recommendation 8 is adopted.

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

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

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

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

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

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

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

For the avoidance of doubt, these awards should be paid in addition to any other sum to be paid under any other head of loss.

Sir, we adopt Recommendations 10, 11, 12, 13, and 15. I'm not going to read them out otherwise we really will be here all day, but we adopt those recommendations as well.

We also say that insurers, financial companies, must provide financial products and mortgages to those infected and affected, and any difference in premium to those who would not be infected or affected should be underwritten by the Government.

We recommend that in its report, the Inquiry emphasises the need for appropriate compensation to be awarded in the following circumstances. We know that some of these categories are already dealt with by Sir Robert, but these are particular ones that concern our clients, and so we put them before you as stand alone recommendations, if you will.

So first of all, where couples were warned that they should not have a child due to the risk that one or the other might be infected with one of the relevant diseases, as a result thereof they lost the opportunity

of having children, there should be an award. Where couples were warned not to continue with a pregnancy because of the risk that one or another might be infected with one of the relevant diseases and that, as a result the pregnancy was terminated, there should be an award.

Where couples were warned after their child was born of the risk that one or other might have been infected with one of the relevant diseases, then whether or not the child was infected -- on second thought, I should just alter that to even where the child was not infected -- they should have an award for any shock, distress.

A separate category. Women carriers of haemophilia who, in the late 1970s and early 1980s, sought advice from clinicians as to the risk of having a child and were not warned of the risk of their child developing hepatitis and/or HIV if they went ahead and had a child, and subsequently it transpired that there had been a significant risk -- and we do know there was a significant risk -- then even though the child was not infected, both parents and child could suffer significant shock, anxiety and upset, and if they did, they should be entitled to claim compensation.

Sir, to the extent we've not argued otherwise, we

adopt Recommendations 16 to 19.

I just want to deal with some additional matters with future compensation. We say that once the Inquiry has reported, it is likely there will be a flurry of activity until the new scheme is up and running. Following that, it is likely that the public, press and Government's interest in the blood scandal will diminish until it becomes, I'm afraid, sir, a distant memory. We contend that, as well as an appropriate scheme of compensation, radical improvements in their healthcare and appropriate findings concerning wrongdoing, the infected and affected have the right to expect that the continued health and wellbeing of the infected and affected is supported, advanced and protected by some independent person or body to be established as soon as possible.

These people who have suffered for so long should not be forgotten or cut adrift. We have invented the title of "Infected Blood Victim Commissioner" but we're open to any more manageable title than that, sir.

We say the infected and affected should play a part in setting up the scheme and, thereafter, their views should be sought at regular intervals. The Commissioner should be fully funded but wholly independent from the Government, both UK and devolved. It is important that

the Commissioner is established at the outset, in order to play a constructive role in the establishing of a scheme.

Sir, when we make this recommendation, we don't seek to replicate the established position of Victim Commissioner, which covers all manner of issues connected with the criminal law. Rather, we invite the Inquiry to give consideration to the role of the Commissioner of Survivors of Institutional Childhood Abuse, an independent organisation established by the Government to assist the victims and survivors following the report of the Historical Institutional Abuse Inquiry in Northern Ireland, which reported in 2017.

The role of the Commissioner -- presently, we believe, Fiona Ryan -- is to empower victims and survivors to exercise their rights. The Commissioner has various statutory powers given to her, including powers to undertake or commission research, to compile information, to provide advice or information, to publish anything concerning their interests and to make representations or recommendations to any person or body concerning the interests of the victims and survivors.

We recommend that a similar commissioner should be set up as soon as possible to represent the interests and to protect the wellbeing of the infected person.

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

Sir, that's all we have to say about compensation. I now want to turn to the issue of healthcare.

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

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

force in Northern Ireland?

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

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

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

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

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

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

SIR BRIAN LANGSTAFF: Yes.

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

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

So, healthcare.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

measures.

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

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

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

The UK Health Departments should ensure that hospital transfusion committees: (i) complete annual audits to determine which blood products are being used, in what quantity, and by which departments; (ii) record the number of transfusion reactions, transfusion incompatibility incidents, bacterial infection, viral infections, and such other adverse reactions as a result of the provision of blood or blood products, however long after the transfusion they present; and report the same to SHOT.

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

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

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

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

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

if we start again at 1.30.

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

So we'll go with the public.

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

MR WILLIAMS: Very well, sir.

(12.52 pm)

(The Luncheon Adjournment)

(1.50 pm)

SIR BRIAN LANGSTAFF: Yes.

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

SIR BRIAN LANGSTAFF: Juniors always were like that!

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

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

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

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

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

So, 23 March 1987.

"Dear Mrs Grindley,

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

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

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

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

Sorry, I'm repeating myself.

It goes down to the last but one paragraph:

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

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

That's an astonishing letter for a minister in the Health Department to write. It's grossly insulting to many groups. One gets a hint of homophobia there. It's insulting to people who don't lead a "good Christian life". It suggests that if you have HIV that maybe you don't lead a good Christian life. It suggests that -- this sounds positively medieval -- but if you are a good Christian, that will stop you getting HIV.

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

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

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

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

I should perhaps have added a sentence, "But please

make sure that no one ever behaves as badly as these people did."

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

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

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

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

That the use of arm's-length bodies was a device by which the UK Government could cover up their control of

the activities of the schemes. The schemes operated as if they were an extension of the DoH, whilst keeping the registrants at arms-length. They did not seek to protect the beneficiaries, rather, they sought to protect the Department of Health.

We then set out some examples.

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

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

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

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

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

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

Those who controlled the schemes, the chair, the

deputy chair, the trustees, took their lead from the Department of Health, and from the civil servants that sat on the boards.

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

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

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

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

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

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

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

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

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

The evidence that the Inquiry has received in

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

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

There were no secretarial resources.

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

The applicant could not support their application with medical evidence.

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

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

The applicant was not entitled to give oral evidence.

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

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

No record was kept of the consideration of the claim.

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

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

There were no regional support workers.

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

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

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

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

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

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

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

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

They were concerned that if they published such a list, the "great unwashed", as these people were described, would use it as a shopping list. What an appalling attitude to bring to the distribution of funds, even the minimum money that was available, in dealing with these applications, and these badly hurt people.

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

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

That's you they didn't want.

SIR BRIAN LANGSTAFF: (unclear) -- there was, for a while,

a partnership group.

MR WILLIAMS: There was, which is why --

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

MR WILLIAMS: I'm terribly sorry for interrupting you. There was, at various stages, which I think is why I prefaced, I hope, my remarks about, "for the most part" or "for most of the time".

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

MR WILLIAMS: Yes.

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

MR WILLIAMS: Yes.

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

MR WILLIAMS: Yes.

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

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

Eileen Trust is an odd body on these trusts and schemes. There seemed to have been an element of class -- that would be the next point I was going to make any way -- an element of class, because the people going to the Eileen Trust would have been perhaps middle class, perhaps working class.

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

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

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

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

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

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

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

MR WILLIAMS: Yes.

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

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

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

MR WILLIAMS: Yes.

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

SIR BRIAN LANGSTAFF: Well, I have the submission that the board should have been more representative.

MR WILLIAMS: Yes, or just behaved themselves, behaved accordingly.

SIR BRIAN LANGSTAFF: I understand that point too, very well.

MR WILLIAMS: So, sir, I'd just like to, as a last point, deal with a particular family. It's the Lewis family from Cardiff. So perhaps we can have the photo of Mr and Mrs Lewis up, please. There we are.

Ladies and gentlemen, this photograph has been produced before. That's Haydn Lewis with his wife. There's also a picture which we don't need to turn to, of Gareth Lewis. Gareth was Haydn's brother. They lived in Cardiff. Haydn and Gareth developed HIV and hepatitis C.

They had received that whilst being treated by Dr Bloom at the University Hospital. Haydn wasn't immediately told that he had HIV, as a result of which he infected his wife, that's Gaynor Lewis. They had two children. Fortunately, the children survive and so does Mrs Lewis.

At a very early stage, particularly Haydn but also Gareth, became involved in campaigning for the rights of the infected and affected. The prompt for that seems to have been the result of the death of a young boy in the

clinic. We've had his name, Colin. Such was the distress they felt was they thought they should do something about it. So the two of them set up the Birchgrove Group, in the Birchgrove pub, and that went on to be the Birchgrove organisation more generally, and then I think became Tainted Blood.

Although, from the descriptions we've had, Gareth was a somewhat fiery individual, Haydn was less so. Haydn has been described as a thoughtful, polite, hardworking young man. Unfortunately, because he was a campaigner, he seems to have fallen foul of Mr Peter Stevens. Mr Stevens -- a degree from Oxford University, obviously very clever -- became a financial analyst during the course of his professional career, became a trustee of the Macfarlane Trust in -- if I can read my writing -- '87. He then sat on nearly every board that was dealing with compensation -- well, dealing with support, and he ended up a director of the Skipton Fund.

For reasons which are inexplicable, Mr Stevens, treated Mr Haydn Lewis in a terrible manner.

In making these remarks, I bear in mind that Mr Stevens also suffered grievous loss in this medical disaster, with at least one son infected and one son infected who died. That makes his behaviour even

more -- sorry. That makes his behaviour that much more surprising.

I want to deal with the cross-examination of Gaynor.

So this is the transcript, sir, 26 July 2019, of Gaynor Lewis. She deals with a number of things. As we will see.

So the question -- I think it was Ms Richards who was conducting the questioning:

"I just want to ask you, as the last area of questioning that I have for you, about the Macfarlane Trust.

"Mmm.

"Haydn had a lot of dealings over the years with the Macfarlane Trust. You've described them in your statement from your own perspective as terrible to deal with?

"Mmm.

"An uphill battle with obstacles in the way and Haydn was particularly concerned that they weren't providing enough financial help and support.

"That's right and there was one time when we moved to the house we're now in, there was work being done, a downstairs bathroom. We called them adaptations but the Macfarlane Trust would see it as renovations and the council would pay so much towards the work but there was

5,000 needed and we asked or Haydn asked for the money and this was bouncing back and forth for a couple of months, I think. And Fran rang one day and said, 'We've had a meeting and I'm sorry you can't have it' [the money]. I burst into tears because I could see the work being done, it was boosting him and giving him something to get up for, you know.

"So I burst into tears and she said 'I'll phone you back, hang on', they changed their mind just like that. What if I hadn't burst into tears? What about all those other people that just accept it? No, they were awful."

So we say that was appalling behaviour. There either is a rule that they apply, and guidance that they apply, or there isn't. But they're persuaded to go one way not the other because of whatever reasons they had for not advancing the money to Mr Haydn Lewis, and then they changed because a woman cries. As she herself says, what if she hadn't cried? They wouldn't have got the money, they'd have had a building half finished.

Then Ms Richards goes on:

"We're going to look first of all at a letter and then at some emails.

"The letter is 2368009, please ...

"This a letter dated 30 April 1996, from the Macfarlane Trust. It's addressed to Dr Dasani and it says this ..."

I should explain, Dr Dasani was one of the main people in charge of the haemophilic --

Only two more days then you can have your phone on whenever you like!

Dr Dasani was one of the doctors in charge at the Cardiff haemophilia centre. It says:

"'Dr Dasani, your patient shown above has made a request to the Trust for the financial assistance, which will be considered by our trustees at their meeting in three weeks' time. Since on present policy single payments are almost invariably health related the trustees have decided that the anonymous case summaries which they receive in advance of their meetings should contain up-to-date health information gathered in a consistent fashion. To meet this aim where the health information held on a particular patient is older than six months a doctor's report will be requested.'

"Then there's reference to how often doctors might be asked to provide information. Then it says this:

"'All the information contained in the completed report will be treated as given in confidence to the Trust and will not be shared with the patient concerned.'"

Gaynor: "It doesn't surprise me.

"Were you aware the Macfarlane Trust was asking for confidential medical reports --

"No.

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

"No."

Once again, sir, it hardly needs saying, what appalling conduct. They're getting secret reports from a patient and getting a doctor to conspire in that by not telling their client -- sorry, their patient -- what they're doing. Then it says:

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

"We're going to look at some details between Martin Harvey, Chief Executive of the Macfarlane Trust, and Peter Stevens, Chair of ..."

Then Gaynor intervenes:

"Can I just say that before -- well, before we read this, the context of this is that Haydn -- I didn't -- kept the £20,000 when the first payment and my boys didn't get the Category G payment either so Haydn was talking to the Trust. He didn't want a penny more or a penny less, only what we deserved and this is the outcome."

Ms Richards: "You were what the Trust termed and the Inquiry has heard the phrase before in relation to other

witnesses an infected intimate?

"Yeah, nice.

"We see -- thank you for explaining the context. We see what the email is."

So a quotation:

"'Martin, what's with these people?

"'Funnily enough, when you set it out as you have done it makes one wonder why infected intimates are treated exactly as registrants, since they do not have haemophilia to worry about. We might see if we can review that when we get round to looking at regpay [which I'm reliably informed were the regular payments that were made] at the NSSC (that would be a way of pissing off the Lewis contingent).'"

Unbelievable, sir, that someone could write about that with one brother infected with HIV, hepatitis B, the other brother also infected, and he knew that Gaynor also had HIV.

"The second email we're going to look at is the second page, please ... We'll just look at the top, first of all. The context here is an email here from Haydn referred to a meeting he'd attended where he had lost his temper and it's an email in which he says he was so angry and frustrated with the meeting, he was unable to make his point and get any sensible answers,

and he lost his temper and he says in the email at the top:

"'I would like to apologise to all present at the meeting.'"

That's Haydn apologising.

"Then he says this:

"'I ended the matter with a statement of never writing to either the Chairman or the [Chief Executive] again which is a sad conclusion to the whole matter. What I am even sadder about is that the Chairman and CE don't even seem to care that one registrant has now lost all faith in the honesty and integrity of those involved and I'm left with no way of contacting the Trust with any belief of what they will tell me is true.'

"Then further on he adds that you will now be dealing with the Trust on behalf of both of them."

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

"Then if we go down to the bottom email, please [then Ms Richards reads it out]. It's from Peter Stevens to Martin Harvey:

"'Martin, as I prepare to go to bed I recall that I shall never have a private email from Haydn Lewis again. Oh happy day! (Indeed, Calloo! Callay! but I have not yet discovered whether you, too, nurse a Lewis Carroll streak).

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

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

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

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

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

"'It's irritating that someboyd [sic] so thick can

come up with such meddlesome suggestions.'

"He spelt 'somebody' wrong!

"Yes, spelt incorrectly."

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

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

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

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

MR WILLIAMS: Yes.

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

MR WILLIAMS: No.

Then Ms Richards continues:

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

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

exchanges. It's not specifically directed at any issues relating to Haydn, but it just says this:

"'Nobody will argue with the sentiment that whatever the amount of money available, registrants do not get sufficient financial support (to recompense for what has happened to them) and that each and every one of them would swop their MFT involvement for a clean bill of health'."

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

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

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

(Video played)

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

SIR BRIAN LANGSTAFF: Yes.

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

SIR BRIAN LANGSTAFF: In my younger days!

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

Closing Statement by MR HOWELLS

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

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

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

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

It is well known in this Inquiry that when the

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

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

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

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.

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

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

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

WIBSS was given statutory powers to make payments to eligible persons by the Wales Infected Blood Support Scheme (No. 2) Directions 2017. Those directions were made under the National Health Service (Wales) Act 2006, which is an Act of the UK Parliament. If that Act gave the Welsh Ministers a power to make payments to infected persons through WIBSS, there is no proper basis for saying that it did so only in relation to hepatitis C and not HIV.

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

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

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

Lawrence, it's DHSC0042275_012.

If I could just have the summary to begin.

Sir, the summary says:

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

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

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

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

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

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

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

Then, Lawrence, paragraph 16, page 4.

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

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

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

That's the reasoning.

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

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

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

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

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

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

three reasons.

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

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

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

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

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

To conclude in this segment, sir, there are two

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

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

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

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

"This was very disappointing, given that this

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

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

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

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

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

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

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

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

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

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

Northern Ireland to achieve self-sufficiency.

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

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

He said this:

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

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

There was all sorts of available monies from pharmaceutical companies.

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

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

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

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

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

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

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

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

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

The reference for that, sir, is LDOW0000018.

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

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

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

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

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

expensive imports.

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

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

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

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

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

taxpayer."

So the problem is there to be seen in 1981.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a coordinating role. But the Department was involved.

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

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

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

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

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

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

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

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

that arrangement would continue.

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

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

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

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

nations and that was normally left to administrators.

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

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

Office.

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

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

So the system was topsy-turvy.

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

The Public Health Administration Expert Group made it clear that the Secretary of State for Health and Social Services was not responsible for health in Wales, Northern Ireland or Scotland. They identified a complication in that Wales and England were integrated for the purpose of some legislation and high level policy. They commented that the lack of documentation in relation to decisions being made in Wales and Northern Ireland on blood policy may be attributable to the fact that the Secretary of State for Wales and the Secretary of State for Northern Ireland were not dedicated to health but had a wider policy portfolio.

They were unsurprised by the evidence of the ministers in the Department of Health and Social Services that they had little dialogue with their counterparts in the four nations, as this was a reflection of the Anglo-centric approach of the Department of Health and Social Services.

They identified that the missed opportunity was not creating a National Blood Transfusion Service that made the most of both BPL and PFC. The devolution problem, it seems, compounded matters as there was a failure to recognise that there were different systems in place.

I move now to address the exponential increase in

the use of imported concentrates and how this impacted upon the policy of self-sufficiency.

Sir, I note the time, it is 3.15. Would you like to take a break or would you like me to continue?

SIR BRIAN LANGSTAFF: Well, how much longer do you have to go, do you reckon?

MR HOWELLS: Sir, that rather depends on how long you're willing to give me.

SIR BRIAN LANGSTAFF: Well, being as short as you can reasonably be, within your allotted timespan -- you mustn't take a disproportionate amount of time compared to others -- how much longer do you think it might be? Otherwise, we'll take a break now.

MR HOWELLS: Yes, I would ask for at least another 30 minutes.

SIR BRIAN LANGSTAFF: Well, let's take a break now, shall we?

MR HOWELLS: Thank you, sir.

SIR BRIAN LANGSTAFF: Come back at 3.45.

(3.17 pm)

(A short break)

(3.45 pm)

SIR BRIAN LANGSTAFF: Yes.

MR HOWELLS: Sir, having addressed you in relation to the adoption of policies for self-sufficiency I won't now

address you in relation to the exponential increase of the use of imported concentrates, save to say that they were a combination of two factors in our submission: firstly, the development of prophylaxis treatment; and, secondly, the refusal of Haemophilia Centre Directors to relinquish control of the purchase and stock of imported concentrates. They were very keen and felt very strongly about the fact that that should be retained within the centres.

Sir, I will also not address you generally in relation to knowledge of risk in relation to non-A, non-B and HIV, but I do wish to make some specific points relating to Dr Dempsey and Professor Bloom.

Firstly in relation to non-A, non-B, Dr Dempsey gave evidence that when he arrived at the children's hospital in Belfast, cryoprecipitate was exclusively used. He stated that Dr Mayne and Dr Bridges discussed with him the risk of non-A, non-B and its association with liver disease in 1978 or 1979. However, in 1981 Dr Dempsey started using commercial concentrates on children, and he did so until July 1983, when he stopped in response to the emerging information in relation to AIDS.

So, on his evidence, he started using commercial concentrates on children when the seriousness of the

risk of non-A, non-B should have been known to him.

His justification was twofold. Firstly, that his confidence in cryoprecipitate was shaken due to one incident when it didn't stop an internal bleed in 1981. And secondly, Armour and Hemofil were keen to assuage any concerns that he had in relation to the safety of their products.

Dr Mayne states in paragraph 14.3 of her witness statement that Dr Dempsey was more enthusiastic about only using cryoprecipitate on children than she was. That is plainly incorrect.

Dr Mayne accepts at paragraph 22.3 that between the late 1970s and the mid-1980s, there was growing evidence that non-A, non-B was not benign. She also states at paragraph 33.5 and 43.1 that, in response to the emerging evidence about AIDS, patients were offered a return to cryoprecipitate but rejected it. That is not a version of the truth that our clients recognise.

Mr Aldworth KC made a submission that Dr Mayne followed the 1983 guidance from the UKHCDO. Even if that is correct, it carries little weight in light of the fact that Dr Dempsey had been treating children with commercial concentrate for the previous two years or so.

Dr Dempsey, moving on to HIV, accepted that he was in no major doubt from the end of 1982 that AIDS was transmissible by blood and blood products, as the other theories did not hold water. However, he stated that the haemophilia community were not prepared to commit themselves to the idea that AIDS was related to blood and blood products. And, of course, he continued to use imported concentrates on children he treated after the end of 1982.

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

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

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

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

Then on 7 March 1983 Professor Bloom received

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

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

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

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

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

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

Thank you.

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

received the report from Professor Bloom of probable AIDS on 26 April 1983; and a representative from the Health Authority, Dr Napier and Professor Bloom.

Lawrence, can we go to page 2, please.

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

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

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

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

Then, Lawrence, top of page 3, please.

We see here the remark that:

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

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

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

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

"a. a reduction in patients treated;

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

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

The heading is "Can we go on using factor 8?"

It says that:

"The asserted greater risk arising from the use of purchased blood as opposed to voluntary donated blood is less than hitherto with the greater awareness of the AIDS problem."

It goes on to say in the next paragraph that:

"There is no justification on the basis of facts so far established to ban the importation of factor 8 though it was thought preferable in the case of children to restrict treatment to the BPL concentrate produced in Britain."

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

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

fractionate Welsh plasma.

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

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

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

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

Can we scroll down? Thank you.

(b), to modify a home treatment facility.

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

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

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

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

SIR BRIAN LANGSTAFF: Yes.

MR HOWELLS: So it's misleading.

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

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

a greater awareness of the AIDS problem."

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

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

SIR BRIAN LANGSTAFF: But he also had commercial concentrate.

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

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

SIR BRIAN LANGSTAFF: Yes.

Well, I -- it's not altogether clear to me at the moment what it's trying to say.

MR HOWELLS: Well, if we --

SIR BRIAN LANGSTAFF: It's obviously saying something which avoids those who were at the meeting doing anything about it.

MR HOWELLS: Perhaps the answer lies back on page 1, from recollection. So if we go to the "Background History".

SIR BRIAN LANGSTAFF: Yes.

MR HOWELLS: You can see in the first paragraph the reference to the fact that he had British Factor VIII.

SIR BRIAN LANGSTAFF: Yes.

MR HOWELLS: So there was an attempt by Professor Bloom to blame the British product rather than imported concentrate.

SIR BRIAN LANGSTAFF: Thank you very much.

MR HOWELLS: The other document that is relevant to this point, sir, is the briefing, the Q&A briefing, which is -- I won't bring it on screen but it's HSSG0010056_035.

Finally, on this document, the submission is that the statement that there was no justification to ban imported concentrates was unreasonable. Five days later, Dr Galbraith wrote to Dr Field at the DHSS suggesting exactly that. The then incidence of AIDS

amongst haemophiliacs in the UK did not represent the risk and Professor Bloom knew that, given what he was told in January and March.

So this was a missed opportunity for the Welsh Office to discuss putting in place arrangements for PFC to fractionate plasma from Wales. There seems to be no discussion or collaboration with the counterparts in Scotland or Northern Ireland, otherwise PFC would surely have been discussed at this meeting. It is regrettable that the Chief Medical Officer for Wales was not in a position to advise on the points identified that I've made a moment ago, and the Inquiry has received no evidence as to whether the Welsh Medical Officers liaised with the counterparts in the other four nations.

In other words, it may well have been that the Chief Medical Officer for Wales was entirely reliant on Professor Bloom for accurate advice, and this is in fact what Professor Stephen Palmer suggests, and I'll come back to his evidence in a moment. Professor Bloom, as we know, was also on the subcommittee of the CSM(B) that provided the advice that they did, that the ban was not justifiable at that time.

The advice that went to the Minister following that meeting is contained at HSSG0010055_002. I won't bring it up but it is misleading in two additional ways.

Firstly, it's stated that there is no proven connection between the Cardiff case and the use of imported Factor VIII, even though, for the reasons I've already explained, a link could not be excluded and it was more likely that the transmission was from the USA products rather than the UK product, given the high prevalence of AIDS in the USA at that time. Secondly, it's stated that the level of risk created by imported blood products was very small and there was no cause for precipitate action.

There was no proper basis for Professor Bloom to describe the risk as "very small".

We note from the presentation by Counsel to the Inquiry on Wales that Professor Stephen Palmer was the PHLS CDSC's first medical consultant epidemiologist for Wales. He took up his post shortly after this meeting in May 1983. Prior to taking up his role, he spent time in Atlanta on a secondment from the CDC from late 1982. His role included supporting the office of the Chief Medical Officer for Wales. The greater part of his time, he says, was devoted to supporting the NHS and local authorities in Wales by developing epidemiological surveillance of communicable diseases, undertaking field investigations, giving advice on the management and control of incidents, and supervising training in field

epidemiology.

He states in his witness statement, a draft witness statement, that the risk groups became evident quickly, including reports of patients with haemophilia developing AIDS. Though the cause of AIDS was not known, the most likely scenario was transmission following a hepatitis B model.

So he agreed with Professor Tuddenham that it had all the hallmarks of hepatitis B and should have been treated that way, and he picked that up in Atlanta.

Notwithstanding his role and his experience with the AIDS outbreak in the USA, the presentation summarises his evidence on his involvement with AIDS in the UK this way, and I'm referring to the presentation because still the statement is not yet available on Relativity. The presentation says:

"Professor Palmer does not recall being party to decisions about blood and blood products, although he would have discussed the probable sources of infection of AIDS with Dr Crompton and his colleagues. The Welsh Office looked at Professor Bloom as director of the haemophilia centre in Cardiff and to Dr Napier as the director of the Regional Transfusion Centre, for specialist advice. As well as the Department of Health, Professor Palmer did not have a direct working 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

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

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

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 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

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

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.

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

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

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

They've all fallen short of the duty of candour that Mr Bowie, King's Counsel, accepted applied to public bodies in Scotland. They've fallen short of reasonable expectations as to how Government and Health Authorities should conduct themselves even now.

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

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

Unless I can be of any further assistance.

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

MR HOWELLS: Thank you, sir.

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

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

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

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

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

(4.21 pm)

(The hearing adjourned until 10.00 am the following day)

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