Thursday, 2 February 2023

(10.00 am)

Closing statement by MR DAWSON KC

On behalf of 293 individual Core Participants,

Haemophilia Scotland and the Scottish Infected Blood Forum

SIR BRIAN LANGSTAFF: Yes, Mr Dawson.

MR DAWSON: Good morning, sir. I am Jamie Dawson KC and I appear with my learned junior, Ms Heather Arlidge of the English Bar. This closing statement is delivered on behalf of the 293 individual Core Participants clients and the two charity Core Participant clients, namely Haemophilia Scotland and the Scottish Infected Blood Forum, commonly referred to as SIBF, who are represented by Thompsons Scotland. I'm very pleased, sir, to welcome here a large number of my clients, most, if not all, of whom have made their way here from Scotland to listen to the closing statement made on their behalf.

At the end of his oral evidence at the end of 2019 my client, Bill Wright, said on behalf of himself and the infected and affected of Scotland, "We all stand and will continue to do so until this matter is resolved". Here they are making good on that commitment. They will continue to do so.

I must say that a number more had intended to be here today but the ongoing train strikes south of the

border prevented them from doing so. The theme of the legitimate hopes and aspirations of the Scots being thwarted by the limitations of English systems is a theme to which I will return.

Those whose travel plans were frustrated are watching remotely, as are many others. They would wish you to know, sir, that they are watching and are listening and have, throughout the process of your Inquiry when geographical, medical or other restrictions have prevented their personal attendance.

Some have watched all or very nearly all of the hearings. Many have been regular attenders at meetings we have held or have been held by the Inquiry. Many have contributed ideas and questions on a wide variety of the topics which the Inquiry considered. They have participated meaningfully and passionately, sir, as you requested them to do.

They took that request seriously, as did we, their representatives. Then there are those who did not make it. I'm informed by one of my clients that 104 beneficiaries of the Scottish Infected Blood Support Scheme have died since this Inquiry was announced in July 2017. Before embarking on the main part of our oral presentation, in which I seek to summarise and highlight key elements of our written submission,

I would like to say a number of things about the following: first of all, the written submissions; secondly an overview of our assessment of the evidence; thirdly, my clients and the areas of importance to them; and, finally, the approach which we have advocated that the Inquiry take, to the preparation of its final report and the presentation of its findings and recommendations.

So the written submissions. It was the habit, sir, of one of our late senators of the College of Justice in Scotland, when admitting advocates to the bar, to give them the following advice, "The three greatest qualities of an advocate are faith, hope and clarity, but the greatest of these is brevity". As our written submission to the Inquiry runs to some 1,322 pages, I fear, sir, that we may be lacking in at least one of these qualities but I hope only one, if that is true the responsibility of that failing is entirely mine.

The submission in line with our approach to the Inquiry throughout has been designed to assist the Inquiry in fulfilling as fully as possible its terms of reference, to reflect the concerns and views of the clients whom we represent and to draw as widely as has been practically possible on evidence available to this Inquiry to inform and guide its wide-ranging and

difficult task.

It has been compiled with a faith, which those whom I represent have acquired during the course of this process, that the Inquiry will get to the bottom of what caused the contaminated blood disaster, in particular in Scotland. It has been compiled with the hope that it will identify the failings which took and blighted so many lives and those responsible for those failings.

It has been compiled, I hope, with the clarity about why the conclusions which we would have the Inquiry reach and the recommendations we would have the Inquiry make, are the correct way for the Inquiry to fulfil its important function.

I will return to the position adopted by other Core Participants in a moment but the way in which the submission is compiled is an attempt to bring together the diverse sources of evidence available to the Inquiry in an effort to get to the truth.

Evidence heard by this Inquiry was necessarily often heard in isolation. In real time, things occurred together and impacted upon each other, things which examined or occurred in one -- which happened in one space had an influence on others elsewhere in time or space. A significant effort has been made in our written submission to bring these sources together to

assist the Inquiry in making its findings in light of the whole evidence available to it.

We approach the task of preparing the written submission in light of our interpretation of the material elements of the statement of approach, which you issued to guide us. In light of this, we submit that our written submission will be of more value and assistance to you in writing your report than those of certain other state actors.

In her oral presentation on behalf of the DHSC, Ms Grey contended that there was no prescribed way in which to participate in a public inquiry or to make submissions. The position taken in this regard may be correct but there are a number of important observations to make about it which, in our submission, devalue the usefulness of the contributions which these state actors have made.

Though there may be more than one way to go about the task, they have chosen to approach their submissions as they have. They have chosen not to take a position. They have chosen not to take the part of ex-ministers, civil servants, doctors or other agents of the state, the instruments by which, in practice, the state discharged its legal and moral duties.

By taking this path, we submit, they have chosen not

to provide you with the assistance you asked for in the task with which you are charged. The result is that their submissions are of limited assistance to you, we say.

Further, you provided specific direction for them to follow which they have not. Ms Grey contended the DHSC thought that the way that they had approached the matter, by not taking a position and focusing on evidence given by their witnesses, was helpful and fairer. She, like the Scottish Government and the NHS in Scotland, to whom I will return, narrowly construed their role and their remit. They claim not to take a position but then proceed to do so on a limited consideration of the relevant evidence.

Whether that is their clients' view or not, it is, in our submission, not what you asked them to do.

In the statement of approach, you asked parties to do a number of things. At paragraph 3, you said that "Core Participants should provide submissions on those matters within the terms of reference that are of most importance to them". This is all part of the general duty to assist the Inquiry in its work with the recognition that the issues in which different Core Participants will have an interest will vary.

The state actors have chosen not to do this but to

refer you predominantly to evidence in which they have a greater interest. As you, sir, will be tasked at looking at the whole evidence available to you, this does not replicate the task which you will need to perform.

In our submission, we have not sought to shy away from the evidence or points of view or arguments which seek to defend the state's position. We have looked at them and analysed them in light of the whole evidence, as you will require to do. We say that this provides a sound basis for the conclusions which we ask you to reach.

At paragraph 8(c) of the statement of approach, you indicated that you were aware that there are disputes in the evidence and invited Core Participants to urge the Inquiry to take a particular view of the general quality of the evidence of individual witnesses. You counselled us not to seek to do so on a subjective basis. We have assessed the evidence and made arguments as to why certain evidence is inherently incredible or unreliable, compared it with evidence given by others and with documentary evidence available from the time which contradict it. Given that they have not taken a position or made a case, the state Core Participants have not conducted that exercise. Again, this is

a significant limitation on what assistance we say you will find in their submissions.

The Scottish Government say that they do not wish to make comment on or criticise any previous administrations. Given that this is the precise task with which you are charged, to find out what happened, what went wrong and who was responsible, choosing to take that position is tantamount to saying they have chosen not to help you with your task.

The fact that the NHS in Scotland has not seen fit to make submission on the part of any of those who acted on its behalf in many areas, those who were the way in which it discharged its responsibilities and interacted with the user of its service is equally, we say, of limited value. It has chosen to take this path where it could have done otherwise and did at the Penrose Inquiry. That choice means that it has provided limited meaningful assistance on how the whole evidence on any given matter should be weighed or assessed.

It is noted, however, and appreciated, by those whom I represent, that our non-financial recommendations have clearly been carefully considered by them, that they have obviously appreciated the need, as you said, sir, to make specific apologies for matters in respect of which they wish to make one and that a number of

important concessions on significant issues appear to have been made, at least at a corporate level.

However, the concessions on these matters are made in a limited way, the apologies given are similarly limited. Both are made on behalf of the current executives of the various NHS bodies, and no more. They specifically reserve to you the possibility that argument made in their evidence by clinicians or other professionals may still be accepted by you. Despite this, in places, the current executives are clear that criticisms, in their view, in a number of important areas, are well founded. That they appear to be suggesting to you, sir, that you should guddle about in the evidence to try to ascertain the position being advanced by clinicians and others without assistance is, in our submission, a near impossible task. In our submission, that approach is unhelpful and unsatisfactory.

This approach on behalf of the Scottish NHS and other state actors can lead to one conclusion only: in a number of material respects they have chosen not to attempt to defend the indefensible. Though the concessions which have been made are welcome, they are limited in the way I have described. They should not, sir, be taken to minimise the need for detailed and

specific criticism to be made in appropriate places in your report. Though these concessions from the executives are welcome, I say they are both too little and too late.

The departure of the Scottish NHS's position from the position which they took at the Penrose Inquiry is noted and is also significant. It should be recalled, sir, that on 28 March 2011, it was said on their behalf that: there is no justification for the description of events as a scandal. There is and was no scandal, that word always carrying with it the connotation of wrongdoing of one sort or another.

The current boards and the current management of the SNBTS appear to have come a long way since their position was represented with those words. In our submission, they had a very long way to come. The fact that it has taken many decades to get to this point has, as I am sure you can appreciate, sir, caused decades of unnecessary suspicion, mistrust and harm.

It is important, however, to mark the concessions which have been made. They are significant. They do represent a considerable step forward. I note the sincerity with which my learned friend Mr Bowie spoke of the self reflection which this Inquiry has prompted in his current clients.

I have made it clear to those whom I represent that the spirit in which they were delivered by Mr Bowie is reliable and that that is the spirit in which they should be taken. Equally important are the genuine apologies which have been issued. The clarity as to what they were for was clearly and audibly appreciated by my clients who were present on Tuesday.

I should add though, sir, that in a number of regards the concessions which I understand have been made do not go as far as I say the evidence suggests they should. I will try to point out for your assistance where I believe that to be the case as I go along.

The fact that the NHS in Scotland has taken a corporate position is, of course, of a particular significance in light of the evidence which has been heard about the way things worked at the time.

The Inquiry has heard that in many spheres relevant to its investigation, significant autonomy or clinical freedom was accorded to individuals in the treatment of patients or the collection or processing of blood and its components. For example: the haemophilia directors exercised significant autonomy over the way that their centres were run, despite the existence of a National Medical Director; the Regional Transfusion Directors

being left to operate the system of blood collection with a considerable and unchecked amount of freedom; doctors were left to transfuse blood across the NHS and Scotland with little guidance or control.

Thus not to take the part of these individuals, in effect not to defend many of the decisions made and actions taken.

One might say, sir, that the very fact that submissions have been made on behalf of the SNBTS and the Health Boards separately is redolent of a continuing issue within the system, that being the separation between these two bodies when they ought to have acted in the interests of patients together.

The system, as I say, allowed autonomy to individuals to make decisions. At one point in relation to the conduct of the infamous December 1984 meeting at the Royal Infirmary of Edinburgh, the NHS appears to accept there was insufficient corporate oversight of the way that information was transmitted to patients about the fact that some had been found to be HIV positive. There are multiple other areas where there was an apparent lack of corporate oversight where we say it should have been and where the NHS in Scotland appears not to make a similar concession.

Examples of where there appears to have been no

clear corporate influence, assistance or control would include: (a) the need to take reasonable steps to contribute to the achievement of a safe and consistent approach to blood transfusion; (b) the need to take reasonable steps to contribute to the achievement of a safe and consistent approach to the use of blood products; (c) the need to take reasonable steps to contribute to the achievement of a consistent and safe programme of donor exclusion in the patients' interests; (d) the need to take reasonable steps to contribute to the achievement of clear communication to those in positions of clinical responsibility of the most accurate and up-to-date information about viral threat; and (e) the need to take steps regarding the communication of that information to patients who were at the potential of being exposed.

Viewed in this way, sir, although the concession in relation to the meeting is welcome, there are a number of other areas in which I say corporate oversight would have played a significant part in making the system safer, and in connection with which, in our written submission, we criticise that system.

There is one other element -- procedural element, sir, of the state's response to this Inquiry to which I would like to make reference, and that is the subject

of the Rule 9 responses which have been made by clinicians in individual cases.

In order to respond, sir, as I understand it, to the possibility that the final report in the Inquiry could be delayed by the Maxwellisation process, the Inquiry has routinely intimated potential criticisms to individuals and organisations. These are separate from the general Rule 9 process which has led to witnesses' general statements and, where relevant, oral evidence. Most have been issued to, and responses to them received from, clinicians, certainly the ones to which we have been privy.

Sir, in our submission, the tenor of these responses runs very much contrary to the constructive and self reflective attitude of NHS Scotland in their submissions to the Inquiry. The responses which have been drawn to my attention have been in places defensive, in places vitriolic and in places disdainful of the process of this Inquiry.

Further, in many cases respondents have seen fit to use this process to stray beyond the ambit of the very specific criticisms and questions addressed to them and to stray into the more general territory which has been addressed in the oral hearings.

This approach, in my submission, is reminiscent of

the attempt made by the Scottish haemophilia clinicians on the first morning of Professor Ludlam's evidence in 2020 to present to the Inquiry a submission which they had put together, unsolicited, which ultimately was not accepted. The content of these Rule 9 responses have for the most part not been ventilated in the oral hearings, often due to the timing of their production.

Some of my clients have taken a limited opportunity to respond, largely to indicate their dissatisfaction with the response received from those criticised and simply to reiterate their original positions with some further clarifications.

For those reasons, sir, we would submit that you should place little if any weight on the content of these Rule 9 responses in your final report.

Ms Grey sought to make something of the openness in the way in which her clients had responded to requests for documentary access and other evidential requests in the Inquiry. As if that were the only obligation of the state in answering the calls of a public Inquiry.

In fact, my general characterisation of the evidence heard by those who were part of state activity relating to the use of blood and blood products was far from open in substance. Lord Clarke, for example, frequently questioned the utility of detailed questions being put

to him by counsel to the Inquiry and claimed to have little involvement in matters, which the written evidence showed simply to be inaccurate.

This is, on one view, hardly surprising and merely consistent with the lack of candour and openness with which matters had been dealt by the state during the entire history of the disaster.

We have provided a detailed assessment of how evidence of key players in the state handling of the disaster should be treated by you -- as you asked us to do, sir -- from page 25 of our written submission.

Our position, sir, is that the evidence of criticised individuals, generally given in a defensive and often dismissive manner, should be contrasted with the evidence to this Inquiry, and certain others, of those in similar positions who were, in broad terms, open and honest, not relying on faded memory but doing what they could to assist. Examples, in our submission, include Dr Brian McClelland, Dr Jack Gillon and Professor Ian Hann. Their willingness to take responsibility for their actions and to assist the Inquiry was a feature both of their evidence and indeed their actions at the time of the events under examination.

Further, Mr Bowie appeared not to take issue with

the weight of the evidence heard from the infected and affected. He was wise not to do so, in our view. Their evidence was consistent on all broad themes and unanimous on many. It constituted a formidable body of evidence about what happened and the consequences. The Scottish participants gave evidence willingly, submitting to all and any questions though some were on the most personal and distressing of matters. Though sick and grieving, none of them were a bit tired to answer any questions.

Their recollections were clear and did not cause them difficulty in giving fulsome answers. They answered the questions and did not seek to divert attention into areas of their as opposed to counsel to the Inquiry's choosing, in contrast to many of the state actors. They respected the process. These are ways in which we would suggest the evidence of all of the state and medical witnesses can be described unfortunately.

In our submission, these comparisons are significant insofar as the Inquiry requires to weigh the evidence of each side against one another insofar as any live dispute remains.

Now, contrary to the position taken by the state, sir, as I have said, our written submission attempts to engage with the detail, as you will require to do, sir.

You have asked us to concentrate on what was important to us.

The breadth and number of clients whom I represent and their different, varied but united interests mean that there are numerous such issues. My clients have been offered an opportunity to be heard and listened to. This is participation on the basis upon which you asked us to participate, sir, and not on the basis of how we chose to define our own role.

It has proven in the past to be important to engage with the detail. In fact, many of the state responses have sought to provide the appearance of detail or medical or scientific expertise in order to bamboozle or to baffle, often diverting away from the reality, the truth, on any given matter.

Answers which have been given were often not entirely untrue but were not the whole truth. An example might be the line that there was no conclusive proof that AIDS was transmitted by a virus which could be present in blood or blood products.

Though not strictly speaking untrue, a closer analysis of the evidence shows this to be a limited version of the truth, and hence misleading, as Mr Bowie and, perhaps more importantly, Dr Brian McClelland fulsomely accepted. Therefore engagement with the

detail is important in order to demonstrate the unreliability of the given state responses, which of course influenced not only our interpretation of what happened but the state's response to the disaster over many years.

This has been our approach from the outset of the Inquiry. We advocate that you should follow that approach too, sir, and hope that we have assisted you in doing so. As a result of our detailed approach in the written submissions, I do not intend today, sir, you will be pleased to hear, to make detailed evidential references or to take you to detailed passages of the voluminous evidence available to you. The detail, I venture to suggest, has been covered in writing. Instead, the intention is to highlight some key themes of our submission and of the evidence which you have heard, designed, as all of our work to the Inquiry has been, to assist your work and that of your team as fully as possible.

Sir, I move on now to give what I hope is a relatively brief overview of our assessment of all of the evidence which the Inquiry has heard. Our contention, sir, is that the evidence which you have heard shows clearly that the infection of Scottish patients with HIV and HCV, and indeed HBV, was in many

cases entirely avoidable.

Not only were they avoidable in theory, we argue that many cases of infection ought to have been prevented. The state failed in its most basic obligation to care for those who sought medical assistance from the NHS in a vulnerable state. It failed in its obligation to take reasonable steps to prevent the harm which would be caused by the predictable dangers created by the uncontrolled and unnecessary use of blood products and the unsafe system for the collection and processing of blood in Scotland.

In some instances, patients were valued for information which they could provide to the state and the medical profession, as opposed to their own best interests being placed at the heart of their NHS treatment experience.

Blood and blood products were routinely reached for and administered without consideration of their risks, far less consultation with patients about them.

The disastrous effects are unprecedented in their depth but also in their breadth. The loss and suffering endured by victims was further unnecessarily and completely avoidably compounded by the reaction of the medical profession and the Government to those victims' plights. The damage has been irrevocably magnified,

redoubled, and redoubled again, by the defensiveness of those charged with the care of the harmed. The state could and should have taken a different course in the way that it managed the horrors of infection, having universally and unethically denied patients or their representatives autonomy in the collection of their treatment. Patients were routinely tested without their informed consent, not traced by the state or informed of their positive status, creating avoidable and unnecessary risk to their loved ones and denying access to treatment advice or support.

When they were informed, many learned of their devastating life sentences without care or compassion, leaving them alone to face their fate without any assistance or support from the state which had imposed it upon them.

The victims were left in the dark as to how this had happened. Some lived in isolation for many years, thinking it was only them. Others were consigned to isolation by stigma or advice from the medical profession that isolation was the only way. Innocent victims were stigmatised and demeaned often at the hands of the state. The physical and psychological consequences of infection are uniquely complex, as the result of the ravages of viral exposure, all bestowed on

individuals who were infected at a time of vulnerability and compounded by treatments which were often worse than the origin infections.

Searches for answers fell on deaf ears, from doctors, Health Boards, governments, the courts, the GMC, the police, all of the emanations of the state. The state's response based on a fear of exposure of its inadequacies and the financial consequences which may follow, led to years of obstruction of efforts made to obtain answers to which all patients had been morally entitled from the start. The scale of the disaster was used as an illegitimate reason for individual victims to be denied rights they would otherwise have enjoyed.

Independent scrutiny was routinely denied. Those who caused the disaster were allowed to rule on how it should be judged and how its consequences should be handled. Campaigners sacrificed their own lives in the search for justice. The state routinely underestimated their resolve, expecting them to give up or die before the truth came to light.

Some did die, often in the most horrific of circumstances. Those left behind were equally cast aside. They too required to fight, despite their grief and isolation. Until recently, support handed out by the state was inadequate and dehumanising.

We submit, sir, that this is a truly unique disaster in the scale of its mental and physical consequences, in depth and in breadth, and in the scale and variety of the state's culpability over decades.

We call on the Inquiry to recommend unique solutions and to use the tragic stories which it has heard about the very soul and purpose of our National Health Service to do what it can to seek to redeem it, to do what it can to seek to save it from itself.

Sir, I'm going to move now onto some comments about my clients and how the clients have impacted upon the way in which we approached our submission and approach to the Inquiry.

The vast majority of the clients on whose behalf this presentation is made were infected or related to someone who was infected in Scotland. Thus, in the exercise of our responsibility to do what we can to assist the Inquiry in the investigation of the matters falling within its terms of reference, we have focused on the circumstances in which infections occurred in Scotland, measures which could and, we say, should have been taken to avoid them and the aftermath of the contamination disaster in Scotland. These are the issues of which are of the greatest importance to those whom we represent and has thus formed the focus of our

work and our submissions as is required by the statement of approach.

I should make clear, however, that the extent of our interest is not purely in Scottish matters. It is our position, to which I will return, that the independence of the Scottish system provided opportunities and did result in separate decisions being made for Scotland at times.

We are critical of the systemic failure on the part of the various elements of the Scottish state, again understood widely, to take advantage of that independence. These failures led, in our view, to inadequacies of decision making and action at a UK level being unnecessarily inflicted on Scottish patients and their families.

We are thus critical of Scottish decisions and actions, the failure to take separate Scottish decisions but also of decisions made at UK level which impacted on Scottish patients.

In places the arguments clearly cross over with those advanced on behalf of others, when they are made in a general context, such as relating to the knowledge of risk of viral transmission, the advantages and disadvantages of different products, the perceived scientific utility of measures which might have been

taken in the collection of blood or the production of blood products within the UK. On that basis, in places where the Scottish patients bore the brunt of the inadequacies of the UK-wide position, or in areas of general application, we stand, in most if not all regards, alongside the criticisms made by the representatives of other infected and affected Core Participant groups which have eloquently and accurately been presented by my learned friends, and will no doubt be by Mr Stein tomorrow.

I observe, as Mr Snowden did, that there appears to us to be little material differences in our positions, a fact which, in my submission, should be taken to add to the strengths of the position being adopted in the infected and affected community as a whole.

Though the physical, psychological and other effects of the disaster on those who were infected and affected are broadly similar to those experienced by those elsewhere in the UK, the circumstances in Scotland were different from the general picture in a number of material respects. These are outlined in significant detail in our written submission but some of the important elements are as follows:

Scotland had a completely autonomous system in every regard. It had its own National Health Service governed

by a separate statutory regime and indeed law. It had it's own system of blood collection operated by an autonomous blood transfusion service. In the event, it had its own fractionation facility. Despite that, it did not achieve self-sufficiency until around 1984. This is lauded as a significant treatment, which is, to an extent, misleading.

The availability of its own fractionation facility meant Scotland had the advantages of a system which allowed domestic production to a greater extent than elsewhere in the UK. Domestic production was about relative safety. As a result, it had advantages and assets not enjoyed elsewhere in the UK. As a result, more ought to have been expected in terms of safety. Despite these advantages and assets, the Scottish system still culpably failed to take reasonable steps to minimise the risk of potentially lethal infection.

As far as government was concerned, health was a matter which was devolved before 1999 to the Scottish Office and its Scottish Home and Health Department, which dealt with policy relating to the operation of the NHS in Scotland and, formally after the Scotland Act 1998, from 1999 to the Scottish Parliament.

The result of this, in our submission, is that Scotland had the opportunity to take a path which was

precautionary, reactive to danger which would inevitably rear its head at some point, and designed in the interests of patients as its separate statutory regime required. There was less HIV infection in Scotland amongst bleeding disorder patients due to the lesser reliance on imported concentrates. However, we contend that these infections ought to have been avoided completely or at least significantly reduced. Imports could certainly have been avoided completely.

Though the statistic relating to the number of HIV infections in the haemophilia community is often banded about, I will return, sir, to the significance of the statistic examined within your Inquiry's statistics expert group report, that the number of infections identified with HIV in the transfusion community is significantly higher in Scotland when analysed on a per capita basis, a statistic of some significance.

So, sir, as regards the approach which we would advocate you should take to the task. We are of the view that the Inquiry should be clear as to the standards which it is applying in the assessment of decision making and action. Analysing the evidence and coming to the conclusion that things were unfortunate or regrettable are unlikely to be very instructive as conclusions. We have suggested in our written

submission in some detail that decisions, actions or inaction should be judged on whether they were reasonable and in the best interests of patients.

The state should be expected to have lived up to these standards. Our contention is that the state and the actors of the state caused the disaster by multiple breaches of its moral duty, which it owed to patients.

SIR BRIAN LANGSTAFF: Mr Dawson, I'm sorry to interrupt, I have just been passed a note which reads simply like this, "Stenographers would like Jamie to slow down a little". I can understand why they are asking.

MR DAWSON: Thank you very much, sir. It will not surprise you to hear that's not the first time I have been given such a warning and, as on previous occasions, I will endeavour to do my very best to take care of the stenographer.

I was talking, sir, about the multiple breaches of the moral duty, which we say the state owed to patients. We accept that the establishment of whether there was a breach or there were breaches of this moral duty is correct, depends to an extent on taking account of what ought to have been known, what could and what should have been done at the time.

However, we also advocate that decisions and actions should at times also be judged with hindsight when

things have been discovered subsequently, which can inform learning lessons and making recommendations.

In addition, sir, this is not a clinical negligence trial. In many places the Inquiry has heard evidence that comfort was taken in blindly sticking to the way that things had been done before, against a background where constant re-evaluation of the threat of viral transmission from blood and blood products was necessary in the interests of the safety of patients.

This led, in our submission, to a stagnation which was dangerously out of kilter with the reality of the viral threat. Thus the Inquiry should be careful to assess what was reasonable and what was in the interests of patients against an objective standard of reasonableness and not based simply on the fact that a course of action, or indeed inaction, was the same as what others were doing or not doing at the time.

Some of the written submissions made on behalf of the emanations of the state have focused on the need to be aware of the dangerous of hindsight, in particular the DHSC submission. It is unusual, we submit, that a department of the same government which ordered the Inquiry and thus thought that an Inquiry was necessary and would be useful, should now say that the length of time since the events in question means that the Inquiry

is hampered by that delay.

We argue that for the Inquiry to serve its purpose and to discharge its terms of reference fully in light of the delay and the inevitable loss of evidence and memory in which that delay has resulted, the Inquiry must approach the evidence with the attitude that must have been in the contemplation of those who set up the Inquiry that it could reach firm conclusions by exercising reasonable inference.

As was stated in the evidence by one of our campaigning clients, the exercise in which the Inquiry is engaged is one of trying to make out the jigsaw which portrays the events within its remit. The fact that there may inevitably be missing pieces does not mean that enough cannot be made for a clear sense of the picture and for firm conclusions to be drawn about what happened, what went wrong, who was responsible and what should be done to prevent such things happening in the future.

To do otherwise would undermine the expectations of those who set up the Inquiry and it would be to encourage those who may be found wanting in their efforts to deal with such public health crises in the future to seek to obfuscate or delay, in the knowledge that the passage of time can be used as a defence.

In any event, we argue, sir, that there is more than adequate evidence for the Inquiry to draw firm conclusions about what happened and what individuals or what entities were responsible.

This is particularly the case when one comes to the assessment of the narrative relating to Scotland, with which we are primarily concerned. In this regard we note the two Core Participant entities of the Scottish NHS do not appear to take the general stance of the Department of Health, to the effect that there is insufficient evidence from which clear unambiguous conclusions about wrongful or unreasonable conduct can be drawn. Far from it, in places the NHS appears positively to endorse such criticisms.

Therefore, whether the warning about the dangers of hindsight is well founded at UK level or not, this, in our submission, is not the case with the evidence pertaining to Scotland, where the evidence available to the Inquiry -- resulting in part from previous investigations, in particular the extensive gathering of evidence undertaken by the Penrose Inquiry -- does not create this difficulty.

This means that many more pieces of the jigsaw are available. In its closing statement to that Inquiry, it should be noted that the Scottish Government said on

28 March 2012 that by the time of the announcement of that Inquiry in April 2008, many of the key documents were already in the public domain.

The passage of time has not, in fact, caused any material prejudice to the ability of this Inquiry, in our submission, to get to the bottom of events.

In our written submission we have not shied away from the volume of relevant evidence available which assists with understanding the events and the direct and indirect causes of the disaster in Scotland. There is a suggestion in some of the submissions made to the Inquiry that standards have changed. We disagree, many of the standards which we assert have been breached are fundamental, such as patient autonomy and the need to take reasonable care in the prevention of the spread of invidious diseases. If these were not the standards to which there was adherence, they should have been.

In certain instances nothing was done at all, which would suggest that no applicable standard was adhered to.

The best evidence of what happened should, in our submission, be found in the contemporaneous material. To the extent that document availability issues or issues with memory cause difficulties elsewhere, this is not the case for the Scottish story. The key documents

compiled by the Penrose Inquiry and released on its Courtbook system were retained and made available to this Inquiry. By definition, these were the most relevant materials to Scottish issues. They are still available.

Memory issues were not a considerable matter for the Penrose witnesses, many of whom were still employed or recently ceased employment at the time they gave evidence. Many gave multiple statements and some gave detailed oral evidence over multiple sessions where their evidence was examined and challenged in detail. It is clear from that evidence why decisions were made and actions taken. Thus the dangers of making assumptions based on hindsight appear not to have been the position of those witnesses at that time.

Insofar as the terms of the reference to this Inquiry differ from those of Penrose, which they do, the main areas in which they differ cover more recent events so that any delay has been less of an issue as far as the comprehensiveness of the available evidence is concerned, such as term of reference 9 relating to government response after the infections occurred, the more recent vCJD risk, and the development and operation of the trusts and schemes.

Importantly, the vast body of evidence from the

infected and affected stands as a clear and coherent statement of their position on the facts. No challenge appears to be made to the accuracy of that evidence by the Scottish Core Participants. In many areas, such as treatment regimes, informed consent, testing, the timing and manner of patients being informed about infection, stigma, impact and treatment for infection, this evidence is a sufficient basis upon which to know exactly what happened.

There can thus be no danger arising from delay or the application of hindsight in those areas. The result of this is that the Inquiry has ample evidence available to it to reach a clear picture of what happened in Scotland and why.

Indeed, those instructing me, irrespective of any limitations which may be found to exist in the evidence elsewhere, have what I assert is a perfectly reasonable expectation that a detailed analysis of the facts and causes of the Scottish disaster will feature in the Inquiry's final report. Our written submission has been designed to assist the Inquiry with meeting that expectation.

Having said that, we think that you should have regard to the Penrose evidence. This Inquiry is of course not bound by its conclusions. Some witnesses,

like Professor Gordon Lowe, seemed to think that to refer to the Penrose conclusions was appropriate and was sufficient to discharge his responsibility to answer questions, as if those conclusions were in some way res judicata on the matters before this Inquiry.

The terms of reference are not subject to any need to minimise duplication or in any way subject to the Penrose investigation or conclusions. Of course this Inquiry is independent.

To the extent that it remains open to the Inquiry to find criticisms made of the state to be unfounded, we have argued in both general and specific detail as to why the oral testimony of those who may be deemed to have been responsible for the disaster in Scotland should be rejected. The fact that some did a good job, which we accept, is indicative of the fact that others could and should have done better in the discharge of their responsibilities. Often they did not. Sometimes the system did not enable them to do so or did not require them to, when it should have done.

We would urge you, sir, as a matter of general consideration, as I have already mentioned I think, to take particular care in evaluating and assessing the importance of the statistical evidence which is available to the Inquiry.

We present a detailed analysis in our written submission in section C of that evidence and refer to the value of the material from statistical sources in understanding key issues throughout.

In our opening to the Inquiry we urged you, sir, to seek statistical evidence as early as possible in your Inquiry's work, as we suggested that it would help to identify and narrow the issues for the Inquiry's consideration in the discharge of its wide terms of reference.

We note that the UKHCDO has been asked to provide some statistical material to this Inquiry, similar in nature to that that it provided to Penrose. That along with the valuable statistical report, the latter as we understand coming late in the day, when we might have hoped that it would come earlier due to the important duties of the experts in the Covid crisis. The Penrose statistical material has, however, always been available throughout the Inquiry and we have conducted an analysis of it in our submission, alongside the additional evidence given by the Inquiry's statistical group.

I will refer, as I go along today, to various matters of importance which emerged from the evidence, the statistical evidence, in more detail. But they include important context to the resolution of the

matters in the final report. They include the nature and extent of product use in different places at different times, which is of course relevant to ascertaining the causes of infection, and assists with what steps might have been taken to avoid it, as well as variations in treatment regimes.

Also, the evidence helps with ascertaining the timing of infection, in particular with HIV in both the bleeding disorder and in the transfusion community, which, in our submission, assists significantly with questions as to the avoidability of these infections had alternative steps been taken and also the actual timing of the introduction of infective viral threat into the system.

It should, of course, be understood that nothing in what I say about the statistical or other material should be taken to suggest that we wish the Inquiry to approach matters in any dehumanised fashion. My position is, of course, quite the opposite, ie that the Inquiry does need to take significant account of the sum total of individuals' testimony and bear in mind, as I am sure it will at all times, that it is dealing with real human experiences.

It is merely a reflection of the fact that the Inquiry requires to find ways of dealing with matters

covered in its terms of reference at a systemic level, that the statistics will help, in our view.

Like Mr Snowden, as another general observation, we agree that language is of particular importance in this Inquiry. I, like him, will make some specific references to how we say that manifests itself in the evidence which the Inquiry has heard.

One further matter about the general approach to the evidence, sir. We would remind the Inquiry that the factual, medical or other state witnesses are not experts. This was clarified in one of the Inquiry's statements of approach. Though expert often in terms of their experience and expertise, they were rarely, if ever, independent and their opinions on matters are often, in our submission, of little value for other reasons. This is an important consideration that the Inquiry must bear in mind when assessing the defences advanced on behalf of the state.

If the Inquiry were to do so, it would, in our submission, merely compound the failures and consequently the harms which such an approach created in other investigations of the disaster, including but not limited to the Scottish Executive Investigation of 1999 to 2000, which relied upon the testimony of those who might be criticised, in preference to the evidence of

the patients, to reach the erroneous conclusion that there had been no failings in the state's approach to the disaster.

Similarly to accept the *ipse dixit* pronouncements of such witnesses would, in our view, be misguided and would be likely to lead to error.

For example, where the Scottish NHS seeks to pray in aid opinions expressed by Professor Hann about the treatment regime instituted by his predecessor Dr Willoughby at Yorkhill Hospital in Glasgow, despite its corporate acceptance that such a defence cannot be advanced, it should be borne in mind that this is an opinion expressed by a man who accepted to only even meeting Dr Willoughby once and, of course, explained in detail that he presided over a fundamental change in the treatment regime when he took charge in early 1983. In our submission, any such assertion in defence of Dr Willoughby would, in the face of that evidence, carry no weight at all.

In contrast, sir, evidence is available to the Inquiry, which is of considerable value, from independent experts who do not have a stake in the outcome. They are thus truly independent. Many of them were able to express views from a perspective of considerable expertise in the matters with which the

Inquiry is concerned and I will refer to the reports and evidence of a number of the Inquiry's expert panels in due course.

May I also, sir, for your assistance, refer you to some of the genuinely independent expert evidence given to the Penrose Inquiry, which, in our submission, is of considerable general value.

Such expert evidence came from the likes of Professor Andrew Lever, an infectious diseases expert, and Professor Howard Thomas, a hepatologist who gave evidence also to this Inquiry, largely on his experience with the Skipton appeal panel. They were not from the haemophilia world and were thus able to express expert views on matters which were unencumbered by the responsibility borne by many involved on the decisions which led to many infections. Their background showed, however, that they knew a huge amount about the relevant matters and, therefore, our submission relies heavily on that testimony in addition to the expert testimony of the groups given to this Inquiry.

A detailed analysis of the important elements is therefore in our written submissions.

Sir, that brings me to what might be described as the main body of my submission, which is an attempt to summarise, in the time available to me, the 1,322 pages

of our written submission and, as others have said, to try to draw together some of the important threads in order to assist you, sir, in the compilation of your report.

To do so, sir, I have split most of the rest of my presentation into ten separate themes and they are as follows: (1) the context of the disaster; (2) the assets and advantages which Scotland enjoyed; (3) the myth of the volunteer donor; (4) the concentrate juggernaut; (5) the transfusion of blood; (6) the domino effect, patients as people and as pioneers; (7) compounding the harms; (8) the myth of devolution; (9) the solutions; and (10) conclusion.

I suppose having set those out now, sir, I have got to try and get through them all in the time available to me. So with the added pressure of not upsetting the stenographer, I will attempt to do so.

So, sir, the first of my areas is the context of the disaster. It was frequently suggested in the evidence of those who sought to defend the actions of the state that HIV and other viral risks came out of the blue and could not have been predicted or prevented. We refute this suggestion, based on the significant, historical context. We address the context and the developing knowledge of risk both generally and specifically

connected with those infections in section E of our written submission.

This context makes clear that blood was a hazardous substance and that the recipients of blood and, in particular, blood products would need there to be a well prepared, reactive system for them to avoid infection, if they were to receive any protection at all.

Recipients of pool products were frequently compared to canaries in a coal mine in this regard. We submit that the state owed an obligation to take reasonable steps to protect the canaries too.

We submit that the system failed repeatedly to heed the lessons and warnings of the past, repeated the same mistakes again and again, displayed a wilful blindness to the known risks, and failed entirely to protect those for whom the system was designed.

Increasing knowledge from the period during which the majority of infections took place, with which the Inquiry is concerned, should have led to a precautionary approach. It was known from the time of World War II, when there were mass outbreaks of serum hepatitis from the yellow fever vaccine, that the industrial production of products derived from human blood had the potential to cause significant harm. Professor Contreras told us she would write "Blood can kill" on the board when

teaching her students.

This was not a mere abstract ghost story designed for dramatic effect to catch the attention of bleary-eyed medical students in an early lecture.

Blood had killed. It had killed in Edinburgh in the late 1960s in the renal unit, killing amongst others, Professor Cash's assistant. Our written submission contains an analysis of the Rosenheim Review into this and other similar incidents around the UK and the failed opportunity which it presented to change the system into a precautionary one.

The law would normally require extensive precautions to be taken when dealing with hazardous substances or activities. The Inquiry should conclude that the context here should have required the same such responsibility of the state in its role in relation to blood and blood products, a responsibility in which it multiply failed.

At the same time as blood appears to have been marked as "hazardous" in hospital labs for the production of staff, as was the blood of patients who received it, the risks of the source and the recipients were well known.

Yet the evidence showed that patients were largely unaware of the risk or the effects which gave rise to

the need for such warnings. It was consistently suggested before the Inquiry that there were economic impediments to action being taken, which might have improved safety. In our view, such arguments had the ring of a political comfort blanket, reached for when things go wrong, without much consideration of whether it was actually the real reason why things were not done. It seems hard to understand why money could not be found to invest in domestic blood collection or the manufacture of blood products to achieve self-sufficiency when, at the same time, huge amounts of money were being spent on commercial concentrates.

A sensible economic consideration of the situation would have demonstrated that investment in the domestic system would, in fact, save money spent on expensive imports in the long run.

The state took responsibility for the collection of blood, its processing and the production of blood products. There was no long-term planning as to how that could be done safely. Financial planning was short sighted, not only for that reason. In 1968, in an article entitled "The Price of Blood" Professor Zuckerman had argued that the failure to invest properly would be a long-term disaster as the cost of disease would ultimately far outweigh the investment which would

be needed to avoid it. The reference is RLIT0000072.

No heed appears to have been taken of these arguments, about the need for investment as safety, as a necessary part of running a safe blood system.

In this regard, sir, we refer you to a number of other important documents which indicate there were a number of historical warnings which were not heeded. In particular, sir, we have dwelled in our submission on a number of Scottish papers which are instructive. In particular, we have referred you, sir, to the 1972 papers delivered to the Royal Society of Edinburgh from a number of different people but including Professor Cash, whose submission is found at PRSE0002637. We deal with these papers in our submission from page 978.

Now, we also refer you, sir, to a paper which was written two years later by Professor Cash and a colleague Mary Spencely from 1974, which is PRSE0001255, in which an analysis for the future needs of concentrate is set out, and sets out a number of warnings which have a resonance later on in the story but which were not heeded.

Like Mr Bowie, we considered that the 1980 Glasgow Symposium papers stand in direct contrast to the policy of the day of massively increasing concentrate use in

Scotland. In that regard I refer to our submission as well.

This increased Factor VIII usage in Edinburgh in particular, when compared with the usage levels in the 1970s, continued throughout the first half of the 1980s, despite the warnings given in the 1980 Symposium by a number of contributors, including Professor Thomas to whom I have already referred.

Importantly, sir, we think that, in a general sense, these risks were not hidden or particularly controversial. That risks would present themselves was well known. It was out in the open, ventilated in the press, for all of those with responsibility for the transfusion of blood or the production of blood products to see.

Many of our clients gave evidence about raising direct questions about risk, for example about HIV as early as 1982. This created an obligation, in our submission, for these risks to be assessed and for systems to be put in place to minimise and manage them. They simply were not. The result of this was that guidelines, action and initiatives invariably came too late. Danger and harm was entirely predictable but there was no capacity in the system to react when it manifested itself. One unique feature is those who got

blood, and in particular blood products, were always going to be first in the firing line. The system needed to accommodate safety mechanisms for them. Invariably it did not. It took comfort in avoiding responsibility until there was conclusive proof or, its scientific equivalent in the viral sphere, Koch's postulates.

The system was not reactive. It was entirely foreseeable that it would need to be. The long latency period of diseases known to be transmitted by blood and blood products, in particular hepatitis B, meant that conclusive proof would never be possible or at least waiting for that would always be too late. The reliance on the doctrine of conclusive proof either represents wilful blindness at the time or an ex post facto attempt to justify the inadequacy of the contemporary assessment of risk. The practical manifestation of this at the time was the apparent lack of appreciation of the difference between incidence and risk. Waiting to know how many AIDS cases there were before acting would always mean acting too late when it was known that infection generally occurred long before the disease became apparent.

It has been suggested by emanations of the state in this Inquiry that things were not known. We say that this is essentially the same as using the "conclusive

proof" line. Either things were known or they ought to have been known by the application of reasonable scientific diligence, such that things could be predicted or estimated.

For example, it was suggested that the incidence of non-A, non-B hepatitis was not known in connection with discussions around the possibility of surrogate testing for that disease being introduced.

It could not have been known to the standard which the suggestion implies. The virus had not even been discovered. So clearly direct testing for its prevalence could not have been gauged. To suggest that in those circumstances not knowing to that standard is an excuse, is, in fact, to say that there was no obligation to inquire, to estimate and to act accordingly.

In fact, the evidence shows that Dr Gunson stated in 1987 under the subject of the best estimate of incidence of transfusion-associated non-A, non-B hepatitis in the UK from published data as being 3 per cent. As it happens that number was incorrectly reported back by Dr Forester to Scotland as 2.5 per cent. All of this is analysed in our submission in some detail from page 417.

The point, sir, though is that to say that things

were not known is simply not good enough. At the time scientific estimates were made and those scientific estimates should, in our submission, should have been acted upon.

In the political sphere too, this misapprehension of the inherent danger of blood and in particular blood products produced on an industrialised scale from multiple potentially harmful donations had a detrimental influence on the way that matters relating to blood and its various uses were handled.

In his evidence to the Inquiry, Lord Clarke stated that that the blood transfusion system was, in general terms, an oasis of calm. This, in essence, was the problem. These infective episodes were predictable, if not inevitable, without proper management, investment and control. The result of this was that matters relating to blood were simply not prepared for.

The internal structure of the Civil Service, within the Department of Health, and indeed within the devolved departments, including the SHHD, saw blood and infectious disease as separate disciplines, administratively handled in the Department of Health within Dr Walford's Med SEB and the separate Med IMCD respectively. The context of this disaster made it clear in our submission that blood and infectious

disease went hand in hand. The latter was always a danger of the former.

The political system was not set up to deal with the inevitable and viral emergencies with anything like the predictably required urgency. It was entirely predictable that when new viral threats emerged, an urgent precautionary approach would always be necessary to provide protection to those who would be in the frontline of the first wave.

Instead, the evidence heard by the Inquiry makes it clear that the system, rather than being defined to deal swiftly and efficiently with inevitable viral outbreaks, was instead designed, rather, for those in positions of power to evade responsibility. The evidence of the systems can accurately be characterised, in our submission, as reminiscent of the account of the Cabinet Office given by Mr Dominic Cummings in more recent years in connection with decision-making in connection with the Covid 19 pandemic: ministers, civil servants and medical experts all pointing the finger at each other when asked who bore ultimate responsibility for those decisions and actions which were required to be taken to minimise the risk. Mr Snowden used the phrase, I think, "pass the parcel", and we are referring to something broadly similar.

The position taken in the written submissions of the state actors and the Inquiry tends to suggest that little has changed. Overall, the state's position has the impression of a multiple accused criminal trial where the accused start blaming each other. As is often the outcome in such situations, the Inquiry should, in our submission, find that the disaster was caused as a result of a combination of multiple, culpable failings on the part of all of them.

The evidence frequently showed that inadequate advisory structures were put in place to deal with the predictable urgency of the viral threat, which would inevitably emerge at some point from blood and blood products. This manifested itself in many different ways. When threats emerged they were not analysed comprehensively. The threat of HTLV-III appears to have been assessed without any consideration being given to the fact that it was a threat additional to the existing non-A, non-B danger.

Despite the fact that it was known from the early days of AIDS that the disease presented with a lengthy prodromal period, a common feature of viral disease, and which had been the case too with the chronic carrier state of HBV, incidence and risk were constantly confused in the limited risk assessment.

Government papers and UKHCDO minutes around this period are littered with the number who have been found to have AIDS. It seems not to have been appreciated that different medical disciplines would inevitably take different views of the risk due to their different experiences and perspectives. It was entirely predictable that that would happen. Haematologists like Professor Bloom would inevitably see things more from the point of view of the need to maintain treatment for bleeding, yet Professor Bloom's advice on the AIDS threat was followed as if he was providing a balanced, comprehensive view. The system seemed to be set up to allow any view to be adopted which happened to be the most political convenient, as opposed to the minister or others in government acting as an assessor, and aware of all of the relevant views.

Professor Hann recognised in his evidence that there was a distinct lack of a virological input at that time overall. One might also add to that the lack of attention paid to experts in infectious diseases, epidemiology and public health.

The question constantly addressed, as I say, sir, was the incidence of the disease and not the risk. Basic procedures with which we are now familiar, due to the Covid-19 crisis, about disease modelling, appear not

to have formed any significant part of the picture.

There is no reason why this could not have been done at the time and the views of individuals, like Dr Spence Galbraith, given more prominence based on his experience being a significant part of the risk assessment.

Further, our client, Mr Norville, described the public health risk which resulted from this lack of precaution. Not only were he and his fellow recipients of blood products being put at risk, but they were also vectors, as he put it, for the transmission of disease into wider society. Nobody seemed to look at things that way.

As regards the specific evidence of the viral risk with which you are concerned, sir, we argue in our written submission that the general context of the association of blood and blood products with viral disease meant that a precautionary and reactive approach to the emergence of these new threats was necessitated. In any event, we also argue, as others have done, in written and oral submission, that knowledge of risk of these specific viral threats -- HBV, HCV and HIV -- was not assessed and responded to adequately, putting patients at unnecessary risk.

We analyse in detail the emerging information about the transmissibility of viruses but also the likely

severity of the consequences of infection.

In this regard, the arguments presented are a little different. It was known, we say, from the time of The Prince paper in 1974 that another form of hepatitis was being transmitted, that the agent or agents had not been identified was not the real issue as harm was being caused and a viral agent was assumed.

The real issue was whether the disease would be likely to become serious or serious enough to offset the perceived benefits of treatment by which the patient continued to be exposed to the risk. Either the need for transfusion or the treatment of a bleeding disorder.

In any event, we argue that the history of HBV, which of course was still being transmitted due to the relatively ineffective screening for it in the 1970s, and thus still prevalent in pool concentrates, assessment of evidence of severity ought to have been treated with caution, given the possibility that the true ramification of such diseases might not be seen for many years, as has been referred to, I think, by at least by two speakers. By 1979 Dr Walford wrote that she thought non-A, non-B hepatitis was a disease which could be rapidly fatal.

As far as HIV is concerned, or more specifically HTLV-III, the seriousness of AIDS appears to have been

understood from the outset. The issue appears to be more about the question of whether it was spread by a virus or otherwise through blood products. Many of the submissions made on behalf of the state appear to suggest that there was no consensus at the time on certain matters or that evidence relating to the risks was limited in some way, such as the difficulties inherent in undertaking biopsies on haemophilia patients.

This would tend to suggest that consensus was necessary before action was required to be taken. It is, in our submission, inherent in the nature of viral disease that information will emerge about its prevalence, aetiology, transmissibility and potential consequences over time.

This was all the more of an issue with diseases like hepatitis C, due to their long latency period between infection and symptoms. The state relies upon the paucity of information about the risks and potential consequences of infection. We argue that this is not an accurate assessment in light of the evidence which was available and which ought to have been judged in a precautionary manner.

However, to the extent that information was not available about disease, that too is the fault of the

state. Means by which information about disease could have been gleaned, like a TTV-style study advocated by Dr McClelland from 1981, were not taken up. Poor disease notification systems were maintained, despite the Rosenheim recommendations. Suggesting that "We did not know" is hardly a defence when you should have educated yourself.

In his oral submission, Mr Cory-Wright painted an evocative picture of the limitations of the age, citing in general terms the constrained communication of the pre-internet era and suggested that attendance at international conferences was limited. Though a poetic description of the time, the submission bore no resemblance to the evidence.

Blood and industrialised blood products like vaccines had been infectious and killing people since the war. The advantages of blood and plasma had always been known to be associated with viral threat. They ought rationally to have been handled together. They were not.

Further, the evidence showed that those involved in the collection and processing of blood had, in fact, every opportunity to access cutting edge information about viral threats, to which I will return, to which they should have been alive, given the association

between blood and viral disease.

Professor Hann, for example, explained that he attended a conference in Stirling in Scotland in 1982, at which time the most cutting-edge information about AIDS was being openly discussed. If there were limitations about what was known about the viral threat, this was because of a systemic failure to implement mechanisms to be alive and reactive to that reality.

Sir, that brings me to the end of my first section. I see it is 11.15 if that would be an appropriate moment for a break that would be suitable for me.

SIR BRIAN LANGSTAFF: Yes, indeed. We will come back at 11.45 am.

(11.15 am)

(A short break)

(11.45 am)

SIR BRIAN LANGSTAFF: Yes.

MR DAWSON: Thank you, sir. Before the break, I was going through my ten sections. I had reached section 2, which was the assets and advantages of the Scottish system.

In assessing the events which led to the harms which have been visited upon victims of the disaster in Scotland, we believe that the extent of the culpability of the state in both causing and compounding those harms must be judged against the backdrop of the assets and

advantages which the evidence shows that the Scottish system enjoyed.

These were as follows: first of all, sir, as I have already mentioned, Scotland both before and after formal devolution enjoyed political autonomy in relation to the matters with which the Inquiry is concerned.

Though called administrative devolution before the Scotland Act, the Scottish Office enjoyed the same freedoms with regard to matters of health relating to political and financial matters.

This, we say, enabled there to be political consideration of what would be in the best interests of Scottish patients, judged within the particular parameters and considerations which applied to them.

Both before and after devolution, Scotland's separate political governance meant that had a different course could have been taken to handling both the causation of infection and the aftermath of the disaster and putting victims first. That it consistently failed to do so exposes, in our view, what we call the "myth of devolution", to which I will return.

As I already mentioned, secondly, sir, Scotland had its own fractionation centre, the Protein Fractionation Centre in Edinburgh. It was situated in the same relatively small city, within a few miles of a major

teaching hospital, one of the five Regional Transfusion Centres, the headquarters of the SNBTS and much of Scotland's Civil Service. These practical advantages offered an ideal opportunity for the creation and maintenance of a dynamic and cohesive system of fractionation. The PFC had the power to make its own blood products and exercise control over the way in which blood to make them was sourced, along with the SNBTS, and the products were manufactured.

The evidence shows that it had been intended, as others have said, that the facility might ultimately be used to fractionate plasma for other parts of the UK. The facility was thus a considerable advantage for the Scottish system to have at its disposal and under its control. It ought to have made Scotland self-sufficient in blood products much earlier than it did and also to avoid the use of clearly unsafe commercial imports, which is a feature of the Scottish system to which I will return.

Furthermore, within the fractionation system, as the Inquiry has heard, was Peter Foster. At the Penrose Inquiry, of Peter Foster, Professor Cash said "If we had 25 Peter Fosters, we would have been fractionating on the Moon".

Given his attempts to dumb down for us mere mortals

the intricacies of the fractionation process, it was apparent that he was a considerable asset. In our submission, when he was faced with technological challenges, when he was permitted to do so, he was generally able to solve them relatively soon. Scotland managed to, as we have heard from the SNBTS, achieve heat treatment of Factor VIII such as to eradicate HIV in December 1984. Peter Foster had become aware of the existence of a technology which might achieve that only two months before at the Groningen conference.

Similarly, a matter to which I will return, he pioneered techniques relating to the yield of the Factor VIII protein from plasma, which significantly changed the landscape of the Scottish system, a matter to which I will return.

In our submission with these assets, Scotland's fractionation programme, if properly resourced and matters properly prioritised, would have been able to make progress towards the achievement of these technological milestones long before it actually did, another asset which failed to be used.

As I already said also, Scotland had its own National Blood Transfusion Service. It had complete operational freedom to operate the blood transfusion systems it saw fit in the best interests of all

involved, including its ultimate users. Over much of the material period the service had the notional benefit also of a well-informed, experienced, National Medical Director, in the form of Professor Cash, a man not short of an opinion or indeed expertise on a number of important matters. As I have already said, sir, he was the author of a number of papers which pointed out the need for there to be greater attention on matters pertaining to safety.

In his submission, relating to the limitations of the English transfusion system, Mr Cory-Wright described the structural limitations as having impeded the system in England and Wales before the formation of the NBA. Despite the fact that this was not an issue in Scotland, Scotland chose to operate a system of regional autonomy within a national system where directors were allowed to tread their own path, even in the face of known danger. The valuable Professor Cash was little more than a powerless commentator on matters of safety.

Fourthly, sir, Scotland was and is relatively small. That size, alongside the systems and facilities to which I have already referred, created the possibility of devising and operating a service which was more nimble and reactive to the needs of patients, in particular relating to safety.

Fifthly, in the case of patients with bleeding disorders, in the frontline of danger from blood borne viral infection, it had a knowledgeable and highly motivated client body. The evidence available to the Inquiry was that the communities of patients were characterised by strong families and groups who tended to take the lead in raising questions with the centres. The Mackies in Edinburgh, another prominent family in Dundee, the late Philip Dolan in Glasgow, and the parents group at Yorkhill, they were an intelligent, engaged and willing patient group. They were a group who could have been enlisted into the betterment of their care in accordance with the ethical responsibility to do so. Yet they were routinely kept in the dark and their right to autonomy and engagement denied.

Scotland also enjoyed considerable technical and scientific expertise, inventiveness and medical and scientific independence. This is exemplified by the ability of the Scottish laboratories, in particular in the West of Scotland laboratory run by Dr Eddie Follett, to develop their own tests and carry out their own studies about the incidents of disease in Scotland and in the donor population.

Yet testing in Scotland was either not introduced or was delayed, causing unnecessary and clearly avoidable

infection. Research, which was suggested, with a sound evidence base and foresight in the early 1980s, such as the TTV-style study to which I referred, and for which Dr McClelland advocated, were never taken up. A wilful blindness to the emerging threat which was allowed to prevail.

Scotland also had its own statutory system for disease notification, which we say in our submission operated inefficiently. Mr Cory-Wright suggested in his oral statement, as I have said, that there were limitations on information exchange in the pre-internet era, and limited attendance at international conferences.

This assertion, as I have said, runs contrary to the evidence of information access, in Scotland at least, at the material time. The Scottish system was plugged into an information superhighway of its own about matters relating to safety. Scotland had its own Royal Colleges and world-class medical universities, with teaching hospitals based in those in at least four of the same places as the transfusion centres and the haemophilia centres.

In 1983 Dr Foster had attended two international conferences to enable him to access information about the realities of the AIDS threat. I have already

referred to the conference attended by Professor Hann in Stirling on the same subject.

Dr Foster obtained information about the success of dry heating against the HTLV-III threat in October 1984 at the Groningen Conference. Dr McClelland and Dr Forbes had reliable access to US sources of cutting edge knowledge about risk and developments in viral risk, the former most prominently about the value of the TTV study, to which he had been allowed access in the US, and the latter in his close contact with the prominent Dr Ratnoff in Cleveland, who had told him about an AIDS case amongst his patients as early as 1981, which was not reported until 1983.

Professor Cash was given a vial of Australia antigen by no less than Alfred Prince in 1969, from which it developed Scotland's separate assays for testing for that virus, after he brought it back to Scotland.

Testing was made available to the Glasgow Centre for HTLV-III from the US centre run by Dr Gallo. The Glasgow Centre collaborated with the Danish Melbye group in their immune function and AIDS research.

Dr Ludlam corresponded with Dr Gordon in the US about the emerging threat of AIDS and the use of his patients in research. And Dr Perry corresponded with the Montagnier group in France who discovered LAV

in 1983.

As we will see later, the British medical literature was flooded with information about hepatitis and AIDS. As to the issue of communication, the mechanisms of communication and safety-orientated decision-making were available. Regular meetings were taking place of UKHCDO directors and of the Scottish directors separately, and of the Scottish SNBTS national directors.

They regularly met with each other in the SHHD. Dr -- Dr (sic) probably did not need email to agree to spread his views on risk to Dr Ludlam. Their offices were in the same corridor.

If the facilities for accessing information, assimilating and sharing it were available, they were not used profitably.

Furthermore, Scotland -- the evidence showed that Scotland had significant access to what might be described as lower risk blood products than concentrate. Cryoprecipitate was widely available and could have been used. In Edinburgh it had been the mainstay of treatment before the arrival of Dr Ludlam in around 1980. Similarly, from around 1977, writings by Dr John Wallace confirmed that it was the mainstay of the other main treatment centre in Scotland, at the Glasgow Royal Infirmary, during the 1970s.

Freeze-dried cryoprecipitate, a low donor, freeze-dried product produced by Dr Gabra at Law Hospital, the advantage of which he extolled at the time and explained in his evidence, was also available. It was used at Yorkhill Hospital successfully for the treatment of children there. It was, of course, a product eminently suitable for the treatment of children due to their smaller size and lesser need for Factor VIII to achieve haemostasis. It was not used, the preference being for the unsafe Armour Factor VIII commercial product.

It is interesting to note, we say, that the failure of Scotland to take forward Dr Gabra's project at Law Hospital is mirrored shortly after its abandonment in documentation relating to the state response to the Council of Europe recommendation relating to AIDS from 1983. In one document, the reference of which is DHSC0001655_0002, Dr Gunson provided an analysis of the recommendations, which we have looked at in some detail. You will recall, sir, that recommendation 1, which related to the use of lower pool, lower risk products, he said could not be achieved in England and Wales because of the fact that there were issues about moving the system away from concentrates to such products.

The evidence tends to suggest that this could have

been done in Scotland had a different attitude been taken to Dr Gabra's product, which in effect would have been a different attitude to safety. No separate consideration was given to this possibility. We notice, in this regard, the submission made by Mr Snowden in connection with the outcomes which happened with regard to HIV in Finland, where lower pool products were preferred until the point where heat treatment could be used.

Finally, sir, there were close links in Scotland between hospitals and the transfusion service, which should have allowed information sharing between the transfusion doctors and clinical staff about the risks of blood and blood products and the need to minimise their use and also should have made look-back more achievable.

These attributes and advantages show that, contrary to the submissions of some of the emanations of the state to this Inquiry, knowledge was available on which action was mandated, safer or alternatives were available, patients could have been afforded choice, and ultimately lives could and should have been spared.

These attributes and advantages were, however, wiped out, not used or deliberately eschewed, such that, instead of being what it should have been, the Scottish

experience of the disaster involved missed opportunity, was defined by the strength of its weakest links instead of its strongest, and was characterised by largely avoidable infection and much compounded harm and loss.

Clinicians, ministers and others have given evidence to the effect that these things were not advantages which meant that Scotland should have taken a different path, time and time again. In many but not all such cases, those who were here to explain their evidence themselves gave evidence which would have accorded with what we in our written submission have labelled the "party lines", similar to the myths and lies to which Mr Snowden referred and to which I will return.

As a result of this, the evidence which they gave was often defensive, incomplete, inconsistent and the other written or oral evidence was unreliable. Two important points flow from this in our submission. In addition to the evidence of the infected and affected by the very nature of this Inquiry, there are instances where the search for evidence goes beyond what they know. The fact they were consistently kept in the dark about the truth of what was going on and their search for answers is an important and predominant theme.

In our submission, the truth about what happened and what was achievable is often to be found in the factual

evidence of those who were not responsible or in the line of fire but who were there at the time, are reliable, dispassionate witnesses with no axe to grind. They show that due to the advantages and assets of the system, things could and should have been achieved which were not. They are not *ex post facto* justifications, but based on evidence from the time. We would urge you to bear this in mind when analysing and weighing the evidence. For example when weighing the evidence about the culture of patient engagement and information at the Royal Infirmary of Edinburgh, do not prefer the evidence of Professor Ludlam but that of his colleagues Billie Reynolds or Alison Richardson, who witnessed it first hand.

When weighing the evidence about the AIDS risk and whether it was thought merely to be a foreign problem not caused by a virus, do not prefer the evidence of Professor Ludlam who considered it to be, but that of Dr Foster, whose internationally acquired information about the real risks in the UK, in particular to his laboratory colleagues via the domestic supply of blood and blood products, are expressed in his letters from 1983 to his union about the danger of the Government line at the time.

When weighing the evidence about the culture of the

West of Scotland Blood Transfusion Service and their refusal to follow the safety measures taken or proposed to be taken elsewhere, prefer the evidence of Dr Gillon, who said it was their practice to do their own thing, different from the more safety-conscious South East Service.

When weighing the question as to whether donations were given voluntarily in military institutions, prior to his arrival in the SEBTS(sic) in 1985, do not prefer the evidence of the likes of Dr Mitchell, prefer the evidence of Dr Gillon who said that they were not and at that time stopped them.

When weighing the evidence about whether prison donations were known to be high risk, do not accept the evidence available from the likes of Dr Mitchell, but that of Dr Walford, who said that they were known to be dangerous.

When weighing the evidence as to why surrogate testing should have been introduced, do not prefer the evidence from the Scottish Home and Health Department but that of Dr McClelland, who said that a TTV study could and should have been done in 1981 and who was part of a team which recommended that surrogate testing needed to be introduced, published in The Lancet in April 1997.

When weighing the evidence about why a look-back was not done, do not prefer the evidence of the Government, but that of the expert, Dr Gillon, who said it could have been and that it was ethically wrong for it not to have been in 1991.

Secondly, and importantly, sir, it is a consistent theme of the parties lines, as we have called them, advanced on behalf of the state, that they seek to say that things were not known or could not have been done or were not reasonable to expect. In the civil law we judge questions of negligence in accordance with what was known or ought to have been known, and the reasonable standard applied to the circumstances of what the law should expect of an individual in his or her particular circumstances.

The advantages of this context, in which the Inquiry should judge the excuses and defences advanced by those who might be criticised, is important.

It is because of these assets and advantages that I can invite you, sir, to accept the following broad propositions in analysing the evidence by the state and state actors in the defence of its position.

When they say they did not know, they did or they ought to have done. When they say they could not, they could have done, and what they say they did not, they

should have done.

In setting up this Inquiry, the then Prime Minister Theresa May said that thousands of patients expected the world class care our NHS is famous for. When they say there were reasons that expectations were not met, it was despite the fact that these advantages existed. The fact that the disaster was allowed to happen in Scotland despite these assets and advantages is, in our view, what makes the state culpable. The multiplicity and egregiousness of its failures, despite these advantages, are what, in our submission, give rise to the submission which we make that the state now has a moral duty to compensate and look after those who have been so failed.

Despite the assets and advantages which it enjoyed in technology, in thinking, in ambition and, in some places, in those with a genuine commitment to patients, the system allowed itself to fail. It allowed itself to be defined by its weakest parts, by its failings and by its shortcomings. It had available to it a cohort of bleeding disorder patients who were motivated, educated and willing to participate in their own treatment. It could have been so much more, as the Prime Minister Theresa May said that patients were entitled to expect.

The idea that the tragedy was unavoidable is simply untrue. This is the lie around which the state circled,

as Jeremy Hunt put it.

Sir, the third section I intend to move on to is entitled "The myth of the voluntary donor".

Lord Owen gave evidence to the Inquiry about his acquaintance with the book by Richard Titmuss entitled *The Gift Relationship*, essentially a comparison between the systems of blood donation in the United Kingdom and the United States. This relative approach to the collection systems was, we say, at the root of the problem in reality. It was legitimate as a matter of theory, as Lord Owen said, to assume that blood and the components of blood freely given by altruistic blood donors was likely to be safer than that given by the paid donors portrayed so clearly in the *World in Action* documentary in 1975 and elsewhere.

This, however, was not the same as saying that blood collected within the unremunerated system was always given voluntarily or that the UK system was safe, as opposed to just likely to be safer in relative terms.

The evidence, in our submission, is overwhelming that the domestic system of blood collection processing and use, provided completely inadequate protection to the recipients of blood and blood products in Scotland. The main way by which safety could be maintained against pathogens which had not yet been isolated, and could

therefore not be screened for, was donor selection.

It would be incorrect to assume that the ability to benefit from the altruism of the volunteer donor was the only factor of the UK system which created a potential advantage over the other systems which were built on paid donations. In addition to the altruistic argument, there was the fact that a UK system was one over which the transfusion system was able and indeed obliged to exercise control and also the fact that the donations that were made were local.

However, the requirement to use reasonable endeavours to make sure that these three aspects of the system, the donations being voluntary, the donations being controlled and the donations being local, were, in our submission, inadequate.

The assumption that the volunteer donor was a safe donor appeared to pervade the entire system, despite these defects.

The fact that the donor system should be local was designed to stop the introduction of foreign pathogens into the UK. The fact that blood products were imported from abroad, of course, made the recipients of them vectors and was a clear and unnecessary danger to public health in Scotland. However, the fact that blood donations were also, on the evidence, taken from

tourists meant that the risks of foreign pathogens were part of the UK systems as well. Even their press, we know, was reporting the possibility in early 1983 that Edinburgh may become the AIDS capital of Europe due to the influx of tourists for the festival in the summer of 1983. Dr McClelland acknowledged that visitors gave blood in Scotland and of course they could transmit viruses to UK donors sexually. The reality of foreign travel and the dangers created by the easy transmissibility of HIV and HBV by sexual activity were not acted upon.

These activities are, of course, generally secret in nature and not recorded anywhere. They created dangers which were not appreciated or acted upon. Further, the Scottish system collected blood from foreign nationals within high risk groups, in particular the military from US bases in Scotland, to which I will return.

Against this background, the collection of blood within the revered system operating in Scotland meant that donations could be not described as voluntary or properly controlled. Though apparent throughout the period of the Inquiry's investigation, this became particularly apparent as the AIDS crisis emerged, in particular in Edinburgh.

The evidence showed that Dr McClelland was privy to

infections in the city from his hospital colleagues in the GUM department at the hospital. The extent of the problem in Edinburgh led to Dr Ray Brettle, subsequently colloquially referred to as Dr Death, an AIDS specialist, being employed at the city hospital in October 1983.

A local general practitioner, named Dr Roy Robertson, was monitoring local intravenous drug users in his area in the north of Edinburgh for hepatitis B infection from 1982. The transmission similarities noted between the two diseases were known from the outset of the earliest reports of AIDS. This risk was not acted upon.

Mr Cory-Wright talked about the fact that discussions about sex were different at that time. That was, in our submission, precisely the reason why stringent procedures were predictably needed to keep risky donors out. This was all the more so in Scotland where homosexuality had remained illegal until 1980 and it remained difficult for many to discuss openly for years thereafter. How it could be thought that without proper detailed individualised donor screening that donations could be thought to be voluntary, in particular in workplaces where the social stigma associated with the recently legalised homosexual

activity meant it would not be openly discussed.

The system of donor selection in Scotland meant that it was not voluntary, it was not controlled, it was not local. Donations from prisons continued in Scotland until 1984, we say in all regions until 1983, that is contrary to the evidence of Dr McClelland, who thought that it ended in Edinburgh in 1981. In that regard I refer you, sir, to reference PRSE0000193, 29 March 1983 Scottish Transfusion Directors meeting, where it confirms that, at that time, in March 1983, all regions were still collecting from prison sessions.

Due to the well known criminalisation of intravenous drug use in Scotland, referred to by Lord Forsyth as an attitude which he tried to eradicate as minister and then Secretary of State for Scotland in the 1990s, if you wanted to find a person who was a likely intravenous drug user or who was a man who had had sex with a man, the first place you would try would be a prison.

If you read Titmuss, captive donors are not classed as according to the ideal to which Lord Owen subscribed in 1985, they are separately categorised as regards whether their donations can be described as voluntary or not.

Donations were collected from military bases. The evidence was that in Inverness, for example, this was

a material part of the system. Dr Gillon gave evidence to the fact that he stopped military donations in the South East Region in 1985, on the basis they were not voluntary. As with many of the sensible attitudes he instituted and carried out, this was too little too late. The system had already been polluted for years.

In the military, homosexuality remained illegal for the entirety of the period of infection with which the Inquiry is concerned. For those who continued to go there, how could there ever have been an expectation that a donor who had been ordered to be at the session would confess to an activity which would end his career?

And for whom were these donations collected: children needing leukaemia treatment; patients needing dialysis; accident victims? Not in Scotland. There would have been enough red cells for them, a matter to which I will return, with a much more restrictive selection policy, for the unnecessarily aggressive treatment policies of the haemophilia directors, whose demand for plasma drove the system, was the reason why these donation sessions continued, in our submission.

As to the advantages of locality and control, as I say, these were myths in reality. The drive for plasma meant the collections took place in US military bases in Scotland too. We explain the mystery of the

evidence of Mr X in our submission. He received a blood transfusion in the late 1970s in Dumfries and the nurse told him he would, from that point onwards, be likely to speak with an American accent. How could that be true as the UK did not import blood from America? The answer? They did collect blood from Americans, high risk Americans, who were not volunteers. In response to questioning about news articles in 1983 about the risk of AIDS from tourists, Dr McClelland, as I said, confirmed that he did receive donations from such visitors.

The system, or at least Dr McClelland, and, indeed, the press were not blind to these risks. The system just did nothing about them.

Equally, sir, at regular donor sessions little or no control was exercised, in our submission. Donor exclusion criteria were based on habit. Asking patients about a history of jaundice appeared to have little scientific currency or validity. They were, in any event, poorly policed. Donors described in evidence as sometimes having the aura of a charitable exercise, as opposed to a professional activity. The system was not using any adequate mechanisms to exclude high risk donors. The inadequacies of the systems are demonstrated by the summary of the Medicines

Inspectorate Report on Donor Selection, made by Professor Cash, in a letter to Dr Brookes, dated 5 July 1983 -- that's PRSE0003112 -- where Professor Cash says:

"One of the general points made by the Medicines Inspectorate was that in the SNBTS the acceptance of a donor was largely a matter of chance."

Clearly, a gross exaggeration but it has been well known for many years that the consistency between centres is less than desirable.

This neatly encapsulates both the complete lack of any donor selection protections in absence of screening then, the only protection the system had against viral transmission, as independently assessed and also the apparent lack of regard which the professor had for the significance of that finding.

Interestingly, in connection with prison sessions, Dr Brookes, who sat on the UK Working Party on Donor Selection was charged, at that time, with looking into what was happening in this area "on a national level with a view to creating greater consistency in Scotland".

This also raises the issue that Professor Cash was keen to secure consistency in the context of what the rest of the UK was doing. As I have said, the pressures

on the systems elsewhere and hence their donor selection policies being different, different donor selection exclusion and ultimately screening policies needed to be considered, another manifestation of the myth of medical devolution on a practical level.

Despite those pressures, ironically, the information provided was that prison sessions happened relatively infrequently in England at that time, which, of course, was consistent with the evidence given by Dr Walford when she expressed that they were known and considered to be dangerous.

When Dr McClelland suggested his donor leaflet be used across Scotland, the response indicated the prevailing issue.

In document PRSE0003620_005 a Transfusion Directors meeting of 24 May 1983, Dr McClelland introduced his leaflet. Dr Mitchell, however, had merely decided "to introduce into the health questionnaire to donors a question inviting those who were worried about AIDS to consult the doctor at the session". Dr Urbaniak from Aberdeen did not even entertain the possibility. He had decided to do nothing, "his view being that once a donor had entered the session, it was too late to make an approach".

Mr Bowie has accepted that insufficient systemic

face to face questioning of donors regarding intravenous drug use took place and that it should have taken place from the mid-1970s, based on the known association between that activity and infectivity.

He accepted that it would have been better if they had excluded IVDUs much earlier than they did and if they had had a more systematic donor selection process across all SNBTS regions.

The SNBTS apologised for these failures.

He also accepted that other regions chose not to adopt the leaflet in May 1983 and expressed his clients' regret that it was not more widely adopted prior to the national September 1983 leaflet.

Though the acceptance of these points is helpful and appreciated, they are very much more limited concessions than the evidence would suggest are appropriate. The regional autonomy point is just part of the problem. The responses of Drs Mitchell and Urbaniak indicate a much more widespread reality, that there was no real system for the prevention of high risk donors or any real willingness to institute one.

This was also the finding of the Medicines Inspectorate. In any event, the concession about the lack of personal interview surely has wider ramifications than merely the failure to exclude IVDUs,

significant as that failure was. We also argue the leaflets were hopelessly inadequate in their wording. Systems for their dissemination and use to seek to prevent donation by high risk donors were also inadequate in light of the known potentially fatal consequences of infection.

We look in some detail in our written submission about the wording and point out what we consider to be the inadequacies.

What was the effect of all of this? Scotland's system of blood collection was as far from the altruistic ideal which Titmuss had painted. It was, in our submission, on a par with the sewer of viruses as my learned friend, Mr Snowden, accurately described the US system.

The theoretical advantages of a voluntary donor system had been given up, in practice. The system of blood donation was a myth. It was not voluntary. It was not local. It was not controlled.

In addition, the Titmuss principles relating to the advantages of the volunteer donor should not be understood in isolation. They were but one part of a social contract which worked on the basis that volunteer donors would be likely to be safer than those which were taken from remunerated donors, who had

an obvious incentive to conceal information which might prevent their donation in the interests of safety.

This worked on the basis of probability. It was probably right that volunteer donors would be less likely to transmit viruses than remunerated ones, not that it was likely that a system which relied on volunteer donors would be safe. In a system where blood was transfused to patients without any control and in every pooled product bleeding disorder patients were exposed to many, many donors, something greater than hope was necessary. Active steps to make sure the hope was realised were needed but not taken.

One of the results of the faith in the voluntary system was, in our submission, the priority given to the donor in the system. The transfusionists, on the evidence you have had heard, sir, rather looked at the donors as their patients needing to be prioritised at every turn.

Mr Cory-Wright, in his submission on behalf of NHSBT, accepted that for his clients now, of the various considerations to be weighed in the selection of disease prevention measures, the safety of the recipient was the primary one. He also provided a useful tutorial on the importance in screening tests, in particular the need to consider the concepts of sensitivity and specificity,

concepts which are also analysed in detail in our submission.

Although the primacy of recipient safety now is, of course, most welcome we submit that it certainly was not in the past, both in relation to donor screening and selection.

The total deference to donors in both of these aspects of the system meant the balance was inappropriately weighted against the recipients. As to donor selection, the lack of any real system of speaking to and assessing donor risk, not only meant there was no real protection, as the Medicines Inspectorate report said, but it also seemed to misunderstand the philosophical principles of Titmuss underlying them.

The social contract principle was based on altruism being given, in the hope that a similar gift would be returned if the donor or a loved one ever needed it in the form of a blood transfusion.

This symbiotic relationship depended on honesty of the donor, which was not in fact reciprocated. Why did the system think that a donor would react badly if a donation was rejected on medical advice that it was a risky one? Would he or she not want risk to be minimised as far as possible, if he or she or a loved one were ultimately the recipient of the gift?

Why was it thought to be such a bad thing if a potential risk was flagged up to a donor by the act of donation? Could the likelihood of that indicating underlying disease or some other medical problem not be explained as part of the social contract? Why would the donor not want to know about that state of affairs and potentially seek medical advice or change their lifestyle as a result?

The reverence accorded to the donor was misplaced, in our submission, in these regards. Similarly, in screening, much of the same illegitimate weight was placed on these considerations. In screening -- we invite you, sir, in our written submission on the subject, to find that there was a failure to institute screening and that delays in doing so were unnecessary and illegitimately influenced by these donor related considerations.

Thus, in the balance, considerations of issues of specificity, the problem of false negatives, were given undue weight where there was acceptable proven sensitivity, the possibility of false negatives, in that the aspiration of Mr Cory-Wright's clients today to make the primary consideration the safety of the end user, was not routinely realised.

Mr Cory-Wright ultimately agreed with the forceful

pleas made on behalf of the UK Thalassaemia Society in front of you, sir, that donors needed to be treated honestly, in particular that they should know about the vulnerability of the recipients of their gift. We agree with that. This was far from the system which operated at the time in Scotland at least. There was no reason why it should not have done. Indeed, it was consistent with the Titmuss principles of the gift relationship which underpinned the whole relationship.

In our submission, sir, the faith in the voluntary donor system led to a faith in the safety of blood which was not justified. This combined with an apparent lack of the proper analysis of the necessity of blood, and the quantities in which it was transfused, or the necessity of pooled blood products in the treatment of bleeding disorders, led to safer practices being allowed to dwindle and die. Low pool concentrate from Law Hospital was sacrificed. Cryoprecipitate production was allowed to dwindle. The blind faith in the voluntary system, which was not voluntary, which was not local, and which was not adequately controlled, led to a misplaced faith that blood and blood products from Scotland were safe as patients were invariably told they were if they asked.

They were not.

Sir, I would like to say a couple of things in general terms about a matter relating to this topic, those being the Medicines Inspectorate reports. There are a number of such reports, sir, which contain, I think it is fair to say, a scathing analysis of the operation of the blood transfusion collection system in Scotland in the early 1980s.

The underfunding and lack of attention to the system created, in our submission, a breeding ground for the transmission of disease. The aspiration of the system, should adhere to good manufacturing practice, frequently mentioned by those who work within the system, could not have been further from the truth. The inspection showed up an issue which specifically related to the viral threat, in particular the continued collection of blood from prisons, a practice which had been internationally condemned and was not followed generally south of the border.

In addition, the need to deal to some extent with the practical outcome with the Medicines Inspectorate findings practically diverted key staff at an important time. Dr McClelland was hampered in his ability to be able to take steps to resist the HIV threat, based on the fact that he spent, in his evidence, a large amount of his time dealing with the inadequacies of the

Edinburgh systems.

Ironically, these woeful inadequacies, which were shown up in these reports and, which, it is stated in them, would, in other circumstances have led to licences being revoked, were identified in an entirely toothless and ultimately futile process. The doctrine of Crown immunity, which was relied upon at the time, had led to licences which had been granted in the '70s having lapsed by the early '80s. Positivist legal theorists like John Austin would have identified the lack of sanction as a flaw in the system. We would agree.

The system which was the only line of defence against at least one, soon to become two, potentially fatal diseases was unlicensed, inadequate and unsafe.

The blind faith in the safety of the supposedly volunteer donors provided no real protection.

As I said, sir, one further matter I would like to speak about is the fact that in Scotland the system was plasma driven.

In his oral statement to the Inquiry, Mr Cory-Wright pointed out that the maintenance of the blood supply was an important reason in England and Wales why proposed safety measures could not be taken. Such measures would have reduced the numbers of donations which could be used, either by deterring donors or introducing

surrogate or more direct testing methods which would have run the risks of blood or blood components not being available meet the demand for transfusion.

Importantly, sir, this was not the position in Scotland throughout this period. The whole system was driven by the need for plasma to make Factor VIII concentrates, such was the demand for it. The idea that blood required to be collected from the early 1980s, to meet the demand for transfusion, is simply inaccurate. The driver in the system was for plasma to meet the huge increase in demand for Factor VIII concentrate. The need to meet the quotas is clearly exemplified by the increasingly frantic tenor of the correspondence between Dr Bolton, deputy director of the South East Scotland Blood Transfusion Service, and Dr Ludlam, which is analysed in detail in our submission.

It shows a system fit to burst and explains why risky donors required to be retained and donor exclusion policies kept to a minimum. Dr Bolton has, of course, been an experienced haemophilia clinician himself and no doubt this was part of the decision to put him in the firing line in order to try to handle the Ludlam issue. His deference to Dr Ludlam was shown by his evidence, which he gave relating to an episode in 1987, when he mistakenly prescribed a trial product to a patient about

which he issued an effusive apology.

The statistics are also instructive in this regard. Professor Ludlam threatened the use of commercial product if he did not get sufficient supply of the domestic product, which he preferred. This was not an idle threat. In 1981, the statistics show that a significant amount of the concentrate used in Edinburgh was of commercial origin. Dr Bolton and Dr McClelland therefore knew that if they failed to meet the quotas this would have an unsafe effect.

All involved were committed to the use of domestic products. The warning given by Professor Ludlam was that "If you do not strain the system as I have asked, I will go elsewhere, which we all know to be unsafe". I will return to the theme of the effect of the plasma drive later.

It is important to note, sir, that in Scotland, unlike in other places where the risks from products were defined by the fact that patients were exposed predominantly to commercial products, the commercial practices which resulted had a knock-on effect for transfusions as well.

The drive for plasma meant that the need to continue poor collection practices, that meant that transfusions were also less safe, transfusion patients were

prejudiced by the drive for plasma which, in turn, was caused by the use of Factor VIII concentrate. This was the fatal flaw of the self-sufficiency position in Scotland.

Self-sufficiency should have been an achievable target in Scotland. The facilities which had been made available, in particular its control over the PFC, meant that Scotland could and should have been able to be self sufficient throughout this period. If it had been, it would have been safer not only for those in receipt of blood products but for transfusion patients as well.

My fourth theme, sir, which is connected with the subject which I have just been addressing, is what we call the "concentrate juggernaut".

The commitment to the usage of concentrate in Scotland to some extent is traced back to the 1960s, in our submission.

Decisions were made about the construction of the PFC at that time. The evidence which you heard, sir, from Sarah Middleton, who you will remember, sir, was giving evidence predominantly on the basis of her experience as an employee of Speywood but also had experience of working at the PFC in the early days, explained the processes which were involved there had absolutely no regard whatsoever to safety or to matters

which would assist with the achievement of safety, such as the use of stabilisers to be able to promote the possibility of heat treatment.

Despite the lectures, to which I have referred, that were given to the Royal Society in the 1970s, the PFC project proceeded during the 1970s without any particular regard to safety.

It is important, sir, to understand in Scotland, as I have already said, that the position predominantly in the two major centres, in Edinburgh and Glasgow, was that cryoprecipitate was the main stay of treatment during the 1970s. In Edinburgh, that is most easily characterised in the change of director, which occurred in 1980. The previous director, Dr Howard Davies, had had a policy of using -- which was really two pronged.

One was that he liked to use local products because he thought they were safer and one was that he liked to use cryoprecipitate because he thought that was safer because it exposed patients to a lower number of donors.

Despite the lack of any safety features, the use of concentrate in Scotland grew massively from around 1980 and not as early as other parts of the UK. The increased Factor VIII usage in Edinburgh, by our calculations, when one compares the latter half of the 1970s to the first five years of the 1980s, our

calculations, which we set out, suggest that the amount of Factor VIII concentrate being used in those two periods indicates that six times as much was used in the first half of the 1980s as has been used in the latter half of the 1970s.

Increases were apparent also in the other centres but not to the same extent: 2.39 times in Aberdeen; 3.08 times in Dundee; 1.77 times at the Royal Infirmary in Glasgow; 3.96 times at Yorkhill; and 1.96 times at Inverness.

All of this, of course, sir, occurred after evidence such as the Preston paper emerged about the dangerous associated with concentrates and the possible severity of non-A, non-B hepatitis.

Despite the known risk, the tendency to reach for a concentrate as the treatment for a bleeding disorder, without consideration of the risk or the alternative, or the particular characteristics of the patient, far less their views, which were invariably not sought, led to the risks of patients being increased considerably throughout the period over which the infections predominantly occurred.

This manifested itself in patients receiving concentrates when it was not necessary.

Dr Walford accepted in her evidence that the risks

of using concentrate in the period in which she was active in the early 1980s outweighed the benefits for mild or moderate patients.

Professor Forbes conceded at the Penrose Inquiry that in Glasgow he simply reached for what concentrate was on the shelf, sometimes domestic, sometimes commercial, with apparently no regard for the safety differences between the two.

The evidence was that many young children were treated in the early 1980s with concentrates. An analysis of a number of these such cases is presented in our written submission.

These products were simply reached for. This was despite the fact that evidence was also heard from the likes of Dr Gabra about the Factor VIII study group which had started to meet in 1991. Dr McClelland agreed with him that they both had faith that solutions would be found to make the product safe.

Therefore, all that was needed was a temporary cessation of aggressive regimes, which could be adopted more safely when these advancements were achieved, as was the case in other countries.

The juggernaut were launched in Scotland, as I say, sir, without any breaks. As I have said already, Sarah Middleton's evidence in this regard is useful and

we would point you towards that.

In his submission, Mr Snowden pointed to information from Finland which supported the contention that treatment with concentrates may have offered a small clinical advantage over cryoprecipitate, but that that small clinical advantage was dwarfed when one considered the safety advantages of cryo. He argued, as we do, that the big step forward in the mortality advantages offered by treatment came with cryoprecipitate and not with concentrates. That is a contention with which the fractionation group agrees.

In addition, we argue that the perceived clinical advantages of cryoprecipitate over concentrate is not as material a consideration as some may claim. This is because the evidence shows that the intermediate purity concentrate used over the period when infections were occurring in Scotland did have many of the impurity-associated disadvantages which were listed as being associated with cryo: Possible allergic reactions, inconsistent amount of Factor VIII activity, et cetera. At one point those products were described by Dr Ludlam as "crud".

Though we argue that these considerations are, once again, overplayed by clinicians, and significant in weight compared to the considerations of safety, these

are -- the advantages of concentrates over cryo in these regards really were minimal.

It is an essential part of the Inquiry's investigation of its terms of reference, not just in relation to the propriety of treatment per se but also the way in which governments were led to believe that there was no realistic alternative to carrying on with treatment as it was then being administered as was represented, for example, in the Professor Bloom advice which was expressed in The Haemophilia Society letter of May 1983.

The line goes that the treatment regimes which had been instituted in the early 1980s were necessary to prevent the most serious ravages of the condition of haemophilia, in the form of crippling joint bleeds and even death in the form of intracranial haemorrhage. We argue in some detail in our written submission that this line of argument was simply inaccurate. It was the key party line developed by haemophilia clinicians to defend the treatment regimes which they had devised in Scotland exclusively on the evidence without involving -- in Scotland, without ever involving their patients or their parents in those decisions.

This is for the following reasons: it would be remiss to think that the evidence -- that the

consequences of failing to carry on with treatment regimes would be as the clinicians claimed. The evidence addressed in detail in the questioning of Professor Hay showed that the early mortality data upon which he was relying was historic and did not take account of the significant advantages of mortality achieved by cryoprecipitate not concentrates. As I have said, in Edinburgh and Glasgow the mainstay of treatment until the late 1970s had been with cryo. Many patients survived.

In any event, the line argument makes out that the choice was between one known consideration, the advantage of aggressive treatment regimes for bleeding, as against one unknown, the possible consequences of disease, which were not fully understood.

We argue that not only was the likelihood and severity not as was made out, however, it could -- it is also not the case that the advantages with regard to the bleeding were, to use the government's words, conclusively proven.

Professor Hann described Dr Willoughby's prophylactic treatments at Yorkhill as ahead of their time but not standard practice. The evidence of what the outcomes would have been without those regimes far from support the theory that these treatments offered

significant bleeding advantages. Indeed, many of our clients who have survived with serious transmissible diseases have questions whether these regimes did in fact improve their joints. And of course there are many others who are not with us to describe that, but it was not haemophilia that led to their death but, in many cases, infection.

In any event, the small risk of death or serious joint damage was an argument only even theoretically applicable to more severe cases of haemophilia. Aggressive treatment regimes involving the liberal use of concentrates were simply not necessary for moderate or mild patients. No distinction or nuance to this effect was ever set out by the clinicians.

The idea that treatment regimes would have continued forever as I have said was an illusion. Only temporary suspension of more aggressive regimes was necessary until advances could be made that would eradicate the risks. These were predicted. Thus, considering the effects of permanent changes to treatment regimes was misleading. There was an institutional wilful blindness to the risks and the ongoing harm, which was perceived not to be occurring during a period described by Dr Winter as the "golden interval".

This was the interval during which, he suggested,

that increased concentrate use from around the time of the licensing of commercial products in 1973 was thought to be justified on the basis that screening had eradicated the HBV risk and there was no particular reason to be concerned about other risks.

In our submission, of course, sir, over that period the clear evidence of harm which has shown in some of the research suggests this is in fact not correct. In any event, it was not until later in the period that what we describe as the concentrate juggernaut was launched in Scotland. At which time the knowledge about harm, from sources such as the Preston paper, was much more apparent.

Sir, I have already said a number of things about the system with regard to the fact that the system was plasma-driven. I would just refer you, sir, for the sake of the transcript, to one particular reference which is helpful in that regard. That's PRSE0000512.

This is a letter in which Professor Cash explains to the Scottish Home and Health Department a phenomenon which Mr Cory-Wright referred to in his submission: the fact that the system was primarily plasma-driven meant that, as he said, "The SNBTS [this was in 1985] currently outdates 30 per cent of its shelf-able blood intake".

Sir, that is important because Mr Cory-Wright argued that, first of all, there were desperate shortages of blood in England and Wales that meant they had to rely on assistance from Scotland, which is correct. But the importance of this with regard to Scotland is that because of the fact that so much blood was able to be effectively unused, what that meant in reality was that it was only the aggressive treatment regimes that were driving the system, and therefore considerations of matters such as surrogate testing could have been achieved without impact on the blood available for transfusion, which Mr Cory-Wright at least argued would not have been the case in England, and the only thing that would have needed to change to facilitate that would have been reining back the more aggressive Factor VIII concentrate programmes, which I have described.

One element, sir, of the scientific evidence is important in this regard. Dr Perry in his evidence described the scientific developments led by Dr Foster which resulted, during the course of 1983, in greater yield being able to be obtained from the plasma which was delivered to the PFC. He prayed this in aid as being the reason why Scotland was able to swap out unheated stock for 2-hour dry-heated stock in 1984,

a technical innovation resulting from the technical discoveries which Dr Foster had become aware of at the Groningen Conference two months before. The surplus had become so large that the entire stock was able to be replaced in one go.

This is also why the Inquiry has heard evidence of haemophiliacs in London receiving PFC Factor VIII concentrates in around 1984. They had so much they were giving it away. And indeed, Mr Cory-Wright reminded us they had been given away the red cells.

Documentary evidence from November 1983 at PRSE0001576 showed that the stock levels had risen in November of 1983 to 1.4 what the stock had been in the previous year. A concern had in fact arisen that this may result in some of the stock having to be destroyed. In his evidence on 31 March 2022, at pages 126-127, Dr Perry expressed his shock at that time that the stock position had got to that level.

However, the key issue for us is the fact that these technological advances did not result in any material systemic change to blood collection procedures and donor exclusion.

The system was driven by the need for plasma to make that product. The system had been set up to bursting point by that time. All donors were needed to meet the

excruciating targets. When a greater amount of yield was achieved by the scientist much less plasma was needed. At this crucial time it appears that nobody thought that this could lead to more aggressive measures to steer clear of high risk donors. Prison sessions continued. Military donations continued. Donor exclusion remained loose and impersonal. Innovations to deal with the AIDS risk were rejected in the name of the need to maintain donations. All for what? To make products which sat on a shelf.

Sir, it would be remiss of me in my submission about the use of blood products not to make some mention of the tragedy which occurred at Yorkhill Hospital to which my learned friend Mr Bowie has also already made reference.

As I have already referred to, the prophylactic commercial concentrate-based treatment system instituted by Dr Willoughby was described by Professor Hann as being ahead of its time. What he meant by that was that it was later realised by treating clinicians that such an approach may have advantages for the control of the worst extremes of bleeding disorders. Even if this were true, the key question was not whether it would have such an effect but whether such an effect could be achieved safely.

Our written submissions contain a detailed analysis of the Yorkhill tragedy, which resulted in the infection of 21 boys with AIDS. It concludes that the regime was the opposite of the then accepted clinical practice and the principle of self-sufficiency in Scotland. It was negligently unsafe.

Commercial products which were known to be unsafe could be ordered, it appears, without medical or financial oversight. It was contributed to by a lack of facilities at the hospital, which required the boys to be treated mostly away from the hospital. Knowledge of the risk was poorly understood at the hospital. Dr Pettigrew was not aware of the risks of the non-A, non-B hepatitis in the 1980s at all. This was contributed to by Dr Willoughby's unavailability and failure to attend meetings and keep up with and disseminate medical knowledge.

Of course, sir, we also argue that the factor concentrates that were predominantly used at Yorkhill, Armour's Factor VIII, were specifically marketed to children. You will recall the evidence, not challenged by Mr Bishop, who used to work for Armour, that Mr Men stickers were issued with the products, along with other practical items which would be needed to administer treatment. He claimed this was for all users not just

children. This was clearly not evidence which can be accepted. His product was cheaper than other commercial concentrates, conveniently presented but not safe. It should never have been used in Scotland. Its use caused the death of many children who were treated at Yorkhill.

Sir, it is submitted by a number of the state Core Participants that certain of the infections caused by treatment were avoidable -- would not have been avoidable had alternative courses been taken. In our submission, sir, we have an extensive analysis of what we say results in a position which is that many of the infections which were caused in Scotland at least should have been avoided.

We argue that all of the infections with HIV should have been avoided. Those which were caused by the use of commercial products, which tended to occur -- based on, again, the statistical material we have access to -- earlier in the period, should have been avoided simply because those products should not have been used at all.

Those which occurred in the domestic concentrate using community, which tended to happen later in the period, for example the well known Edinburgh cohort infections, occurred in the spring and later into the year in 1984, were all preventable had the warnings about AIDS and its possible transmission, in particular

in light of the inadequate donor selection procedures in Scotland, been heeded.

So that is our position in relation to that aspect of things. Furthermore, sir, a number of arguments are made about the way in which non-A, non-B, HCV infections might have been prevented. Again, our position in broad terms is that many of those could have been prevented by the use of different treatment regimes, by the use of less concentrate, by the use of more cryoprecipitate. In particular, if patients had been consulted about the treatment regime they wished to follow, many have given important evidence to this Inquiry that they would have adopted radically different regimes.

One aspect of this is also important, sir, which is that although it is argued by number of the state actors that people would have been infected in any event, for example, by treatments with cryoprecipitate, if a patient required to be exposed to enough of it such that one would get to the point one would hit an infective donation, if I can put it that way, this in our view fails to recognise that the increased exposure to unnecessary concentrate regimes, which were prevalent at the time, have exposed patients to a much greater degree of viral load than would otherwise have been the case.

Our assessment, sir, was that this is an area which is not particularly well understood in the scientific community as to what the effects of that would be.

In our view, sir, that would tend to result in the likelihood of the infections not being cleared being higher. It would tend to result in the ultimate symptoms being suffered perhaps being worse, in particular for children being treated while still growing. In our view, it opened up the possibility of people becoming infected with multiple genotypes, which might not otherwise have been the case.

One of the recommendations we make, sir, is that the Inquiry should recommend the setting up of a research fund in order to look at a number of questions, including those questions, which, as far as we were able to make out on the evidence, are matters on which there is little basis for you to reach firm conclusions.

It is important for a number of reasons, including the planning for the future treatment and care of those patients, that these matters be better understood. That, of course, applies not just to my clients but to all the infected and affected. I would wish to draw attention to that at this stage.

Sir, our submission also contains a lengthy exploration of the group that I've mentioned earlier

called the Edinburgh cohort. The broad assertion that we make in that regard, and I will return to this in a moment because I do have something to say about research, is that the infections of the Edinburgh cohort occurring at the time they did should have been avoided, and that they were not avoided because of a misplaced impression that AIDS was an American condition that would not become part of the Scottish donor system.

That was despite the fact that, as we will touch on a bit later, there was evidence from Dr Ludlam's immune studies that, in any event, the concentrates were causing harm, even although at the time of the immune studies they had not yet infected the patients.

So I will return to that but I'm not going to go into the detail because we could be here for a number of hours if I do that, sir, but I would obviously like to highlight to you the importance of the analysis of the Edinburgh cohort material to those whom I represent. There are, as I understand it, only two members of the cohort who are still alive, although we also represent a number of others who are affected representatives of the deceased members of the cohort, and we hope and expect, sir, that it will receive careful attention in the final report.

Sir, I'm about to move on to a separate section

relating to the transfusion of blood. I wonder whether at that point it might be an appropriate point to break.

SIR BRIAN LANGSTAFF: Providing we come back at 1.55, yes. Because so far you have dealt with the first four of your ten.

MR DAWSON: We are on the same page in that regard, sir. I am about to go on to number 5.

SIR BRIAN LANGSTAFF: Yes, which leaves you with six to do in the next session.

MR DAWSON: It does.

SIR BRIAN LANGSTAFF: Yes. So we will take a break until 1.55 pm prompt.

MR DAWSON: Thank you, sir.

(12.57 pm)

(A short break)

(1.55 pm)

SIR BRIAN LANGSTAFF: Yes.

MR DAWSON: Thank you, sir. I had reached the fifth of my ten sections. This is entitled "The transfusion of blood".

Much of the investigation which was undertaken by the Inquiry and the focus of its oral hearings have been on the causes and effects of the blood contamination disaster on those who suffered from bleeding disorders.

By far the most numerous group of infected and,

hence, affected people is amongst those who acquired their infection by blood transfusion. In our submission, sir, we recognise that there are perhaps difficulties relating to the identification of themes and trends and systemic failures in the transfusion community, given the diversity of circumstances in which people were infected.

However, our conclusion, which is to be found at section I of our written submissions, is that a number of important themes emerge.

I should say, sir, that the tenacity of the campaign led by those predominantly from the bleeding disorder community and the disparate nature of the circumstances of the transfusion infections has, in our submission, led to them often having no ready-made association or means of organisation.

On occasions, this has meant that the plight of those who are infected by transfusion is being marginalised in the media or by Government. In our submission, this must stop. They have suffered similar consequences and they have been exposed to the same tragedy.

As regards the transfusion infections, we argue that a careful analysis of the available evidence does allow clear conclusions to be drawn. Our analysis of the

evidence concludes that the deficiencies in the way in which blood services operated in Scotland caused multiple unnecessary infections with both HCV and HIV.

The evidence to which I referred earlier presented to the Inquiry by the statistics group shows that this had a real effect and caused unnecessary infection.

The group commented specifically on the fact that the number of HIV infections from transfusion in Scotland was disproportionately high when compared with the rest of the UK. Dr Gillon, who carried out the Scottish HIV look-back in that community, explained to the Inquiry that this was likely to be a minimum number of infections, namely 18, caused by that route.

There are, of course, limitations of the look-back procedure in general and we suggest in our submission that the fact that it's reliant on repeat donors may well mean that that number is, in fact, higher.

In our submission, sir, the number of HIV infections in that community indicates the effect of the poor blood collection and processing practices to which I have already made reference. This is supported by the evidence available in the Crawford paper from 1991 and the statistical analysis undertaken by your statistics expert group, which suggests that, in the HCV population, there was a higher rate of infectivity in

donors in Scotland.

Although this will in part lead you to the fact that there was a higher infectivity in the general community, based, in their assessment, on higher rates of intravenous drug use, Mr Bowie accepted that there had been insufficient efforts to exclude those donors and, in our submission, these higher rates of infection result directly from the practices which I have already outlined.

We have also, in our submissions, sir, conducted an analysis of documentation relating to transfusion practice, by which I mean the actual delivery of the blood transfusions. These reveal that blood was transfused unnecessarily and, at times, the profligate use of blood and blood components in Scotland was evident during the period of infective risk.

The evidence presented by our clients also reveals that blood was generally transfused with little or no regard to the views of patients. Informed consent about risks or reasonable alternatives, frankly did not feature at all.

You will recall, sir, the evidence given by both Dr Keel and Dr McClelland about a much later initiative to try to regulate the use of blood in Scotland, in particular, you may recall Dr McClelland speaking about

his surprise that he found a cardiac surgeon -- I think in Portugal -- who was able to carry out certain procedures without using any blood at all. But those processes, sir, which took place many years later are indicative of the fact that the system had been profligate for many years, that unnecessary transfusions were given, the practice of top ups, which we heard about across the country, was also a feature of the Scottish evidence and that, therefore, risk of infection was increased unnecessarily.

We have also, sir, conducted an analysis of the look-back in relation to HCV. As I have already mentioned, the practical impediments which were identified by Mr Cory-Wright with regard to the difficulties which the predecessor of NHSBT had, in knowing what happened to the blood that they collected, were not impediments which generally existed within Scotland.

Dr Keel, when asked about look-back, pointed to the West of Scotland, where she illustrated the difficulties in this regard by the fact that the West of Scotland Transfusion Centre was situated at Law Hospital in Lanarkshire, rather than in a hospital.

It was interesting, in our submission, that she chose that particular example because that was the only

infected patients in Scotland were lost. Epidemiological analysis undertaken by the statistics group estimates that at least 2,500 were infected with HCV in this community. The approach was, in our submission, redolent of an insurance company seeking to minimise its financial liability, rather than the state in a democratic society with its clear legal and moral obligations to protect those individuals whom it has infected.

The effects of this indifference are plain, we say, from the evidence you have heard. The Inquiry heard from those who were not found. One client of ours, sir, I must unfortunately inform you, who gave evidence, who was from this community has -- who gave oral evidence in 2019 has since passed away. The Inquiry also heard from those who were found. Many have told in their evidence of the matter of fact way in which they were informed, with no apparent realisation that many of them had had no reason to have any contact with health services and no ready made place to go for help.

They were thrust into a world of liver clinics populated by those who had been infected by IV drug use or other means. They were regularly stigmatised and traumatised by medical staff who assumed they were drug users or alcoholics, many did so completely alone,

one of the transfusion centres in Scotland which was not effectively based in a hospital and Dr Gabra, who spoke on behalf of that service, made it clear that one of the first tasks with which he was charged when being engaged by the service was to improve the connections with hospitals.

As a result, therefore, sir, our conclusion is that the transfusion service could and should have done more both to advise those using blood in transfusion in hospitals as to its risks but also the suggestion of there being practical impediments to the look-back were in fact illusory, prevented only by poor practice in record keeping and the Government's culpable unwillingness to find those who might blame them for their fate.

Dr Gillon was, of course, the king of the look-back in Scotland. He stressed the important advantages of doing look-back as near as possible at the time, which was why he felt the HIV look-back conducted by him in the mid-'80s was perhaps more reliable than the HCV which he did not undertake until later in the '90s.

Delay was predictably fatal to the utility of the project, which was already limited in its scope due to its reliance on repeat donors and the considerable limitations of record keeping. As a result, many

thinking unnecessarily they were the only ones to have suffered this unimaginable fate.

Sir, before moving on, on the subject of look-back, I would also like to draw your attention to another couple of elements of it. Although, of course, the main thrust of our arguments about the failures of look-back relate to the failures in finding people who were infected by transfusion, the evidence in Scotland suggests that, during the course of the Scottish Executive Investigation in and around 2000, Drs Ludlam and Lowe brought to the attention of the investigating civil servant, Dr Keel, that there may, in fact, be people from the bleeding disorder community, mostly mild patients, who may have been infected who were not traced.

We have drawn attention, sir, in our submission to a meeting in 2000 where this happened. Our understanding is that, despite those warnings, no efforts were made until many years later to locate those individuals.

Indeed, Dr Keel in her oral evidence was taken to another place where Dr Ludlam had, at one stage, attempted to inform the state that there were possibly infected individuals who had not been found. Dr Ludlam pointed out that there were patients who had received

Scottish Factor IX concentrate for medical matters other than bleeding disorders.

In her evidence, remarkably, Dr Keel suggested that such patients may number in the tens of thousands. Some of those will have been exposed to Factor IX concentrate before heat treatment of the product in October 1985. No efforts appear to have been made to find them.

Sir, I am moving on to my sixth topic now, which is what we call "The domino effect, patients as people and as pioneers".

Like Mr Snowden, our extensive review of the evidence available to the Inquiry from our clients is that not a single one spoke to having been advised of the risk of viral infection from blood or blood products. In our submission, we present an analysis not only of the ethical guidance of today but the long-standing ethical guidance of the time. The lack of informed consent to treatment and testing, the failure to inform patients of their diagnosis and to provide anything like adequate support to them when they did find out, represents in our submission a system-wide abrogation of the state's ethical responsibilities to patients on what, to my knowledge, is an unprecedented scale.

It should, in our view, be borne in mind that many

of the patients infected were not infected in acute situations, though some were. The long-term care of bleeding disorders and other chronic conditions which required transfusion, as well as elective surgery and the ability to plan and approach obstetric emergencies, lent themselves to patient interaction and careful planning in the interests of safety and autonomy. This simply did not happen.

In a written submission we describe in some detail, based largely on a wide review of the evidence from the Scottish community, of a kind of domino effect from not telling the patients about the risks involved in treatment, which is apparent from the evidence.

Having not been involved in decision-making at the start, that locked the clinicians into a position. They committed to the products being safe; in some places, like Edinburgh, despite direct questioning to that effect by the patient.

That then led to difficulties in revealing other matters, such as the fact that patients were involved in research or that risks had begun to emerge. It created difficulties with informing patients about the fact they were being tested. Why would they be being tested if they had been told the products were safe?

Once the terrible reality of infection became

apparent, it was obviously difficult for doctors to reveal that reality to patients. However, it was done completely inadequately. The December 1984 meeting in Edinburgh, to which my learned friend Mr Bowie made reference, represents the ham-fisted attempts of a medical community trying to deal with the terrible reality of their patients' infections against a background of them having failed in the first place to inform the patients about the risks.

Sir, one thing I would like to point out which is of some significance to us is that in this regard one sees in many documents, both from factual witnesses and from those who are assessing that evidence, the reference to the concept of paternalism. This is a good example, sir, of the phenomenon I described earlier of the medical profession simply seeking to say that something happened across the board, and therefore it was acceptable.

Paternalism, sir, might be described as thinking or behaviour by people in authority that results in them making decisions for other people that, although they may be to those people's advantage, prevent them from taking responsibility for their own lives.

It seems to be trotted out as a party line, a defence against allegations of widespread ethical

breaches in this area, as if the defence of "we all did it" in the pre-*Bolitho* era is a good one. In our submission, sir, although there is a similarity between the words "paternalism" and -- "paternalistic" and "paternal", the two things are quite different.

Paternalistic -- obviously they come from the word "pater" in Latin, meaning father. Paternalistic relates to the authoritative element of a father. However, in essence, in our view, paternalism is and was unethical. There was nothing paternal about the way in which many of our clients were treated. In our submission, sir, there was unethical medical practice revealed on a large scale.

In this regard, sir, although I suggested that I don't intend to make reference to the conclusions of the Penrose Inquiry, I think I need to. The conclusions of the Penrose Inquiry in this regard are, in our submission, instructive as to the importance of this area and certain pitfalls that need to be avoided.

The Inquiry was assisted in this regard by two expert witnesses, namely Professor Nathanson and Professor Hay, former Chair of the UKHCDO from whom this Inquiry also heard. Although the latter was not a clinician who worked in Scotland, he was, in our view, clearly not an independent witness.

In paragraph 32 of the report, the position which is adopted or accepted generally by the Penrose Inquiry is that before 1988 there effectively were no ethical rules relating to the matters to which I've made submissions. It suggested that the conduct of medicine before that time was a kind of ethical Wild West, where there were no rules to which adherence could be expected. In our view this approach is flawed. It is not consistent with the evidence of guidance at the time. It conflates factual evidence with a lack of regard for patient autonomy, with the separate issue of what the ethical approach ought to have been. The evidence before this Inquiry, as others have suggested, constitutes a clear basis on which contemporary ethical standards were institutionally disregarded.

This applies to all types of patients in our submission and is a sound basis for the conclusion to be reached that there was a moral duty from the state to its patients which was breached in relation to informed consent, testing and other matters.

As a result, sir, it is an important part of our argument that there is a moral duty for the state to pay compensation in this regard.

Sir, I have already touched on research to a certain extent but I do feel, as it is an important matter to

many of my clients, that I would like to say something further about it.

I do so, in particular, in regard to an observation made by the NHS Scotland submission, which I feel I have to address. The suggestion made by Mr Bowie in his written and obviously referred to in his oral submission, is that one of my clients in her evidence suggested that there had been deliberate infection of patients in Edinburgh with HIV.

In our submission, sir, we make it clear that this is not our assertion. We present a detailed analysis which leads to the conclusion that the Edinburgh patients, those who are still alive, formed the view, in our submission quite reasonably, based on an extensive analysis of evidential material that became available to them after the event that it was possible that something had happened to that effect.

They do not assert that it did but it is, in our position, important to realise that a significant part of the compounding of their harms has been based on the fact that they were, throughout the relevant period, kept in the dark when they asked for explanations they did not receive them and, in circumstances where an extensive evidential search was done by one of my clients, Mrs Mackie, who also gave evidence to the

Inquiry, she reached the view, in our submission, quite reasonably that that may have happened.

Sir, I won't get into the detail of that today but there is a very detailed analysis of the reason why, in our submission, she and her husband and many others were driven to that conclusion.

Research in Edinburgh, and not exclusively in Edinburgh because a significant amount of research also took place in Glasgow, was an essential part of the system of the treatment of haemophiliacs. My client, Mr Norval, asked the question at the end of his evidence, "What are haemophiliacs for?" It would be impossible, in my view, to come to the conclusion that research undertaken on haemophiliacs, who willingly offer up their arms and their blood, in their evidence, for the checking of their factor levels, have not been subject to research on a grand scale.

In his submission to the Inquiry, Mr Cummins, in relation to the treatment of the boys at Treloar's, said that his clients had come to the view, based on the evidence examined by this Inquiry, that research had been undertaken on them which was not in their interests but for the interests of others.

I can well imagine why they have reached that conclusion and the same conclusion has been reached by

those who were involved in research in Scotland.

The Edinburgh research agenda, sir, started almost as soon as Dr Ludlam arrived. A letter was written to Dr Craske by Dr Ludlam on 28 April 1980, shortly after his arrival at the centre. The reference is LOTH0000031_027.

In the interests of time, sir, I'm just going to refer to its text. The context of this is Dr Craske inviting Dr Ludlam to become part of a working party on hepatitis, and this is the reply. He says:

"Dear Dr Craske, thank you for your letter of 28 March, I apologise for the delay in replying but I was away the first half of April and since returning several of the people I wanted to consult before replying to all the points in your letter I now find are away in Edinburgh for the next week or two. Since it is a month since you wrote I thought I should commit as best I can for now and give a more definitive reply shortly.

"Thank you for your invitation to serve on the working party. I am very happy to accept your kind offer. Like most clotologists, most of my training has been in the treatment of haemophilia from the bleeding point of view and I have relatively little knowledge of hepatology. This, however, is obviously an increasingly

important area. I am anxious to learn and I hope I may be of some help to the project.

"I am very conscious of the almost unique group of haemophiliacs we have in Edinburgh because they have never received commercial concentrate. They are therefore, as you are aware, useful material for a variety of studies in relation to liver disease. There are various pressures working against keeping our patients free of non-NHS concentrate but I am doing my utmost to resist these. I think that the liver biopsy project is very worthwhile and I hope to be able to contribute patients to this."

Sir, in our submission, this forms important context to the breakdown in relationships between the Edinburgh patients and their consultant, Dr Ludlam. The unique circumstances of the Edinburgh group went on, of course, to become why it was that they were described as one of the most extensively studied group of HIV-infected individuals in the world.

The research which has been undertaken is, in our submission, instructive about the causes of infection and other matters which are relevant to the Inquiry's remit. They reveal that infection with concentrates in Edinburgh was more likely to occur in circumstances where people were exposed to more product. As I have

already said, in the period under examination, the amount of product used compared to the second half of the 1960s rose by six times.

SIR BRIAN LANGSTAFF: Second half of the 1970s.

MR DAWSON: Sorry, compared to the second half of the 1970s rose by six times. That is correct, sorry, sir.

The position, sir, therefore, is that, as a result of the information becoming available to patients subsequent to infection, the role of research has, in my submission, become quite reasonably part of their analysis of what the motivation was for why they became infected.

As the boys from Treloar's have put it, my clients have become of the view that extensive research in the interests of others was prioritised over their safety. They continued to be exposed to concentrates, which the immune studies in 1983 showed were harmful, if not infective, they showed that they affected immune function and, therefore, exposed patients to greater risk. Despite this, sir, the study continued and, in my submission, the conclusions which were reached by those who researched the position, having been left in ignorance by their consultant, were entirely reasonable.

These concerns were added to, sir, by the way in which the December 1984 meeting was handled. You will

remember, sir, Mr Bowie accepted, quite rightly, in our view, that the way in which that had been handled was unacceptable and, on that particular occasion, my recollection was that his clients, Lothian Health Board, I assume, accepted corporate responsibility for the failure to engage in that.

A general point I would make in that regard, sir, one I have made already, is it is slightly odd, it seems to me, that they would accept corporate responsibility for that but not other things but the concession is appreciated.

You are aware, sir, that in the aftermath of that meeting, patients having reasonably arrived at the conclusion that they must not be infected, otherwise why would the possibility of infection have been revealed to them in those unusual and unacceptable circumstances, that an advice leaflet was sent to the patients. That advice leaflet can be found at PRSE0002785 and the particular page is the final page, which is_0003.

The final page of the advice sheet sent to the patients in early 1985 contains the statement that "As of now, all Factor VIII concentrate is being heat treated to destroy the virus. You will be given heat-treated Factor VIII as soon as possible". It also has a final paragraph entitled "Reassurance", which

includes the paternalistic expression, which Mr Bowie referred to, that "Patients must continue to treat themselves with concentrates".

This, of course, is a big part of the reason why those who received the letter thought they were uninfected. Why would this good news be portrayed to a patient if he were already infected, the clear inference was that they had dodged the bullet.

However, sir, the position on the heat-treated concentrates was stated clearly and unequivocally. Mrs Mackie, whose evidence is referred to by my learned friends, was aware that for this to be said with any scientific accuracy, it would have needed to have been tried on living patients. It was not until Dr Foster gave evidence to this Inquiry that it became apparent it was, in fact, accepted at that time that that statement was not accurate, that it was not known that the heat treatment would be successful to destroy the virus because it had not yet been tested on living patients.

That, sir, is the specific context of the allegation or the suggestion made by my learned friends about Mrs Mackie's evidence. In my submission, she has not said that people were deliberately infected. However, she has said with some force and relevance that she and her husband and many others were quite reasonably driven

to that conclusion. The specification with which she came up with the theory about the heat treatment trial, which she referred to in her evidence, was merely an expression of her belief that that may have happened and, in my submission, that belief was quite reasonable, based on the assurances given in the letter.

Sir, there is a detailed analysis in our submission of the various elements of research, which obviously I won't go into detail about today. They are very important, in my submission, both in understanding elements of the circumstances in which people became infected but in understanding the attitude of indifference, it would seem, that treating clinicians appear to have had to what Dr Ludlam described as "useful material".

I have also included in our submission details of other research beyond the research that I have talked about already. That being research related to liver dysfunction, hepatitis, the immune function research in both Edinburgh and Glasgow, and the ongoing research into the effects of AIDS on the Edinburgh cohort patients.

I would draw your attention also, sir, to the fact that a number of family members of patients in Edinburgh also, it would appear, were involved in research, both

of the living members of the Edinburgh cohort have given clear evidence about the fact that wider family members, including those not genetically related to the infected person had blood taken for research too.

It seems the "useful material" extended beyond the patients to their families.

We would also draw your attention, sir, to the submission we have made about one AIDS case arising from the Yorkhill group, where, despite representation having been made to the hospital after the boy's death to the contrary effect, research on that boy continued even after he had died.

Sir, my next section is entitled "Compounding the harms". In her oral statement, my learned friend Ms Grey said that the evidence from the infected and affected of the impact heard by the Inquiry spoke for itself. Mr Cory-Wright described the harms caused and compounded as unimaginable. Though we took them simply to mean that this was a formidable body of evidence that they did not seek to challenge, in our submission some risks arise from the fact that this attitude is taken to that body of evidence, of which we would like to make the Inquiry aware.

We have a detailed section in our submission, which is section D, which we have entitled "Impact".

Although, sir, this may not need to be said, we think that it is an essential part of the Inquiry's function that its report should undertake a detailed analysis of the consequences of the disaster for the infected and affected, detailing the depth, the variety and intensity of the harms, the breadth, the number and variety of people whom it has affected, and the damage which it has done.

Some inquiries, such as the Scottish Child Abuse Inquiry, contain in their terms of reference a specific requirement that the Inquiry create a public record of the harms. Sir, we would urge you to do the same. The failure of the state ever to undertake a proper assessment of the harm, need or loss of the community was a recurring feature of the evidence. Your report, sir, can remedy that at a community level.

In our submission, the variety and complexity of the harms are required to be carefully analysed and documented as a basis for what should be taken to be the characteristic consequences of infection for the purposes of the compensation scheme which we propose you should recommend.

It is also important, sir, that the known or understood to be acceptable effects of treatment for those conditions should be chartered in the same way.

That task, sir, I think will be considerably helped by the useful summaries given at the end of the expert group reports, in particular on hepatitis and HIV, where they have sought to undertake that task. Rather than simply replicating what they have said, I would simply refer you to that, sir, but also suggest that there are a number of additional areas which the Inquiry might consider, including in those lists, based on the extensive evidence from the infected and affected about consequences which they assert are associated either with infection or with treatment.

Sir, there are a number of particular facets of the evidence of impact to which I would like to make brief reference. First of all, as it arises particularly in the client group which I represent, it is important in our view to make a clear analysis in the report of the extensive and devastating impacts of hepatitis C infection.

A number of my clients have for many years fought for recognition on an individual or collective basis of the full extent of the harms which this deadly virus has caused. The concept of mono-infection which sometimes one sees is not one which finds favour with my clients. Given the propensity which this term has to lessen a full recognition of the extent of the damage which

this terrible virus can cause and its tendency to suggest that those who have hepatitis C and not HIV are, in some perverse way, the lucky ones.

Similarly, sir, it is our submission that the Inquiry has available to it a particularly important body of evidence. That is the evidence which was given by its psychosocial group. Although, sir, I have made reference to a number of important features arising out of the expert group's evidence, I think it important to bring to your attention, sir, that the analysis of this group of the extent and effect of the psychological harms visited on a vulnerable community when they went to obtain their initial treatment was frankly exemplary and should be reflected in the report.

The experience of listening to the evidence was of great cathartic effect for a number of my clients. One must remember, sir, that many clients, due to the very nature of the stigma and the harm suffered, lived for years in isolation thinking they were the only ones who had been affected in this way.

Many saw the expert group's analysis and recognised themselves in the classes of victim and the types of harm which were being described for the first time. The group's analysis of the severity of the impact on the affected community was also a model of clarity.

In this regard too we would refer you, sir, to the importance of a clear exposition being given on the extensive effects of stigma on the infected and affected communities. In itself stigma destroyed lives, in particular where it was meted out by the NHS or the state itself. It is important that we don't look at this simply as an add-on to the physical harms as, to be frank, sometimes the law might. Sir Robert Francis recognised this in his report, creating a distinct head of damages for stigma and associated loss, which in our view was entirely appropriate.

Sir, another theme to which I would simply wish to make brief reference is the theme of family. In our submission, family runs through the evidence which you have heard. You have heard, sir, from a number of witnesses for whom the joyous occasion of the birth of a child was subsequently impacted upon by the fact that transfusions received at that time caused horrible infection. You have heard, sir, how the celebration of new life would forever be associated with a disease treatment which consigned the individual concerned to living a life of infection rather than a life of joy.

Sir, you heard evidence from one particular client of mine, Mrs Fyffe, who heard she received an infection on the day of the birth of her child. As a result of

treatment she received from that infection, which caused an autoimmune reaction, she has had after that point to live her life effectively away from light. On the very day when life was created, light, the very essence of life itself, was taken away.

You heard the familiar heartbreaking stories of mothers, unwittingly having been the genetic source of their son's haemophilia, who did all they could to follow treatment regimes they were assured were best for their boys. You heard of the devastation when that treatment took the lives of the boys away which they had hoped to improve.

You heard from a father, Mr McDougall, who still, 30 years after his son's death from AIDS, contracted at Yorkhill, cannot get to the end of a sentence without breaking down. Who would forget his emotional recollection of the visits to his son's boat Butterfly 23 after his death, still festooned with decorations after his last birthday celebration, family as it was meant to be, joyous celebration, tragically juxtaposed with family cruelly and unnecessarily taken away.

The Yorkhill Parents Group, a dedicated collection of loving parents seeking to help their sons, went to funeral after funeral as the boys passed away from AIDS.

You heard from infected people about the devastation arising from the hereditary nature of haemophilia. Infections ravaged families, brothers and uncles and nephews were infected together. Often a tragic window into one person's possible fate was the person standing next to them or worse, being lowered into the ground.

You heard stories of family lost through stigma and isolation. You heard from widows about the transformation and loss of their infected husbands. You heard from one individual, Mrs AD, who told the tale of her son having to put his father, another victim of AIDS, into a body bag as the undertaker would not touch him. You heard from one lady, Mrs Batters, whose husband had been infected with HCV by transfusion, who in turn had been infected by him. He had died shortly before she gave evidence to the Inquiry in 2019. You heard from the wife of a campaigner, Christine Norval, who was scarcely able to contemplate the possibility that this Inquiry may bring closure to her family.

You heard again, and again, sir, that, despite the ravages of infection, the thing which preyed on the minds of the infected the most, was the impact that their infections, acquired through no fault of their own had had on their loved ones and, above all else, the Earth-shattering and lasting guilt which they felt about

possibly, though unwittingly, having exposed their family to danger too. You heard from family members also subjected to research at the hand of the state alongside their infected loved ones.

Sir, the story of family is at the very heart of the story of the disaster.

Sir, we also have, in our submission, an extensive analysis of the way in which not only were harms caused by infection and treatment but those harms have been irrevocably and multiply compounded and increased by way that the state has reacted.

The compounding of the harm, sir, is one of the most important and unique factors of this disaster. Unique result of the evidence heard, in our submission, is that the infected and affected have, unlike victims of other medical disasters, suffered the consequences of multiple wrongful acts on the part of the state.

Their complex, physical and psychological injuries have been rendered all the more complex, a single indivisible mass of harms with various forces and loss all interacting with and compounding each other.

We urge you, sir, to reflect the uniqueness and complexity of their situations as a result, in your report. Please pay heed to this: whatever the argument about the avoidability of infections or their sequelae,

the entirety of what compounded the harms was completely avoidable.

I also, sir, as I have made reference to the psychosocial report, refer you to the evidence given by that group on 25 February 2020, in particular at page 124, where Professor Weinman predominantly, and also Ms Edwards gave powerful evidence, not simply their own views, but based on literature, namely the Elder paper and Southwick paper, which led Professor Weinman to give the following account of the impacts of the events that take place after medical disasters. He says:

"Again lack of accountability, a lack of explanation, lack of apology, all those sorts of things really emerged in that [meaning the papers] and the effects on people, where 90 per cent of people talked about serious emotional consequences and major financial impacts as a result of all that happening."

Sir, the impacts were huge, absolutely huge. Ms Edwards went on to describe that there were a number of significant behavioural consequences listed in the literature, in that regard.

Sir, we think that the compounding of the harms is a unique and important element of this disaster which again we anticipate you will wish to reflect in your

report.

The eighth section of my submission, sir, is entitled "The myth of devolution". I have touched on a number of matters which arise under this section already, when I talked about the advantages available to the state in Scotland.

It is important to understand, in my submission, sir, that there were a number of decisions which were taken at the time when infections were occurring, which were based on the parameters which pertained to treatment and the balancing of risk, outwith Scotland, which were then simply adopted and imposed upon Scotland.

For example, the Inquiry heard evidence that although the licensing legislation provided for the Secretary of State for Scotland to be involved in licensing matters, the licensing system operated through Medicines Division in the Department of Health and was not separate for Scotland. Therefore, no separate consideration was given for the need for imported products to be licensed or used in Scotland.

As I have outlined, separate considerations in that regard applied in Scotland. Imported products were unnecessary. The products were admitted to Scotland on the basis of non-Scottish considerations.

Furthermore, sir, other decisions were regularly taken in Scotland on advice issued to Government based on what one might describe as non-Scottish considerations.

The UKHCDO advice, in particular the Bloom advice in May 1983, was based on the English position. Guidelines were issued as to treatment practices which were based on the limitations of the English system to be able to provide alternatives to commercial concentrate.

Dr Walford confirmed there was little or no contact with other regional administrations, including the Scottish Office. As a result, no separate consideration of the Scottish position was undertaken at government level.

Similarly, the failure to introduce surrogate testing anti-HIV and anti-HCV testing, due to the perceived need to coordinate these matters with the rest of the UK, showed the fallacy of administrative devolution in healthcare in Scotland. Things were not analysed along Scottish lines.

In our written submission, we address and explain something which we have called the "Cash dichotomy". The phenomenon of Professor Cash apparently taking contradictory positions on these matters. In our view, this was due to the inherent tension in his position.

He knew that things could and should have been done in Scotland earlier but felt the need to protect the inherently dysfunctional national system. He was the living embodiment of the contradiction at the heart of the system, a contradiction which rendered the system unnecessarily safe in Scotland.

Furthermore, sir, there are a number of subsequent examples of Scottish considerations not being looked at and the English position simply being imposed.

You will remember, sir, the correspondence which took place as a result of a solicitor acting for a number of HIV patients in Scotland, a Mr Tyler, having written to the then Secretary of State for Scotland questioning why it was that there had been an announcement that the HIV Litigation was to be settled across the UK, without there having been any consultation whatsoever with him or his clients.

The evidence showed that not only had there been no consultation with Mr Tyler, there had been no consultation with the Secretary of State for Scotland either. As a result of that -- and the Inquiry, of course, has looked at the detailed circumstances in which the HIV Litigation came to be settled in England -- the multiple litigations in Scotland, which of course were conducted on a completely different basis

because the Scottish system was different, were not considered and the HIV Litigation settlement was foisted upon the individuals who were litigants in Scotland.

Just another example of what we call the "myth of devolution".

Sir, we refer in our submission -- the HIV litigation is, of course, a matter of some importance in its own regard. However, in our submission, sir, the HIV Litigation marks an important moment in the history of the disaster for reasons other than its own intrinsic significance. You have heard significant evidence, sir, about the groupthink, which emerged within government, both at Westminster and within the Scottish Office and subsequently in the Scottish Government, or the Scottish Executive, after devolution. That groupthink has its origins somewhere.

The thought which becomes the adopted position through a gradual process, in our submission, started at the time of the HIV Litigation.

We have referred the Inquiry to a number of meetings which took place in 1989 and 1990. One is from 16 June 1989, the reference: PRSE0002656. The other is the 12 February 1990, HCDO0000271_014.

You will remember these meetings, sir, they caught our attention because, although they are both -- the

first is a meeting of the UKHCDO directors, the second a meeting of the UKHCDO AIDS subgroup, both involve a particularly Scottish component. Drs Ludlam and Lowe, and indeed certain medical advisers from Scotland, are involved considerably in the discussions.

It is important, sir, that you take some time to consider the content of these meetings because, in our submission, they are the origin of the groupthink which set in and about which you have heard so much evidence. The doctors effectively got together, came up with what we have described as the party lines. They were shared with Government. Government attended both of those meetings and, in our submission, that is where one finds the origin of what the Leigh Day representatives have described of the defensiveness which we have also set out in our submission.

Sir, there are a number of -- there is, in our submission, also, a detailed examination of the period after devolution. It is important, in our submission, that you take time to consider in some detail the Scottish Executive Investigation which took place in 1999 and 2000.

Susan Deacon in her evidence, then Scottish Health Minister in that administration, explained how, at the time of devolution, there was a new hope that things

would be able to be done differently. She made it quite clear that advice had been tendered to her by civil servants consistent with the Government line, which existed in Westminster and within the Scottish Office.

She explained that she was not prepared to accept that advice and that the *prima facie* evidence available to her suggested this was a matter that needed to be looked at further, and so she did so and ordered an investigation.

Our position, sir, is that that internal inquiry, which was prompted by two petitions that were lodged within the Scottish Parliament, one of which is entitled petition PE45, which asked for a public inquiry and for compensation for haemophilia victims of the disaster -- that inquiry, sir, was completely defective.

Despite the request having been for a public Inquiry, instead, the internal inquiry focused on negligence for some reason, which was a matter for the courts, and not the moral responsibility and failings of the state, which a public inquiry would have done.

The internal inquiry did not address anything like the number of questions which campaigners had posed, which a public inquiry could have done. The internal inquiry ran into trouble when the complexity and multiplicities of the questions raised by the disaster

became apparent, which a public inquiry could have coped with. The internal inquiry failed to engage with the evidence or the allegations of the infected and affected in anything more than a cursory fashion, which a public inquiry could have done.

Most of all, sir, that investigation was not independent, which a public inquiry would have been.

We go into some detail in that regard, sir, about the fact that it was run by Dr Aileen Keel, from whom the Inquiry heard evidence. She was herself a previous haemophilia clinician who explained that she had been involved in the treatment, amongst other places, of the boys at Yorkhill at the time they were being infected with AIDS. She was, of course, also a civil servant who had been tainted by the very party line that Susan Deacon had said she was so keen to resist.

In the end it is not surprising, in our view, that many of the questions which were posed within the investigation were found to have proven no negligence, when the source of evidence which was looked at was predominantly the very people within the medical fraternity whose actions were being criticised. We go into some detail in that regard as well.

Sir, if I may simply again take you to one further document -- I will not put it up, to save time -- the

reference is SCGV0000170_152. I think with this one it might be worth putting it up because it is slightly difficult to follow some of the text.

Just to explain the background, sir, this is a memo on behalf of the First Minister of Scotland, then Donald Dewar, written we think by a civil servant to Ms Falconer, who the evidence -- no, sir, I don't think that's the right reference. It's -- sir, I've given you the wrong reference there. It's SCGV0000170_152.

Sir, in order not to waste any more time I will simply do as I originally proposed, which is simply to read out --

SIR BRIAN LANGSTAFF: We can take this down, I think, it may as well come off the screen.

MR DAWSON: Yes, indeed. Thank you.

This is a memo, sir, written by Ms Jackson on behalf of the First Minister, dated 23 September 1999, to Ms Falconer, who was one of the civil servants involved in conducting the investigation, copied to a number of others who were involved, including Dr Keel.

It is entitled "Haemophiliacs with hepatitis C, the way forward following the meeting with The Haemophilia Society."

The context, you'll remember, sir, was that a meeting had taken place with the minister shortly

before this time and that the broad questions that might be addressed had been laid out --

SIR BRIAN LANGSTAFF: Remind me of the date.

MR DAWSON: The date of this is 23 September 1999. What it says is:

"The First Minister has seen your minute of 17 September to the Minister for Health outlining a way forward following the meeting with the Haemophilia Society. He was a little concerned about the possible financial implications and fears that an open mind could be taken to mean an open cheque book. He would be grateful for information on the likely exposure if compensation were to be awarded."

The reason I was going to put this up, sir, is it is a slightly unusual document, in that it contains what looks like a sticky label where what is written there says:

"Some old papers from FM's office. Interesting to see the wheels of decision-making in private office."

But there is also another handwritten annotation on the document which says:

"Ms Deacon's office advises that this is very much a PR exercise and there is unlikely to be any compensation paid."

Sir, for once I'm not sure I really have anything

I can add to the text that I have read out, which I think is fairly self explanatory.

Sir, even in the period after the investigation we have set out in our submission that the overriding control of the Westminster Civil Service and the fixed attitude based on the HIV Litigation principles continued into the period after the internal investigation, a period in which Malcolm Chisholm was the Health Minister. In our submission he was politically pressured into offering some level of compensation but departed radically from the recommendations of the Ross Committee, which he had set up.

Even his modest offering was reacted to furiously, it would appear, by the then UK Health Minister, Alan Milburn. By the time Lord Reid took over, the political die was cast, but he ensured that Westminster took control of the Skipton Fund. He said in his evidence on 21 July 2022 at page 15 that:

"You can see from the papers that there is a suspicion on the part of some officials, particularly in the Treasury, that we don't want the Scottish tail wagging, you know, the English dog, as it were."

The key was to ensure that Scotland would not bow to political pressure from the petitions, which were still

live, and the health committee to go further and implement the Ross recommendations for compensation. One might describe that eventuality as being the operation of the local democratic process, ie what devolution had been all about.

The culmination of this process was a loss of local control for the Scots and years of reversion to the pre-Skipton position: still not listening to the patients, still no assessment of the needs or losses of the community, still no examination of anything like the full range of the issues arising in Scotland.

In addition, sir, the Inquiry has evidence that each CV litigations based on the similar parameters to the A v National Blood Authority decision were settled for paltry sums which it appears could not possibly have represented the full loss.

None of them, as far as we understand, were settled on a provisional basis, which is my reading of it, specifically provided for in one of the short procedural elements of the A decision. It was of course known at that time that the disease could become much more serious in the future and therefore, in dealing with the possibility that that might happen, and in accordance with the instruction of the then Health Minister to settle the matters fairly, it would, in my submission,

have been appropriate for that to have been the basis upon which the cases could have settled, which would have been a competent way of proceeding in Scotland.

Sir, I move on now to my ninth section, which is the solutions.

As with others, sir, who have spoken on the infected and affected side, we have a lengthy list of proposed non-financial recommendations. I do not intend to go through these today, although I do note that these, as I have said already, have been considered by the Scottish state bodies, and in relation to those they have issued a number of favourable responses, which we find encouraging.

We would say however, sir, that it is important that the general acceptance of the principles which we have proposed in a number of areas should not be taken to encourage you, sir, not to make the recommendations, if you agree with us, that certain steps need to be taken.

We may have outlined, and I think others have too, that we accept that it would not be possible for you, sir, to devise, for example, a new system of palliative care for liver disease in Scotland if you agree with us that that is something which the evidence shows should be looked at. The way in which we would suggest you proceed on that and other matters is as follows:

a general recommendation to that effect could be made, and I note the Scottish Government in particular seems to accept that that would be something with which they would certainly wish to become engaged.

We have recommended that a task force be set up in order to monitor compliance with that general aspiration and to have more discussions about practical matters that will of course have to be attended to about how that matter is dealt with in Scotland.

You will note, sir, which I think was mentioned by my learned friend Mr Johnston, that we have, with regard to the specific recommendation about palliative care, suggested that, rather than that matter be dealt with fully by the task force which will monitor its progress in due course, that a specific short-life working group should be set up. This is following the model which happened after the Penrose Inquiry, when a similar group was set up to have some initial thinking about how its one recommendation would be implemented.

In our submission this would be relevant in relation to the area of palliative care. Because although the commitment made by the Scottish Government is a general one in that area, there are, as we set out in our submissions, a number of important specific matters which arise in relation to end stage liver disease which

merit separate consideration. That's the reason why that has been put forward.

We, sir, have also set out in our submission that it is important that there be a fulsome apology. The reasons for that I think are apparent, again, in the evidence which you can see, sir, in the psychosocial group report and, indeed, the evidence they gave to the Inquiry, where they talk about the importance of a proper and fulsome apology being made.

I recognise, sir, towards the beginning of my oral statement, that in this regard, although limited to being made on a corporate basis, those apologies made by the Scottish NHS are a model of the type of thing that the psychosocial group suggested would have a real impact in allowing people to come to terms with the harms which they have suffered. That is not the case, I should say, on the part of others. That has been addressed, of course, with regard to the Department of Health by other speakers.

Equally, sir, I should draw to your attention that although the Scottish Government made a general apology, and reiterated the apology made by the First Minister at the end of the Penrose Inquiry, that the apology which in general terms we have sought from them relates predominantly to the matters I have just been discussing

in the period after devolution.

None of those matters were part of the terms of reference of the Penrose Inquiry, although they are, of course, part of the terms of reference of this Inquiry.

Therefore, on that one matter, I think it cannot be taken to be the case that the Scottish government could, at that time, have been apologising, in the context of the Penrose Inquiry, for matters that it did not look at. The general nature of the apology gives no indication that that was the case. As a result, sir, I draw your attention to the broad but specific ways in which we would suggest that you invite what I would describe as proper apologies to be made on behalf of government.

I have, sir, in our submission spent quite a lot of time dealing with what one might call the financial solution. I would like to make clear, sir, one point which I think is important. You asked us to address in our written submissions matters of importance to our clients. Although, of course, the possibility of a Robert Francis style compensation arrangement is of importance to all the infected and affected, I would like to make clear that it was not at the instigation of my clients that we dedicated so much time to it. I think in reality, sir, you will see from their

evidence that none of my clients suggested that why they engaged with this Inquiry was out of any financial motive. The reason why we have devoted so much time to it is that, as it happens, the area of reparation is one in which I and my learned junior practice, and therefore we thought that we could, in particular in light of the fact that there were a number of Scots law considerations, be of some assistance to you, and I certainly hope that's the case.

We have, sir, approached this on the basis that, in order to understand why Sir Robert Francis has come to the conclusions which he has reached, it is important to undertake an analysis of the principles which underpin his solution.

We broadly agree with his solution. However, there are a number of areas in which, as a result of the limitations of his investigation, which he set out and readily accepted, he has not gone far enough, we say, and that there are elements of the financial compensation scheme which should be incorporated based on the much fuller evidence to which you, sir, have had access.

There are a number of points which I would like to make in a very general sense about this. The first is, sir, in particular based on the failure of the

government to be able to provide a response to Mr Snowden's question about their intentions with regard to compensation. We, like Ms Gollop's clients, have become concerned about the government's ability to deliver compensation, as she put it.

The one difference between her clients and mine on the face of what she said is that the scepticism, which she described as having arisen in the last couple of weeks, has been a scepticism which, in my submission, quite reasonably has existed within my clients for a matter of decades.

This is because, sir, despite the fact that a number of clinicians suggested that compensation be awarded in Scotland in the late 1990s, and an independent committee, the Ross Committee, which reported 20 years ago, recommended compensation for HCV cases which had reached stage 2 liver disease and damages equivalent to those which would be available to be paid in Scotland in fatal cases where negligence had caused the death, no compensation has been awarded in Scotland.

The medical consequences of infection have, of course, moved on since then. The stage 1, stage 2 classification from Skipton has become slightly outdated.

However, in my submission, sir, this has

an important practical consequence. Our position is that, as a result of that scepticism, we invite you, sir, to try to express a view specifically on as many elements of the compensation scheme as you feel appropriate. We have sought, in our submission, to try to provide you with our assistance on the way in which matters which, under Robert Francis' scheme, would be left to his medical and legal panels, could, in our view, be adjudicated upon by you.

That would have a number of advantages. It would mean that the person who has been sitting for a number of years hearing all the evidence would be the person making the decisions, for example, about the appropriate levels of compensation, at least in certain cases.

It would speed up the process which, of course, was a concern of Robert Francis and one which you yourself expressed, sir, in the interim report, awarding interim compensation.

It also, sir, would, to an extent, allay my clients' scepticism that if this matter is left in the hands of Government, compensation, despite the recommendations which have been made, like at the time of the Ross committee, will simply not happen.

As a result of our Scots law assessment sir, we think that there are a number of areas where it would be

possible for you to come to specific figures which should be awarded for certain categories. If you are not able to do that or don't feel that that would be appropriate, sir, some indication of the parameters, either in terms of the way in which damages might be calculated or, indeed, how much might be awarded would, in our view, be helpful.

As you will see, sir, we have presented an analysis which is based on the principles of Scots law and the principle of parity, which was favoured by Sir Robert.

Though the harms arose across the UK in different ways, we think that the harms are comparable and that there should be parity across the UK. Sir Robert agreed and in his evidence we understood him to be saying that one of the purposes of a compensation tribunal was to try to keep matters based on past history away from the courts.

The need for swift justice and finality and the need to have a system whereby patients could buy into the way things were going dealt with, all meant that it would be appropriate to keep matters away from the courts and litigation, which would inevitably be lengthy, costly and in many respects not suitable, as the evidence of previous litigations has shown.

If it is correct, sir, that Sir Robert suggested

that we wish to keep matters out of the courts, and that therefore, in his assessment, which we agree with, awards should be commensurate with court awards for compensation, with certain bespoke elements relevant to this community that perhaps are not appropriate for the common law at large, it would, in our submission, be logical, sir, that those should be fixed in accordance with Scots law principles.

The reason for that is set out in the helpful opinion which you have received from Mr Milligan KC, which is under the reference INQY0000416.

What that points out is a number of important features, the result of which is that Scots law, in particular in the area of fatal claims, although also in other areas such as interest on past losses -- Scots law would take a different approach from the way that Sir Robert Francis set out his report based on English principles.

Our position, as I stated, sir, is that the tariffs should be fixed for the reasons I set out and that the tariffs should be fixed in accordance with Scots law numbers. The tariffs in particular, in fatal cases, would be greatly assisted in my submission by the fact that, although we don't have a tariff-based system for the award of damages under the Damages (Scotland) Act

2011 in fatal cases, it would be fair to say, as Mr Milligan reflects in his helpful report, that there are quite narrow parameters in which awards tend to be made to different classes of claimant.

I was asked to look at the Milligan report and report if there were any matters on which I took issue. Mr Milligan's undoubted expertise in this area means that there are only a few matters which I have to mention, which I hope are of assistance.

At paragraph 49 of his report he attributes, in fact, higher figures for what he calls "loss of society". That is actually a slightly outdated figure than I have submitted in my analysis. Of course, I take no issue with his figures. I would draw attention, sir, to the very recent case of *Paterson and others v Lanarkshire Health Board,* which is reported under the neutral citation 2003CSOH1, a decision of 6 January of this year of Lord Arthurson, which does seem to support a recent upward trend in awards.

In that fatal case, £70,000 was awarded to the children of the deceased, now adults, which I think is the highest such award to such a category, and £100,000 award was awarded to the deceased's mother, which again is a higher figure than the one which I allocated in my submission but is commensurate with the one suggested by

Mr Milligan.

Furthermore, sir, his commentary on the law related to mitigation of loss appear apposite here. The law requiring that that not be judged too finely on the basis that such criticism does not come well for those whom themselves have created the emergency.

He also, sir, at page 9 draws attention to the fact that the use of half rate interest would, as I have submitted, in a court require to take account of the fact that different judicial rates of interest would apply in the period over which loss has been suffered by the community here.

Therefore, my suggestion that the half rate of interest, which would be applied currently, of 4 per cent is already a compromise, based on the fact that that rates that would have been used in previous years where interest rates were higher might result in a higher figure being used.

Other than that sir, I suggest that the report is extremely helpful in setting out some of these principles and I think accords with the assessment we have made of what you should do.

In this regard, sir, there is one other matter which I would like to mention, that is the submission which has been made on behalf of the Scottish Government

relating to whether or not past payments under the various trusts and schemes should be taken into account in the assessment of compensation.

Broadly speaking sir, we disagree that that would be appropriate and we share the view of Sir Robert that the way in which those payments should be characterised is payments which have been made to alleviate poverty and are of a benevolent nature.

This is consistent with the evidence which you have heard, indeed the evidence that was given by the then Minister, Ms Gougeon, on 18 May 2021 at page 36, confirms it was her position that previous payments had not been intended to be compensatory.

Furthermore, in my submission, the characterisation that Sir Robert places on the previous payments is consistent with other evidence heard by others involved in the administration of schemes, in particular Mr Lister who gave evidence on the Caxton Foundation Payments. He said the purpose of those was to lift people out of poverty which, in many cases, was created by state culpability leading to infection.

In my submission again, that is consistent with the analysis.

Therefore, sir, we do not agree with Mr Johnston's approach and, indeed, we found it slightly surprising,

or those whom I represent did, that the Scottish Government would seek to take such a position, in particular in circumstances where they agree, as I think everyone does, although perhaps for slightly different reasons, that the money should be paid from the UK Government's funds, on the basis that the original infections were all caused before devolution, or at least that's the argument that myself, Ms Gollop and indeed Mr Johnston propose.

There are a number of other arguments, sir, which we don't think are ones you should accept.

An argument was made about fairness, based on the fact that people have received variable amounts in the past. I understood Mr Johnston to accept that it would only be payments which could be classed as compensatory which fall to be deducted but he offered no means of understanding what types of payments would fall to be characterised that way. Furthermore, sir, our submission is that the concern that he had, that there were people, I think, who may not have received compensation under the scheme who should have done might be disadvantaged is not well founded.

I think it must be the Scottish Government's position that those who were due to receive support have received it, in particular because he explained that

extensive efforts had been made to trace untraced transfusion infections with HCV after the Penrose recommendation.

Therefore, it is, I think, the position that, if anyone has received less than they should have done in the past, such that such unfairness in his submission may arise, that, in our submission, would logically be dealt with a back payment of support rather than everyone falling foul of this rule which is being proposed.

Sir, I don't intend to go into, to any extent, any of the other recommendations. They are numerous but I would urge you, sir, to make recommendations on this basis.

One thing which I should mention, sir, is we do associate ourselves with the general position of the Scottish Government in this regard. They have indicated a willingness and indeed a desire to continue to control at least the Scottish Infected Blood Support Scheme. There may be some suggestion made by others that the administration of those schemes should change. We support them in that, on the basis that local accountability and local administration is something which is certainly of considerable importance and value to my clients.

Could I just, as far as non-financial recommendations, sir, point out that I have provided the Inquiry a few days ago with an article which appeared in the Daily Record, which I think neatly set out the Scottish position on what might broadly be described as the "Hillsborough Law".

There is a current controversy in Scotland about this, which has arisen between the Labour opposition and the Government. I simply wish to refer that to you, sir, because it may well be, as others have done, that you wish to make recommendations which fall in that general area and I thought it would be useful for you to be aware of the fact that there is a certain controversy.

The basic position is the Government has rather set its face against a number of the recommendations which are made and which are being so passionately supported by Mr Burnham. They do so, in part, on a technical distinction between there being some difference between fatal accident inquiries in Scotland and coroners' inquests in England. My position would be that substantively there is no different between the two and the difficulties which the Scottish Government seem to have with it are not well founded.

Sir, in concluding, I wish to make brief though

important reference to the dedicated work of you and your team. May I also pay particular tribute to the counsel team. In my humble submission, they are deserving of the highest praise, not only for their professionalism and dedication, but also for the compassion, courtesy and humanity in which they have handled both their professional duties and their personal interactions with the infected and affected: compassion, courtesy and humanity, which they have always deserved but far too seldom encountered with their previous dealings with authority.

If I may, sir, be so bold as to say that in these personal interactions, the approach has mirrored entirely the approach which you and your staff have taken, in all of your dealings with those whom I represent. In that regard and in many others, they wish to pass on their profound gratitude.

Sir, may I also pay tribute to the dignity, courage and responsibility which my clients have shown in their dealings with this Inquiry. From amongst my client group, may I pay particular tribute to the fearlessness and responsibility of Bill Wright, the intelligence and doggedness of Alice Mackie, the scepticism and ferocity of Bruce Norville, and the courage of the late Philip Dolan. They fought on in the face of Government

intransigence to the plight of the infected and affected community, as appears to be recognised in so many of the submissions received by the Inquiry.

In doing so, they suffered incalculable further harm to themselves and their families. It has been a particular privilege to have acted on behalf of those courageous individuals who have spoken for so many others so selflessly for so many years, and others in the community who they represent.

It has been an honour, sir, to speak for those who, through the culpability of the state, are not able to speak for themselves.

Sir, here where the words end, those whom I represent put their fate in your hands. They do so willingly. They do so with faith that you will complete your task with compassion and humanity. They do so with for the first time for many some hope for the future. They do so with clarity about what was needlessly done to them by the state.

I leave you, sir, with a short video presentation. My clients, the infected and affected of Scotland.

(Video is played)

SIR BRIAN LANGSTAFF: Thank you very much.

If I can change the mood a little, when I -- you mustn't apologise too much for the length of your

submissions. I know it is longer than a Walter Scott novel but when I was educated in Scotland I do remember my teacher telling me that there had been at least one sentence that Sir Walter Scott wrote which lasted for 28 pages, and yet you can see the esteem in which he is held. I found what you wrote lengthy certainly, but very helpful. Thank you very much.

MR DAWSON: Thank you, sir.

MS RICHARDS: Sir, just to say tomorrow is the final day of our submissions. We will be hearing from Mr Stein in the morning on behalf of the Core Participants represented by Milners Solicitors, and then from me at 2.00 pm.

SIR BRIAN LANGSTAFF: So tomorrow, 10.00 am.

(3.21 pm)

(The Inquiry adjourned until 10.00 am on 3 February 2023)

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