

Tuesday, 23rd March 2021

(10.00 am)

SIR BRIAN LANGSTAFF: Good morning, Mr Fish. Can you hear me?

THE WITNESS: Yes. Good morning. Yes, I can.

SIR BRIAN LANGSTAFF: Can you see me, or at least some of me?

THE WITNESS: Yes, I can.

SIR BRIAN LANGSTAFF: Now, you are at home, are you, with your wife and children?

THE WITNESS: I am. My wife has taken her to the park for the morning session, so hopefully it will be quiet.

SIR BRIAN LANGSTAFF: Whenever we have a break, just to tell you now, you are not at liberty to discuss the evidence you have given or you think you may yet be asked to give with anyone -- your wife, your child, anyone else -- but you can talk about anything else you want.

THE WITNESS: Okay. Thank you.

SIR BRIAN LANGSTAFF: Indeed, I mention it now, we will take a break, so that you know, this morning at a time which will cover twelve o'clock for those who -- I don't know if you yourself wish to, but for those who wish to join the national observance of the memorial for the anniversary of the first lockdown.

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A. Yes. I was a temp around that time.

Q. In the period up until your appointment as administrator in 2006 what kind of work did you undertake for the Skipton Fund?

A. So I was the administrator's assistant, so helping write letters, gather the evidence needed to assess an application, answer e-mails, all of the general admin duties to support the administrator.

Q. You remained in the post of administrator after your appointment in 2006 I think until around November 2017, when you transferred across to the English Infected Blood Support Scheme; is that right?

A. Yes, that's right.

Q. Then you were made redundant from the English Infected Blood Support Scheme in early 2019?

A. Yes. True.

Q. In terms of the Macfarlane Trust, is this right: your role there was as the assistant to the Chief Executive?

A. It was. Before that I did some support work for the finance department whilst still a temp but, yes, most of my time it was as the assistant to the chief exec.

Q. That was, first of all, Mr Harvey and then Ms Barlow?

A. Yes.

Q. In relation to the Caxton Foundation, you were

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THE WITNESS: Okay.

SIR BRIAN LANGSTAFF: Now, you are talking to an audience which is in part here. A small part. We have eight members of the Inquiry team, one of whom is Mary, who will ask you to take the oath in a moment or two, one of whom a name you'll hear is Soumik, who will make sure that you get the right documents to look at on your screen, but the much wider audience numbers just over 200 normally -- it may be more -- and they are watching from their own homes or elsewhere remotely, and it is to them, largely, that you will be talking.

THE WITNESS: Okay.

SIR BRIAN LANGSTAFF: Okay? Ms Richards will ask you the questions once you have been sworn.

NICHOLAS FISH (sworn)

Questions from MS RICHARDS

MS RICHARDS: Mr Fish, you can you see and hear me?

A. Yes.

Q. You were at various times an employee working at the Skipton Fund, the Macfarlane Trust and the Caxton Foundation; is that right?

A. Yes, that is correct.

Q. In terms of the Skipton Fund, you first started working there, I think, around November 2004; is that right?

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employed in a similar capacity, assistant to the Chief Executive from 2011 onwards, so first of all assistant to Mr Harvey and then to Ms Barlow?

A. Yes, that's right.

Q. I will come back towards the end of my questions to your work in the Macfarlane Trust and the Caxton Foundation, because I am going to be asking you mostly about the Skipton Fund.

What, if anything, did you know about the Skipton Fund when you started work there?

A. Nothing at all. I hadn't heard of it.

Q. What information -- before I ask you that question: what, if anything, did you know about the circumstances in which people had been infected with HIV or hepatitis C through blood and blood products?

A. Again, I hadn't heard of the whole situation at all.

Q. So when you started work what, if any, training or induction or information was provided to you about either of those matters?

A. So we got some background history of what happened and then obviously training on the application process and then we had a talk with Professor Christine Lee about hepatitis C. That was fairly early on in my tenure at the Skipton Fund. So, yes, that was the background and training really.

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1 Q. Did you know anything or did you learn anything in the
 2 years that you worked there about the circumstances in
 3 which the Skipton Fund had come to be set up?
 4 A. I knew it was due to campaigning from I think it was
 5 a haemophilia group in Scotland. So I knew it was due
 6 to pressure from campaign groups on the Government to
 7 obviously offer some compensation or recognition of
 8 what had happened to these people.
 9 Q. We looked yesterday morning, Mr Fish, at a document
 10 called the Ross Report, which was a report to the
 11 Scottish Executive in March 2003, so before you joined
 12 the Skipton Fund and, indeed, before the Skipton Fund
 13 itself was set up, which made certain recommendations
 14 that were for compensation rather than the specific
 15 ex gratia payments that the Skipton Fund ultimately
 16 made. Do you recall any discussions about that report
 17 or about the principle of compensation versus ex
 18 gratia payments when you were at the Skipton Fund?
 19 A. I had heard of the Ross Report, but I didn't know that
 20 there was discussion about whether or not it should be
 21 compensation or ex gratia payment.
 22 Q. In the period prior to your appointment as
 23 administrator were you involved in actually
 24 determining applications for eligibility or was that
 25 still the role of the administrator, Mr Foster?

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1 Q. If he if we look towards the bottom of the page,
 2 paragraph 13.1, you set out there what being scheme
 3 administrator and company secretary entailed. You say
 4 you were:
 5 "... responsible for administering the scheme as
 6 set out by the DHSC which included liaising with
 7 applicants and doctors regarding their applications
 8 ..."
 9 I will come back to the application process,
 10 Mr Fish:
 11 "... making decisions on application jointly
 12 with one of the directors ..."
 13 Again, I'm going to ask you about that in more
 14 detail:
 15 "... managing scheme assistants ..."
 16 How many scheme assistants were there and what
 17 was their role?
 18 A. That fluctuated depending on if there had been changes
 19 to the scheme. Usually it was just one. The maximum
 20 I think we had at any one time were four. That was
 21 around 2011 when the major changes came in. So
 22 generally it was between one and four and their role
 23 was similar to my role had been previously, writing
 24 letters, answering telephone calls, dealing with
 25 e-mails and just generally gathering information for

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1 A. No, that was Mr Foster's role. So I would write
 2 letters to gather information to be passed on for
 3 consideration by the administrator. So, no, I wasn't
 4 involved in the actual decision-making process.
 5 Q. You became the scheme administrator, and I think also
 6 the Company Secretary in the course of 2006 after
 7 Mr Foster was found to have been defrauding the
 8 Skipton Fund. Was any additional training provided to
 9 you at that stage to enable you to take on this new
 10 role of determining applications?
 11 A. It wasn't but I had been there a year and a half by
 12 that stage and because there was only me, the scheme
 13 administrator and one other assistant, obviously we
 14 discussed a lot about applications. So I was very
 15 familiar with how he was considering applications,
 16 what information I needed to gather. So I didn't feel
 17 necessarily that I needed it.
 18 Q. Now, I will come back to the consequences of
 19 Mr Foster's actions at a later stage of your evidence.
 20 I just want to look at a passage in your witness
 21 statement about your responsibilities as
 22 administrator. Soumik, it is WITN4466002, please. If
 23 we could go to page 5. So this is your statement,
 24 Mr Fish?
 25 A. Yes.

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1 the application process.
 2 Q. Was it ever the function of the scheme assistants,
 3 reporting to you as the administrator, to themselves
 4 take decisions on eligibility?
 5 A. No.
 6 Q. Then you refer next to providing feedback, statistics
 7 and forecasts to the Department of Health. What kind
 8 of feedback, statistics or forecasts were you required
 9 to provide to the Department of Health?
 10 A. So monthly statistics about the total number of
 11 applications received, number paid, number declined,
 12 number that had gone to appeal. So basically the
 13 summary of all of the application statuses and that
 14 was on a monthly basis, and forecasts. We used to get
 15 money, I think it was quarterly, in advance, so
 16 I would do a forecast for the number of applications
 17 we expected to pay for that upcoming quarter and the
 18 Department of Health would then pay that money over so
 19 that we had it ready to make payments.
 20 Q. Top of the next -- oh, we have got it on screen.
 21 Thank you:
 22 "... general admin duties associated with
 23 administering a scheme ... keeping the application
 24 form and guidance notes up to date ... content of the
 25 website ..."

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1 Company Secretary responsibilities. Then you
 2 say:
 3 "I also became the secretariat to the
 4 independent Appeals Panel ..."
 5 I will come back later to the panel itself but
 6 what, in broad terms, was your function as the
 7 secretariat to that panel?
 8 **A.** If somebody requested an appeal I would create their
 9 appeal file, so I would make copies of all the
 10 documents that we had received for distribution to the
 11 panel members in advance of their meeting, so
 12 obviously they had a full record of what the
 13 Skipton Fund had received. Then, if there was further
 14 information, quite often the chairman would do
 15 a preliminary look at cases and if he thought there
 16 was further information that might help with the
 17 application, I would send those letters out to the
 18 appellants asking them to provide the additional
 19 information. Also, after me, I think it was the same.
 20 **Q.** Did you attend the meetings of the Appeal Panel?
 21 **A.** No.
 22 **Q.** Were you responsible for drafting the decisions of the
 23 Appeal Panel?
 24 **A.** No, they were drafted by the chairman and they would
 25 be posted for me and I would take a copy for the file

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1 wouldn't necessarily need to be seen by the director.
 2 For instance, the natural clearer where the doctor had
 3 ticked "yes", they were antibody positive and "no" to
 4 the next three questions, so they were not currently
 5 PCR positive and there was no evidence they had been
 6 chronically infected, so those ones wouldn't need to
 7 be seen by a director. But, yes, any borderline ones
 8 and approvals, it was a joint decision.
 9 **Q.** Was there any guidance as to the kind of cases that
 10 would need to have a more detailed discussion with the
 11 director or was that very much left to your judgment?
 12 **A.** Yes, that was left to my judgment.
 13 **Q.** In your witness statement -- I don't think we need to
 14 put it back on screen -- you said that in the more
 15 difficult cases the views of the medical directors
 16 were very important. In the years prior to the
 17 Skipton Fund having a medically qualified director,
 18 what would happen in those more difficult cases? What
 19 would the process be?
 20 **A.** So one of our directors, Elizabeth Boyd had contacts
 21 with the Royal Free. I believe she used to work
 22 there. So she would be able to refer any new cases to
 23 medical experts at the Royal Free Hospital and then
 24 she would bring back the advice to the fund.
 25 **Q.** How did that work? Did you ever learn which doctors

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1 as well.
 2 **Q.** In terms of your role in determining eligibility, the
 3 Inquiry understands that it was also a requirement
 4 that one of the directors of the Skipton Fund sign off
 5 on the decision, if I can put it that way; is that
 6 correct?
 7 **A.** Yes, that's right.
 8 **Q.** Prior to the appointment of a medical director, and
 9 I think the first medical director was
 10 Professor Thomas from whom we are hearing tomorrow,
 11 how did that sign off process work? What was the
 12 director's role in the decision-making process?
 13 **A.** So they would visit the office usually once every week
 14 or two. We would have a pile of applications to
 15 consider. On the front of each one I would usually
 16 summarise the key points as I saw them and then we
 17 would discuss together whether or not we could approve
 18 the application.
 19 **Q.** So is this right, the decisions on eligibility were
 20 usually joint decisions as between you and the
 21 director, rather than you taking the decision and then
 22 it simply being approved by the director?
 23 **A.** Yes, definitely. I mean, we had obviously
 24 straightforward cases and difficult cases. So if it
 25 was a straightforward case that was declined, that

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1 at the Royal Free Hospital were being asked to express
 2 a view?
 3 **A.** No, not specifically. I think it was
 4 Professor Dusheiko, I believe, but he was a liver
 5 specialist. I think she worked in the haematology
 6 department. So, no, I didn't know exactly which
 7 doctor had been spoken to in every case.
 8 **Q.** There would be no way, would there, if you didn't even
 9 know who the doctor was that Ms Boyd was going to, of
 10 testing that doctor's opinion or no way of ensuring
 11 accountability? Did that not give you cause for
 12 concern that you were relying on the views of
 13 an unknown clinician?
 14 **A.** So this was the process that I inherited and it had
 15 been going on for a year and a half by the time I took
 16 over as scheme administrator. So, to me, it seemed to
 17 be working well. The opinions seemed to be sound. So
 18 it didn't particularly cause me concern.
 19 **Q.** Do you know what information about individual cases
 20 Ms Boyd supplied to those she was contacting at the
 21 Royal Free Hospital?
 22 **A.** I believe she took an anonymised copy of the
 23 application form and any supporting evidence, but they
 24 would have had access to the same information as us.
 25 **Q.** What is the basis for your view that the information

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1 she provided was anonymised?

2 **A.** There wasn't much personal information on the

3 application form. So pages 1 and 2 were where the

4 patient's -- the applicant's -- name and address were,

5 so provided she didn't copy page 1 and 2, then it

6 would be anonymous.

7 **Q.** Do you know whether that's what she did or is that

8 your assumption that's what she did because it would

9 have been the right thing to do?

10 **A.** I mean, it is a long time ago. I believe that's what

11 she did but, yes, I can't say 100%.

12 **Q.** Now, you attended meetings from time to time in your

13 capacity as administrator for the Skipton Fund with

14 the Department of Health.

15 **SIR BRIAN LANGSTAFF:** Just changing the subject here

16 a little, can I just ask, you said a moment ago that

17 the medical opinions or the opinions that Ms Boyd

18 brought back seemed to you to be sound. How did you

19 judge that they were sound?

20 **A.** Well, I trust the judgment of a clinician, so I had no

21 reason to think they wouldn't be sound.

22 **SIR BRIAN LANGSTAFF:** So, in other words, you assumed they

23 were sound, rather than made that decision for

24 yourself?

25 **A.** Well, yes. Nothing was unusual about the decisions

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1 Skipton Fund about broadening its remit to include

2 people who had been infected with hepatitis B?

3 **A.** That was never mentioned as an option.

4 **Q.** Now, I am going to ask you a little about the agency

5 agreement which was signed as between the Skipton Fund

6 and the Department of Health.

7 Soumik, could we have SKIP0000033_066. You will

8 see that the date of that is 22 May 2007, so that's

9 nearly three years since the 5 July 2004 date when the

10 Skipton Fund began operating.

11 Did you gain any understanding as to why it took

12 so long for there to be a concluded agency agreement?

13 **A.** No. I know it is to do with the lawyers, back and

14 forth between solicitors, but I am not entirely sure

15 what could have caused such a huge delay. It was

16 always a source of frustration. Didn't know why it

17 was taking so long.

18 **Q.** Do you recall you having any direct involvement in the

19 drafting of the agency agreement or in discussions as

20 to what it should contain?

21 **A.** No, just proofreading before final sign-off. But, no,

22 not the content. I wasn't involved in that.

23 **Q.** If we go to -- Soumik, it is page 7, I think. Yes.

24 If we look at paragraph 2.5, bottom half of the page,

25 we can see at 2.5.4 the agreement provided that:

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1 that they had made to me.

2 **Q.** Well, it would be a "yes" or a "no", in effect,

3 wouldn't it?

4 **A.** Yes.

5 **SIR BRIAN LANGSTAFF:** So whatever they decided, whether it

6 was "yes, this person qualifies" or "no, they don't",

7 you would regard that as sound?

8 **A.** Well, there was usually some background information

9 given about how they'd reached the decision that

10 Ms Boyd would have explained to me. And, yes,

11 nothing -- I didn't ever think anything sounded

12 unusual.

13 **SIR BRIAN LANGSTAFF:** Yes. So, essentially, it was

14 because you thought a doctor who was expressing that

15 view that you thought it was sound?

16 **A.** Yes. An independent medical expert.

17 **SIR BRIAN LANGSTAFF:** Yes, I see. Thank you.

18 **MS RICHARDS:** You attended meetings with the Department of

19 Health in your capacity as administrator of the

20 Skipton Fund. Indeed, I think you also attended

21 meetings with the Department of Health in your

22 capacity as assistant to the Chief Executive of

23 Macfarlane and Caxton.

24 Do you recall there ever being any discussion

25 with the Department of Health or within the

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1 "Skipton acknowledges that it may only alert DH

2 to operational issues and may not make proposals to

3 amend Government policy."

4 What was your understanding of the kind of

5 operational issues that could be raised and the kind

6 of policy issues that couldn't?

7 **A.** Operational issues would be things like if we thought

8 we needed more staff. For instance, if there had been

9 a change to the scheme and we felt we were

10 understaffed. So that would be the sorts of

11 operational issues we could raise.

12 Government policy would have been if we felt

13 that natural clearers should have been included, we

14 weren't able to make that suggestion. So it would

15 have been obviously a major change to the scheme. So

16 anything like that, we were unable to make

17 recommendations or even give our opinion.

18 **Q.** Did you know or ever gain an understanding as to what

19 had been the genesis of this provision?

20 **A.** No, not really. I guess maybe they considered it was

21 the scheme that they'd designed, and we were the agent

22 company to administer the scheme as they designed it.

23 So perhaps they didn't want us making recommendations

24 about the scheme, as it was ultimately their decision

25 what the rules were.

16

1 Q. Now, you have referred to there being major revisions
2 in 2011, and we know that there were some other
3 revisions at different stages of the Skipton Fund's
4 history.

5 Did you or the directors ever have any input or
6 influence about those revisions and the terms upon
7 which they should be made?

8 A. No. So in leading up to the decision, they would be
9 gathering statistics which we knew they were using to
10 assess what changes they might make to the scheme.
11 But, no, in terms of suggesting what they should do,
12 we had no influence at all.

13 Q. You can take that down. Thank you, Soumik.

14 Can you give us a rough idea as to how often you
15 attended meetings in your capacity as administrator of
16 the Skipton Fund with the Department of Health?

17 A. So prior to 2011 and the lead-up to those changes, it
18 would have just been an annual meeting mainly to
19 discuss the statistics and how the fund -- leading up
20 to the changes in 2011, there were definitely more
21 frequent meetings where they would discuss some of the
22 options they were considering, as well as requesting
23 additional statistics or more frequent statistics,
24 which I guess they were using to probably cost out
25 different options. So, yes, we met more frequently

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1 Rowena Jecock was there for a lot of the time. So it
2 was more the people we would have day-to-day dealings
3 with that would change. So, no, I don't think --
4 there was also a consistent civil servant.

5 Q. In the next paragraph, you refer to, as you did
6 a few moments ago, there being periods where more
7 regular meetings occurred because the Department was
8 considering changes to the scheme.

9 How much notice were you generally given of
10 proposed changes to the scheme?

11 A. Yes. So in 2011, we knew roughly what they were
12 considering: an increase to the stage 2 payment. We
13 actually found out the day before what changes were
14 being made to the scheme, so we weren't given any
15 notice at all which was very difficult.

16 Q. How did that impact upon your ability to implement the
17 changes or relay them to potential applicants?

18 A. Yes. So the next day was very stressful. We
19 obviously had to quickly appoint further assistants.
20 So the phone was ringing literally 9 till 5. So me
21 and my assistant were just taking calls during that
22 period, and then at five o'clock, we would stop
23 answering telephone calls and deal with the e-mails.
24 There were probably 100 a day, which I would clear off
25 before I went home each evening. And then, obviously,

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1 leading up to changes.

2 Q. Did you ever make minutes or some other form of notes
3 of the meetings that you attended with the Department
4 of Health?

5 A. Yes. We would take informal notes, and I believe they
6 took their own version, and then we'd agree upon
7 a joint version after the meeting. They weren't
8 formal minutes; they were more notes.

9 Q. If we go to your witness statement again, so Soumik,
10 if we can have WITN4466002, please, and go to page 8.
11 Top of the page, paragraph 17.2, you are talking here
12 about the meetings that you would attend at the
13 Department of Health in your capacity as administrator
14 of the Skipton Fund, and you say in the second
15 sentence:

16 "From the DHSC, it would be the relevant civil
17 servants at the time, which changed numerous times
18 during the period I worked for the Skipton Fund."

19 Did the numerous times that the relevant civil
20 servants changed impact upon the running of the scheme
21 or consideration of revisions to the scheme, as far as
22 you could ascertain?

23 A. No. So it was usually the junior or more junior
24 people that would change, so it was always the same.
25 I think it was Alastair White who was always there.

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1 as we got the assistants in and trained, things began
2 to get more manageable, but certainly for the first
3 few weeks, yes, it was very stressful.

4 Q. You can take the statement down. Thank you.

5 Now, what advertising or publication of the
6 existence and nature of the Skipton scheme was, to
7 your knowledge, undertaken, first of all, by the
8 Department of Health?

9 A. So this would have been in July before I started, but
10 I believe they wrote to hepatology departments and
11 haematology departments, haemophilia centres. I'm not
12 sure what websites they advertised it on, but that was
13 more a question for the Department of Health, but I'm
14 sure they'll be able to confirm. But, yes, I believe
15 they wrote to hospitals to inform them of the scheme.

16 Q. After that initial exercise, what, if any, attempts
17 were made by the Skipton Fund itself to advertise its
18 existence to potential applicants?

19 A. So changes to the scheme, we would advise those on our
20 website, but I believe the agency agreement actually
21 prevented us from advertising changes. There's
22 a clause in there somewhere. I can't remember the
23 number. So we left that to the Department of Health.

24 Q. So would this be correct: the Skipton Fund itself
25 didn't, for example, establish a chain of

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1 communication with hospitals or relevant medical
2 bodies or societies, or relevant patient bodies or
3 societies?

4 **A.** No. That was the Department of Health. I know that
5 the charities actually informed their beneficiaries,
6 so Macfarlane Trust would have notified all of their
7 beneficiaries about changes to the Skipton Fund.
8 Obviously, there was an overlap with beneficiaries and
9 applicants there. But, no, writing to hospitals and
10 maintaining those communication channels, that was
11 down to the Department of Health.

12 **Q.** Do you know whether the Department of Health ever
13 instituted a system whereby all newly diagnosed
14 hepatitis C patients would be told about the Skipton
15 Fund?

16 **A.** I'm not sure. Presumably all of the hepatology
17 departments would have known of the schemes, so
18 provided they were diagnosed by hepatologists. But
19 I can't say for sure.

20 **Q.** In your dealings with applicants over the years, did
21 you ever gain an understanding as to how applicants
22 were finding out about the Skipton Fund?

23 **A.** Yes. It was always through their doctor, or most
24 always.

25 **Q.** If we just look at one set of minutes.

21

1 **Q.** When -- we can take that down. Thank you. When the
2 changes were made in 2011, the major changes made
3 then, what steps did the Skipton Fund take at that
4 stage to notify everyone who either received a stage 1
5 or was an existing stage 2 payment recipient of the
6 new payments?

7 **A.** Yes. So with the assistance of the Department of
8 Health, we telephoned everyone who registered
9 a telephone number, tried those numerous times at
10 different times of the day. We sent e-mails to
11 everybody who had registered an e-mail address. We
12 wrote to doctors who had completed application forms,
13 asking them to let their patients know of the changes
14 to the scheme.

15 **Q.** Was there ever any mechanism whereby someone who
16 wasn't initially eligible or entitled to, for example,
17 any form of annual payment post-2011 could nonetheless
18 be updated as to future changes in the scheme?

19 **A.** Yes. So after 2011, in our letter and our
20 communications with applicants, we said, "From now on,
21 the Skipton Fund will write to you if there are
22 further changes to the scheme. If you are not happy
23 with this, then please inform us". We would have kept
24 them on a separate data base. From that point
25 onwards, we did make people aware that we would start

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1 SKIP0000030_027, please, Soumik. These are minutes of
2 the meeting of the Board of Directors of Skipton Fund,
3 5 October 2006. We can see that you're in attendance.
4 At that point, you're the acting scheme administrator,
5 so Mr Foster has been dismissed, and this is before,
6 I think, your permanent appointment was confirmed.
7 If we look just a little further down the page,
8 we see a heading there, "Administrator's statistics":
9 "Gordon Clarke asked if there was any way of
10 knowing the proportions of haemophiliacs paid from
11 each of the four areas of the UK to highlight any
12 areas where the existence of the Skipton Fund needs
13 promoting. It was noted that there was no way for
14 this to be done and that there is no media budget in
15 place for the Skipton Fund to promote itself in any
16 case."
17 Did that ever change? Was there ever a media
18 budget in place for the Skipton Fund to promote
19 itself?

20 **A.** No, there wasn't. As I mentioned, I think there was
21 actually a clause which I don't think had been signed
22 off by this point. It may have been in the draft of
23 the agency agreement; I can't remember. I believe it
24 said the Skipton Fund couldn't advertise itself in any
25 case, but no, there was never a media budget.

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1 to write to their address if there were further
2 changes. So i.e., maintaining an up-to-date database.

3 **Q.** Was that only the position for those who were already
4 successful applicants? What about those who were not
5 successful or those who hadn't met the criteria at
6 a point in time but might want to be kept informed as
7 to whether those criteria or terms changed?

8 **A.** No, we didn't write to people who had been declined.

9 **Q.** Was there ever any effort by the Skipton Fund to
10 identify groups which represented the interests of
11 non-bleeding disorder beneficiaries or potential
12 beneficiaries and make contact with them?

13 **A.** As far as I was aware, there weren't any groups that
14 existed at that time. There may have been, but
15 I wasn't aware of them.

16 **Q.** What, if any, steps were taken by the Skipton Fund in
17 relation to particular difficulties that might arise
18 for those cases where someone had died without
19 a formal diagnosis of hepatitis C and families might
20 be unaware of the ability to claim. What, if any,
21 consideration was given to that problem and how was it
22 resolved, if at all?

23 **A.** The only method we had was to ask the Macfarlane Trust
24 to write to their group of beneficiaries, which they
25 did, and obviously we had a lot of estates come

24

1 forward to claim via that means. Other than that, we
2 had no access to such databases where we could have
3 pursued that ourselves.

4 **Q.** That might enable you to make contact with or draw the
5 existence of the scheme to those who had had bleeding
6 disorders and whose families were registered with the
7 Macfarlane Trust. But would this be right then: for
8 those who did not have a bleeding disorder, or who had
9 had a bleeding disorder but were not a Macfarlane
10 Trust beneficiary, there was no communication that the
11 Skipton Fund would have with those categories?

12 **A.** Sorry, did you say that was for people who died who
13 may not have been aware they had hepatitis C?

14 **Q.** Yes.

15 **A.** So that -- no, I'm not sure how you could find that
16 group. With people with haemophilia, if they had a
17 clotting factor, we learned that there was 100% chance
18 they were exposed to hepatitis C. In the absence of
19 records, either way we would have known they were
20 exposed to it. And as only about 20% clear naturally,
21 on the balance of probabilities, they would have been
22 chronically infected. But someone who died not
23 knowing they had hepatitis C who hadn't received
24 clotting factor could have been anyone, to be honest.

25 **Q.** I'll ask you a little more about the implications of

25

1 **A.** I think it was to look at the application process;
2 find out how this happened and how it could be
3 prevented in future.
4 **Q.** If we look at the bottom of the page, there's
5 a heading "Implementation of CFSMS suggestions". We
6 see Mr Harvey stating objections to a redesign of the
7 application forms because it would seem from this the
8 impact that might have on previously unsuccessful
9 applicants.

10 Then it says:

11 "After discussion, the following alterations
12 were decided."

13 We can see what's then set out is an obligation
14 on both the applicants and doctors:

15 "... to sign a declaration stating that the
16 information they have supplied is truthful and
17 accurate and that they will be liable for prosecution
18 should it be found not to be so."

19 Was any consideration given as to whether that
20 might be thought to be somewhat off putting both for
21 applicants and clinicians, neither of whom as
22 a category had been in any sense responsible for
23 Mr Foster's fraud?

24 **A.** I believe the Counter Fraud and Security Management
25 Service were quite adamant about the wording of that

27

1 the fraud perpetrated by Mr Foster, your predecessor
2 as scheme administrator. Did you gain any
3 understanding as to how that fraud was able to occur?

4 **A.** Yes. So he was actually using similar bank accounts
5 to make the payments to himself. So we managed to
6 trace all of the fraudulent claims that he'd made. He
7 was essentially filling in a fake application always
8 with the same doctor's name on the back and just
9 circling the correct answers to enable an application
10 to be paid. So he was, yes, just essentially taking
11 forms away and filling them in fraudulently, making
12 people up, and putting an account down that he had
13 access to.

14 **Q.** Now, if we look at SKIP0000025_102, you will see these
15 are notes of a meeting between the Skipton Fund
16 attended by you and the NHS Counter Fraud and Security
17 Management Service.

18 What was the Counter Fraud and Security
19 Management Service of the NHS?

20 **A.** So I think that's an existing department of the NHS
21 that investigates fraud within the NHS, and they were
22 in touch with us by the Department of Health to review
23 the scheme.

24 **Q.** What was the purpose of their involvement at this
25 meeting?

26

1 declaration. So I didn't feel like we had a choice to
2 say we didn't want that in there.

3 **Q.** Is this right, that there wasn't any evidence of
4 either applicants or doctors making any attempts to be
5 untruthful or mislead or defraud the Skipton Fund?
6 The fraud had been perpetrated solely within the
7 Skipton Fund itself by its administrator?

8 **A.** No. Then I suppose you wouldn't have known unless we
9 discovered that there had been a fraud, so ... but no,
10 I didn't know of any, obviously.

11 **Q.** If we go to SKIP --

12 **SIR BRIAN LANGSTAFF:** Just for clarity's sake because of
13 the transcript, the question was the fraud had been
14 perpetrated solely within the squad itself by the
15 administrator. The answer first comes "no". You
16 mean, I think, that was correct, solely by the
17 administrators within the Skipton Fund itself.

18 **A.** That's correct and I did not have any applicant making
19 fraudulent applications, other than the Foster
20 discovery.

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

22 **MS RICHARDS:** If we go to SKIP0000031_163, this is your
23 annual report for the year, I think, ending
24 April 2007. If we go to page 3 -- if we go, first of
25 all, to page 2 -- apologies, Soumik -- we can see

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1 under the heading "Keith Foster" the amount he was
 2 found to have misappropriated, around £400,000 --
 3 £400,000, "around 0.5% of total funds disbursed".
 4 Then it says:
 5 "To date we have recovered £267,321.91 ..."
 6 The details are then set out as to the sources
 7 from which those have been recovered. Did the Skipton
 8 Fund ever recover any more than that?
 9 **A.** No, not as far as I am aware. I think that was the
 10 extent of the recoveries.
 11 **Q.** Did the fraud and the inability to recover the
 12 entirety of the monies defrauded have any impact upon
 13 the amount of money available to the Skipton Fund for
 14 distribution to beneficiaries?
 15 **A.** No, definitely not, because we received our finance
 16 based on my forecasts for the upcoming quarters. So
 17 we were never short of funds. If we had been, we
 18 would have put our invoice in earlier, to ensure we
 19 did have enough.
 20 **Q.** If we go to the next page --
 21 **SIR BRIAN LANGSTAFF:** Just pausing for a moment, if we
 22 may, do you know anything or did you learn anything
 23 about the circumstances in which Mr Foster
 24 misappropriated money from his previous employer, the
 25 British Association of Hand Therapists?

29

1 **A.** I am not sure. That was before I started.
 2 **MS RICHARDS:** If we go to the next page, please, Soumik,
 3 we can see under "Procedural Alterations", a number of
 4 alterations made to the scheme following the discovery
 5 of the fraud: provision by the applicant of their NHS
 6 number; and then the second bullet point is putting
 7 dates and initials of the applicant on all application
 8 forms. There is then the declaration that I have
 9 asked you about previously, but if we go over the
 10 page, in the top half of the page, we can see a more
 11 substantive change to the process. The top paragraph
 12 says:
 13 "The forms also request that the completing
 14 medical practitioner encloses copies of medical
 15 records which confirm the HCV status of the applicant
 16 and that they received contaminated blood or blood
 17 products within the NHS prior to September 1991 (there
 18 is still a degree of flexibility regarding records)."
 19 We will look at the footnote in a moment. Do we
 20 correctly understand that a change that was instituted
 21 was that the medical practitioner completing the form
 22 now had to actually provide the patient's medical
 23 records, both in relation to their hepatitis C
 24 diagnosis and medical records confirming receipt of
 25 contaminated blood or blood products?

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1 **A.** I think he was just writing cheques to himself.
 2 I think he was in charge of writing cheques. I am not
 3 sure how he managed to get away with that, but that's
 4 what I believe he was doing.
 5 **SIR BRIAN LANGSTAFF:** Did you discover how that came to
 6 light?
 7 **A.** Yes, I think the way that we discovered the Foster
 8 fraud is because his previous employer was finding it
 9 very suspicious that they were getting regular sums of
 10 money that he was paying back to them after they
 11 discovered that he had been stealing money from them,
 12 and then they looked up, I think, where he was
 13 currently working and saw it was a payment scheme. So
 14 they put two and two together and informed the police,
 15 who then contacted us, and I think that's the reason
 16 the BAHT paid the money back to us because they had
 17 not reported the crime to the police that he committed
 18 under their employment.
 19 I think they had said to him, provided he paid
 20 the money back, they wouldn't inform the police.
 21 That's my understanding.
 22 **SIR BRIAN LANGSTAFF:** I see. Do you happen to know,
 23 because you may have seen the files, whether any
 24 reference was obtained by Skipton from his previous
 25 employer before he started employment?

30

1 **A.** Yes, so whereas before they just had to say "Yes,
 2 I have seen a copy of records confirming the hep C
 3 status", they have now asked for a photocopy of that
 4 document and likewise for the blood transfusion.
 5 **Q.** In practice, did you receive selections from patient's
 6 medical records made by the completing medical
 7 practitioner or did you receive a whole bundle of
 8 medical records from which you were expected to try to
 9 identify the relevant parts?
 10 **A.** 90% of the time it was the relevant page.
 11 Occasionally, the doctor would supply more
 12 comprehensive record (*unclear: audio distortion*) then
 13 we would try and find. Then as we requested it was
 14 the specific page relating to the qualifying
 15 treatment.
 16 **Q.** We can see the footnotes. It says:
 17 "... (there is still a degree of flexibility
 18 regarding records)."
 19 If we go to the footnote at the bottom of the
 20 page, it says:
 21 "The Directors are still able to exercise
 22 discretion where deemed appropriate. For example in
 23 a case where an applicant's records show the extent of
 24 their injuries were such that a transfusion would
 25 definitely have been needed although this was not

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specifically mentioned in the existing notes. The same applies where records confirm the diagnosis of a disease for which the treatment would have involved the use of blood products without them being specifically mentioned. Other examples might include the case of an elderly applicant who appears to have been infected long ago and the records cannot be traced but the clinician has no doubts of the source of their infection and has written a strong letter of support."

Now, I am going to come back to the question of medical records and burden of proof, and so on, Mr Fish, but whilst we are looking at this document, why in the first example given is the word "definitely" there, bearing in mind you were applying or supposed to apply a balance of probabilities test rather than requiring something to be established definitely?

A. So in case of a one-off transfusion, I don't know the exact stats, but I think the chances of -- obviously, it varied depending on what year you received the transfusion -- I think it was something like 1 in 200 or 1 in 2000 chance of it being contaminated with hepatitis C. So, obviously, where we have definite records of a transfusion and the doctors confirmed no

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entirely sure whether that was their experience. But, yes, I absolutely stress that if their treatment happened a long time ago there was less chance that the records would exist still.

Q. Then the term used is:

"... the clinician has no doubts of the source of their infection and has written a strong letter of support."

Again, in the context of a scheme that was supposed to assess applications on the basis of what was probable, can you assist with why the terminology of "no doubts" or "strong letter of support" is in there?

A. That is the same reason as one-off transfusion. Obviously, many thousands of people had transfusions and didn't contract hepatitis C. So one of the minimum requirements was evidence of a transfusion to be able to assess the balance.

SIR BRIAN LANGSTAFF: I don't really understand that. I don't understand that answer. Earlier, when you were asked about why a transfusion would definitely have been needed, what you told me was the risk of being infected with hepatitis through a transfusion, and weren't, I think, dealing with precisely why the evidence needed to be definite that there had been

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other risks factors, then we assume on balance that was the probable source of infection.

Q. How would you as administrator or your directors, who at this stage were not medically qualified clinicians or did not include any medically qualified clinicians, how would you judge whether this was a case in which the extent of an individual's injuries were such that a transfusion would definitely have been needed?

A. In terms of injuries, we might need to have consulted a doctor via Elizabeth Boyd. For certain conditions it was easier. For instance, if somebody had been diagnosed with leukaemia we would know that would have always required treatment with blood or blood products but, in terms of injuries -- I am not sure there were all that many of these cases but yes, we would have referred them to medical specialists via Elizabeth, if our own research wasn't conclusive.

Q. The last example given refers to, as an example, a case of an elderly applicant who appears to have been infected long ago. The clinician has no doubt as to the source of infection and has written a strong letter of support. What would be the relevance in this context of an applicant's age?

A. I guess it suggests that their treatment (*unclear: audio distortion*) it is a lot longer ago. I am not

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a transfusion. If the evidence is probably a transfusion, why wouldn't that have been enough.

A. Yes. Just because I mentioned about the statistics of having a one-off transfusion. Obviously, the vast majority of one-off transfusions didn't result in hepatitis C infection.

SIR BRIAN LANGSTAFF: That's obviously right but that doesn't exclude the possibility that it might have done. If you have someone who has got hepatitis C and for whom there is no other more obvious, more likely cause that they had it from that other cause, then you are left with the transfusion, aren't you?

A. Yes, but that's the way we were asked to administer the scheme. We needed evidence of a transfusion and the doctor to confirm no other risk factors, so that's what we'd -- that's how we'd been asked to administer the scheme.

SIR BRIAN LANGSTAFF: I think what counsel was asking you was not whether you needed evidence of transfusion. Of course you did, but it is the "definitely", a transfusion definitely had been needed. That was the point that you were being asked to address, but I will leave it there and let counsel continue. Yes.

MS RICHARDS: I want to look at a document the following year also on the subject of records. So it is

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ABMU0000013. We can see this is a letter. It's from you to Dr Hay in his capacity as Chair of the UKHCDO, 28 November 2008.

And you say -- you refer to correspondence with Dr Makris about:

"... the Skipton Fund's request for supporting documentation to be supplied for all applications to the scheme."

We can see from the second paragraph Dr Makris has invited you to write to Dr Hay explaining the position. Then you say this:

"The alteration to the scheme came about when it was discovered that the previous scheme administrator, Mr Keith Foster, fraudulently completed a number of application forms and misappropriated a large sum of money from the Skipton Fund. As a consequence, the Department of Health sent the NHS Counter Fraud and Security Management Service to review the scheme's administrative procedures. The counter fraud measures that were suggested actually went beyond the ones that were finally settled upon by the Skipton Fund directors as they felt that they were impractical.

"However, for all applications, it is now a requirement that we receive medical records to

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any more or don't recall the treatment, would inevitably have their application rejected. Is that correct?

A. We did still receive applications with medical records that didn't explicitly mention a transfusion. But, yes, the form did say, "Have you seen records of a transfusion?" And they had to circle "yes" or "no", and then we did request a copy of those records. So that was the design of the form that I inherited.

Q. Well, this, however, was the end of 2008, so this is no longer an inherited position. This is a change, is it not, which the letter suggests is a change at the instigation of the Counter Fraud and Security Management Service in response to Mr Foster's fraud?

A. No. So on the previous form, they did still have -- *(unclear: audio distortion)* the doctor had to say they'd seen such records. So if they were previously answering yes, that the records suggested a possible transfusion, presumably they would have sent those in instead of records showing a definite transfusion, and we did get very many applications where that was the case.

So I was essentially asking them to provide a copy of what they previously had to have seen -- said they had seen.

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confirm that the applicant received treatment with NHS blood or blood products prior to September 1991 (previously the doctor only had to state that they had seen such records, and this is one of the loopholes that Mr Foster exploited) and that they are currently hepatitis C positive or have undergone interferon-based treatment in an attempt to clear the virus. Part 4B regarding other risk factors must now be completed in all cases as well."

Now, this would appear to suggest in unequivocal terms that in every case it was necessary for there to be medical records confirming treatment with blood or blood products prior to September 1991.

Is that the policy and practice that the Skipton Fund by this time had adopted?

A. Yes. So where a doctor had answered "yes", they'd seen such records, we did now ask for a copy of those.

Q. This goes further than that, though, doesn't it, Mr Fish? It is not saying simply to the doctor, "Please supply us with such medical records as you have seen upon which your opinion is based." It says in terms that it's essential for all applications that there is confirmation from the records of receipt of treatment, which would suggest that an applicant who can't provide that, because their records either don't exist

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Q. I am going to come back to the question of records again in a little while, but just stepping back and looking at the changes overall that were instituted in response to Mr Foster's fraud, it is correct, isn't it, that fraud by an employee of the Skipton Fund resulted in more onerous requirements on innocent applicants in terms of what they had to produce as part of the application process?

A. Hopefully, it didn't make much difference. The doctor had to photocopy the records that they previously said they had seen. I would like to think it didn't cause any additional work for the applicant.

Q. We will perhaps look at that again when we look at the application process in a little more detail.

I want to come on to some other aspects of the application process, first of all. Can you -- actually, we will do this by reference to a document. Can we have SKIP0000031_248, please.

I am going to ask you to talk us through the application process, Mr Fish. We can see this is a document generated by the Skipton Fund. This particular one is a post-2011 reforms information sheet because it refers to the £50,000 payment.

But if we go to the second page, we can see it sets out there "How do I apply?" It refers to

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1 completing an online registration form or applying
 2 direct to the Skipton Fund. So that's the
 3 registration form.

4 Then paragraph (b) says that you'll then send
 5 out an application form. There is a small part of the
 6 form completed by the applicant. And then this goes
 7 on to explain that the rest of the form will be
 8 completed by the doctor. Is that correct?

9 **A.** Yes, that's right.

10 **Q.** If we go to the next page and just look -- it is about
 11 halfway down the page, a little bit further down, we
 12 see a question there:

13 "Can I see what the doctor has written about me
 14 on the application form?"

15 It says:

16 "You are entitled to see the answers your doctor
 17 has made to the questions in the application form. If
 18 you want this information, you should ask your
 19 doctor."

20 Is there any reason why the process was designed
 21 such that the applicant wouldn't automatically have
 22 a completed copy of their application form?

23 **A.** I'm not sure, but we certainly would send copies of
 24 forms to applicants on request, and any unsuccessful
 25 application may have their form returned to them, and

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1 in a separate pile to be discussed with a medical
 2 director or a director, or to be referred to a doctor
 3 by Elizabeth.

4 **Q.** If we could then look at NHBT0090738, please, Soumik.
 5 This is a document about appealing against a refusal
 6 decision.

7 Before I ask you about what's set out in the
 8 document, the Inquiry has seen refusal letters from
 9 you which refer to an ability to appeal and say, "I am
 10 enclosing further information about the appeal
 11 process."

12 Is this the information that would typically be
 13 provided to the unsuccessful applicant?

14 **A.** Yes. That's something the appeals panel put together
 15 fairly early on in their establishment. And then that
 16 was sent to unsuccessful applicants.

17 **Q.** Now, we can see here under the heading "Missing
 18 records" the panel guidance identifies as the most
 19 common reason for an initial refusal the absence of
 20 documented records either because there are records
 21 but they don't mention the transfusion or other
 22 exposure, or the records or lost or destroyed.

23 It then sets out various recommendations to the
 24 appellant to try and get whatever they can about
 25 hospital records, to ask their GP to look back through

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1 any time we wrote for more information, rightly, the
 2 ones that were approved, they wouldn't have seen the
 3 form unless they asked for a copy from us or their
 4 doctor.

5 **Q.** Can you just talk us through the process in a typical
 6 case.

7 On receipt of the application form which you'd
 8 receive typically directly from the clinician, what
 9 would you do?

10 **A.** So, first of all, we would have a look to see if
 11 there's any missing information, and if there was,
 12 we'd write back. And if it had been completed by,
 13 say, a GP or hepatologist and they said no, they
 14 hadn't seen any records, then we'd write to the
 15 applicant and ask them to check with a GP or their
 16 hepatologist or their haematologist or both.

17 So we would write back to gather further
 18 information if anything was missing. If everything
 19 was complete and it was one that could probably be
 20 approved, then I would put that to one side to be
 21 discussed and signed off by a director. If it was one
 22 that was, for instance, a natural clearer where it
 23 could be rejected without needing to be seen by
 24 a director, then I would put that rejection letter
 25 together. And any that were borderline, they would be

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1 GP notes, and if records are not available, to obtain
 2 and produce a letter to that effect from the hospital
 3 records department or your GP.

4 Why was that not already part of the process for
 5 the application at the first stage, so the application
 6 that was being considered by you and a director?

7 **A.** Yes. So if there were missing records, we would have
 8 written something very similar explaining where the
 9 (*inaudible*) or who the applicant should approach to
 10 try and obtain (*inaudible*) --

11 **MS RICHARDS:** Sir, we are now missing bits of Mr Fish's
 12 evidence. We have an audibility problem.

13 **SIR BRIAN LANGSTAFF:** We are. We've been having patchy
 14 sound. Shall we just take a short break and see if we
 15 can get it secured?

16 **MS RICHARDS:** I think we should because previously we have
 17 not missed any of Mr Fish's words, but we missed some
 18 there. It is obviously not Mr Fish's fault. There's
 19 obviously a problem with the technology.

20 **A.** Shall I try it again? Can you hear me now?

21 **MS RICHARDS:** We can. Shall I press on, sir?

22 **SIR BRIAN LANGSTAFF:** We'll go on. If the problem recurs,
 23 we will take a break and see if there are ways of
 24 sorting it. It may depend -- I don't know -- upon how
 25 close you are to the microphone at your end, but let's

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1 keep going and see how we manage it. Just give
2 Mr Fish a moment.

3 **A.** I have moved the microphone.

4 **SIR BRIAN LANGSTAFF:** Okay. Right.

5 **A.** So, yes, such advice we would have put in letters to
6 applicants. So if we received an application where
7 the completing doctor had said they didn't have access
8 to the records or they hadn't seen them, we would then
9 write similar advice in our letters to applicants. So
10 we would say, "This is what this doctor has said.
11 They have not seen or have not got access to any
12 supporting records. We suggest writing to your GP or
13 a previous GP that you may have been registered with,"
14 et cetera. So similar advice would have appeared in
15 individual letters to applicants.

16 **Q.** What we then see in paragraphs 5 to 7 is the appeal
17 panel saying -- inviting the applicant to provide
18 a personal statement giving in as much detail as they
19 can the operation, procedure, accident or illness
20 which led to the procedure, when it occurred, why in
21 their recollection the transfusion or other exposure
22 was needed or occurred.

23 Paragraph 6, any witnesses, get a statement from
24 them.

25 7, photographic evidence of the operation or

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1 and see if you agree or have any comment.

2 The applicant could provide this information at
3 the appeal stage and might succeed, but a consequence
4 of that might be that individuals who were in dire
5 financial straits had to wait longer to receive
6 payments for which they were ultimately found to be
7 eligible. Would you agree that that was a problematic
8 consequence?

9 **A.** Yes, it is possible.

10 **Q.** Secondly, people who may have been very ill,
11 experiencing debilitating symptoms, either of the
12 hepatitis C itself or of their treatment for it, had
13 to go through two processes in order to establish
14 eligibility rather than just one. Would you accept
15 that's again a problematic consequence of the way in
16 which the scheme was run?

17 **A.** Yes, I would.

18 **Q.** Thirdly, people who might otherwise have been able to
19 establish eligibility might give up, having received
20 an initial refusal, because they felt too ill to
21 appeal or felt that there was no point, and so they
22 may have never received a payment to which they would
23 otherwise have been entitled. Would you agree with
24 that as a problematic consequence as well?

25 **A.** Possibly, yes. That hopefully didn't happen in many

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1 injury scar.

2 Now, the design of the application form, as we
3 have seen from the earlier document we looked at,
4 didn't allow for this information to be provided, did
5 it? It was largely an application form completed by
6 the clinician.

7 **A.** Yes. Uh-huh.

8 **Q.** Why was there no provision in the application from the
9 outset for the kind of information we see set out in
10 paragraphs 5, 6 and 7 here to be provided?

11 **A.** So I wasn't involved in the design of the scheme or
12 the initial forms. By the time I was the
13 administrator it was three years later. So that would
14 have been the Department of Health, presumably their
15 decision. I am not quite sure but they set the scheme
16 up in this way that we were to look at the medical
17 evidence rather than personal statements.

18 **Q.** So it is your understanding that the way in which the
19 scheme was administered at the application stage,
20 pre-appeal, was determined by the Department of
21 Health?

22 **A.** Yes, that's my understanding.

23 **Q.** I want to suggest to you there are three possible
24 consequences of not providing for this kind of
25 information to be considered at the application stage,

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1 cases, but yes, I would agree it's possible.

2 **Q.** We can take that document down. Thank you. I might
3 need to come back to parts of it, but hopefully not.

4 How did you approach the assessment of balance
5 of probabilities, Mr Fish? You might have a case in
6 which there's clear documentary evidence of
7 a transfusion and there's clear evidence of the
8 individual being in the chronic stage of hepatitis C.
9 What would your approach be, assuming that it is
10 pre-September 1991 and other aspects of the
11 requirements are satisfied? What would your approach
12 be to those applications?

13 **A.** Yes. Such application, as long as the doctor had also
14 confirmed there were no more significant risk factors,
15 then that would be -- sounds like a straightforward
16 approval.

17 **Q.** So what about cases in which -- again, I am asking at
18 a general level here -- I am going to look with you at
19 specific examples of categories of refusal like drug
20 use, and so on -- but, as a matter of generality, when
21 you had a more difficult or complicated case, because
22 there wasn't a straightforward documentary
23 confirmation of the transfusion or receipt of blood
24 products, how would you go about assessing probable
25 cause?

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1 A. Yes. So we would gather as much information as we
2 could from the doctor about the circumstances -- from
3 the records about the circumstances that led to the
4 need for the transfusion and then I would discuss that
5 with one of the medical directors. In advance of the
6 meeting with them, I would write down the key points
7 as I saw them, as a lay person, and then we would go
8 through the application together and discuss whether
9 or not we had enough to say that the transfusion was
10 probable.

11 Q. The application form would, presumably in such cases,
12 already contain a statement from the clinician
13 completing the form that they considered it probable
14 that the individual had been infected through exposure
15 to blood or blood products prior to September 1991 and
16 that they didn't consider that there were other
17 factors which had caused the hepatitis C. Why was
18 that not enough?

19 A. Quite often that was enough. It was just the case of
20 whether or not we agreed with what the doctors had
21 written, basically the evidence that we had been
22 provided with.

23 Q. What does that answer actually mean in practice,
24 Mr Fish? You haven't got records in this hypothetical
25 cohort of cases I am putting to you. So you haven't

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1 A. If we had been told by the Department of Health that's
2 how we were to look at applications, we could quite
3 easily have done that.

4 Q. So it is your understanding of what the Department of
5 Health required of the scheme that it wasn't enough
6 simply to accept the views of the clinician completing
7 the form; is that right?

8 A. Yes, not without evidence from the medical records.

9 Q. Can we then look at a document at SKIP0000030_045?
10 I am not quite sure why we have got -- thank you. So
11 this is a document, it is a two-page document. It is
12 not dated but it is "The Skipton Fund, Guidance on
13 assessing an application for the £20,000 payment".
14 Can you recall what the genesis of this guidance was,
15 who produced it?

16 A. The first time I saw it was when you made it available
17 to me as part of this Inquiry. I hadn't seen this
18 before.

19 Q. So it is not guidance that you were applying as
20 a document when you took decisions?

21 A. No. I have not seen this before.

22 Q. Can I just ask you whether some of the things that are
23 set out here reflect the way in which you approached
24 applications, even though you had not seen the
25 document itself? So if we look at the top of the

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1 got the nice straightforward "Here is a record of
2 transfusion or record of a receipt of a particular
3 type of blood product", but you have a doctor who may
4 have a long knowledge of the patient saying that in
5 their view, based upon their understanding of what had
6 happened to the patient, they think it is probable
7 that that individual was infected through a blood
8 transfusion and they don't think there are any other
9 risk factors. Would not a straightforward application
10 of the balance of probabilities have just meant,
11 unless you had any particular strong reason to think
12 that the clinician was wrong, you could just approve
13 the application?

14 A. We are asked to look at the evidence supplied by the
15 doctors, by the Department of Health. So we needed to
16 see a copy of the evidence ourselves.

17 Q. But if that evidence was lacking through no fault of
18 the patients, because the records have been destroyed
19 or because such notes as there were didn't record
20 transfusion in the course of operation, or something
21 along those lines, again, why couldn't you just accept
22 the opinion of the treating clinician, who was
23 probably better placed to assess the cause of the
24 individual's hepatitis than you and a non-medically
25 qualified director would be?

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1 page, it says:
2 "Evidence is defined as --
3 "information ... on an application form;
4 "authentic documentation (eg from any NHS
5 establishment, the National Blood Service, et cetera);
6 "opinion, confirmation or signed authority from
7 a practising clinician; or
8 "attestation by an authorising signatory that
9 the claimant has no history of intravenous drug
10 misuse."

11 This doesn't appear to contemplate as evidence,
12 for example, a personal statement from an applicant or
13 a statement from an applicant's relatives or other
14 witnesses, does it?

15 A. No. Exactly.

16 Q. Was the information that we see listed here as
17 evidence in practice the only type of evidence that
18 you looked at?

19 A. Yes. We were looking for evidence from NHS
20 establishments or the service.

21 Q. If we then go down to the bottom of the page, and I am
22 just going to take as an example what we see in
23 Section Three of this document, which is said to be
24 for non-haemophiliacs, there's a question:
25 "Is there any evidence to suggest that the

52

1 claimant's infection occurred because of exposure to
 2 NHS blood or blood products before September 1991?"
 3 If the answer to that is no, then reject the
 4 application; if the answer is yes, then continue to
 5 the section.
 6 Then we go over the page. We look at the top
 7 two questions:
 8 "Is there evidence that a particular incident or
 9 course of treatment with any NHS blood product was
 10 responsible for the claimant's infection?"
 11 "Yes. Continue with this section."
 12 "No. Reject application."
 13 Now, that would seem to suggest that the
 14 applicant had to produce evidence of a particular
 15 incident or course of treatment. Although you didn't
 16 use this document, was that in practice your approach?
 17 A. No. So there was another document that you made
 18 available to me where they were suggesting we would
 19 have had to have gone -- where someone had a blood
 20 transfusion, we would have had to have gone back and
 21 asked about the batch number and then the person who
 22 donated the blood, whether or not they were
 23 hepatitis C positive. So, at one point, it looks as
 24 if that level of detail was being considered by the
 25 Department of Health, but no, in practice, we didn't

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1 seen it until yesterday.
 2 Q. We can take that down. Thank you. In terms of the
 3 application process, was any assistance available to
 4 applicants, practical assistance, to help them
 5 complete their application form?
 6 A. All they had to do was provide their name and address
 7 and signature on page 2. So their doctor would have
 8 assisted with anything else, presumably, but most of
 9 the application was done by their doctor. But, yes,
 10 we could offer advice to the questions about what they
 11 needed to do, and we did frequently.
 12 Q. If we go to SKIP0000030_017, please, minutes of
 13 a Skipton Fund directors' meeting, 1st August 2007 and
 14 you are there. If we go to the bottom half of the
 15 page, you will see under the heading "Matters
 16 Arising", the second paragraph is headed "New
 17 Application Form". Then there is a reference to there
 18 having been further amendments requested by the
 19 Scottish Executive. Are you able to assist with what
 20 amendments had been requested by the Scottish
 21 Executive?
 22 A. As far as I recall, that was all to do third party
 23 transmission. So there were specific requirements for
 24 if somebody who had received a payment themselves
 25 infected someone else. I think they added in some

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1 need it to be a specific blood transfusion that we
 2 wanted linked to the hep C. It just had to have been
 3 treatment with blood or blood products prior to
 4 September 1991. So if there were two incidents, we
 5 didn't need to establish which of the transfusions was
 6 more likely.
 7 Q. Then the next question is this:
 8 "Is there evidence that a source of infection
 9 other than NHS blood or blood products could be
 10 responsible for the claimant's infection?"
 11 Then if the answer to that is "Yes", "Reject
 12 application".
 13 Was that as a matter of practice the approach
 14 that you took?
 15 A. No. So if there was, for instance, a risk factor of
 16 a transfusion in another country as well as in
 17 England, we wouldn't exclude them from the scheme on
 18 that basis. Tattoos, we didn't tend to consider
 19 a greater risk factor than a one-off transfusion. So
 20 no, that's not ...
 21 Q. Are you able to assist us at all then with what the
 22 purpose or role or use was of this document?
 23 A. I am not sure if this was something that was under
 24 consideration or was supposed to have formed the basis
 25 of how we assessed applications. Like I say, I hadn't

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1 additional conditions around that, cohabiting and
 2 something. I can't remember the specifics now, but
 3 I believe it was all to do with that, third party
 4 infections.
 5 Q. We can take that down. Thank you, Soumik.
 6 Was it ever part of the application and
 7 decision-making process for applicants to have to sign
 8 some kind of undertaking or waiver that they wouldn't
 9 sue the government or the NHS in respect of their
 10 infection?
 11 A. No, definitely not for Skipton.
 12 Q. In terms of the Appeal Panel, there was a delay in its
 13 establishment so its first meeting was not held until
 14 early October 2006. Do you know why that delay
 15 occurred?
 16 A. No. The Panel was set up by the Department of Health.
 17 I am not sure why.
 18 Q. Was it correct as a matter of fact, though, that meant
 19 there was effectively a backlog between July 2004 and
 20 October 2006? There would be no means of appeals
 21 being determined?
 22 A. Yes. Definitely. There was about 90 cases, I think.
 23 Q. You have told us what you did in your capacity as the
 24 Panel secretariat. Did you actually make
 25 recommendations to the Panel at all?

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1 A. No. Just copied the file.
 2 Q. There were no oral hearings held by the Panel. Do you
 3 have any understanding as to why that was the case?
 4 A. No. I'm not sure whose decision that was.
 5 Q. Then if we could go, please, to INQY000045, please.
 6 This is a report put together by the Inquiry, Mr Fish,
 7 that you have been provided with a copy of. If we
 8 could go, please, to page 11, in paragraph 42 you will
 9 see there the Inquiry's analysis:
 10 "The Skipton Fund Appeal Panel overturned 49.6%
 11 of the Skipton Fund decisions."
 12 Obviously that's decisions where there was
 13 an appeal. That's a fairly high proportion of
 14 decisions that are being set aside by the Appeal
 15 Panel, and we can see if we trace through the minutes
 16 and annual reports there is reference to numbers of
 17 cases being successful from time to time being
 18 discussed at directors' meetings. Was there ever any
 19 consideration as to why so many appeals were
 20 succeeding?
 21 A. Yes, I think we were aware it must have been to do
 22 with the additional information that they requested.
 23 The Department of Health had access to these stats as
 24 well, but they didn't think to change the scheme, so
 25 ...

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1 that the Appeal Panel were reaching decisions by
 2 exercising judgment where the Skipton Fund could not."
 3 Could you assist us with "exercising judgment
 4 where the Skipton Fund could not"? Is that
 5 a reference to having more and different types of
 6 information available to them?
 7 A. As well as a legally qualified chair, a hepatologist,
 8 a haematologist and a GP, we didn't have that as part
 9 of our make-up.
 10 Q. We can take that down. What did you as administrator,
 11 or the directors as directors, of the Skipton Fund do
 12 in practice to learn from the Appeal Panel
 13 decision-making?
 14 A. So after their decisions had been reached I would
 15 review the applications and find out which ones had
 16 been approved and which ones hadn't.
 17 Q. Did it ever occur to you or to your knowledge to any
 18 of the directors to go back to the Department of
 19 Health and say "Look, the Appeal Panel is allowing
 20 applications because it is looking at a wider range of
 21 information than we are looking at at the first stage,
 22 can we change the design of the process so that we can
 23 look at that information at the first stage as well?"
 24 A. It is quite possibly something that was discussed at
 25 the meetings that we held with them, but I can't

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1 Q. If we go to SKIP0000030_027, please. We looked at
 2 this in the context of the absence of a media budget
 3 earlier this morning. If we go to the second page --
 4 sorry, I should say for the transcript it is minutes
 5 of a meeting of a Board of Directors,
 6 5th October 2006, second half of the page, under the
 7 heading "Appeal Panel", we can see reference there to
 8 the first meeting of the Panel having taken place on
 9 3rd October. Then it refers to the number of cases
 10 being reviewed. Then it says:
 11 "Peter Stevens ... reviewed the Panel's
 12 decisions ... and asked NF [that's you] to seek
 13 clarification of how the panel reached their decision
 14 on two particular cases."
 15 Now, I am not expecting you to remember two
 16 individual cases, Mr Fish, but can you recall why you
 17 were being asked to seek clarification about the
 18 Panel's decision-making process at all?
 19 A. No, not specifically, but it must have been to
 20 ascertain how they came to their decision to help us
 21 potentially with the way we considered similar cases.
 22 But, no, I can't remember the specifics,
 23 unfortunately.
 24 Q. Then it continues:
 25 "Overall he [that's Mr Stevens] was satisfied

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1 remember specifically those discussions but I am sure
 2 it was mentioned. As I said a bit earlier, they were
 3 aware of the Appeals Panel's statistics of approvals
 4 and declines. I used to provide those on a monthly
 5 basis as well. So yes, they were aware.
 6 Q. Would you agree it would have been a good idea to
 7 reform the scheme so that you and the directors could
 8 look at the wider range of information from the
 9 outset?
 10 A. Yes, it would have been helpful. That's why we did
 11 get medical directors in the end.
 12 Q. Can we then look at -- I am just going to check the
 13 reference, Mr Fish -- NHBT0090394_001, and if we go to
 14 the next page, we can see that at the top of the page
 15 is an e-mail from you dated 31st May 2007. Is that
 16 an e-mail addressed to some of the members of the
 17 Appeal Panel?
 18 A. Yes, that's the five members at the time.
 19 Q. It says:
 20 "Please see below the response I received from
 21 the Chairman of the Skipton Fund regarding John's
 22 question of assessing applications on the balance of
 23 probabilities."
 24 Then you refer to a document and reference the
 25 document having been amended to satisfy the Scottish

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1 Executive.

2 If we look below, I think we see what is

3 presumably the chairman's response to you. It refers

4 in the first paragraph to the agency agreement

5 referring to balance of probabilities. There is then

6 a reference in the second paragraph to the guidance

7 notes for the application form.

8 Third paragraph he says:

9 "I have not kept all my drafts so cannot show at

10 what stage 'balance of probabilities' raised its head

11 ..."

12 Then in the next paragraph, he says this:

13 "There are some quite detailed early notes dated

14 2 October 2003, written by Martin (a Skipton Fund

15 Director) ..."

16 That was Mr Harvey, I think, is that right? He

17 was a director of the Skipton Fund?

18 **A.** Yes.

19 **Q.** "... in which the following phrase occurs: 'This

20 authorisation would confirm that the HCV infection was

21 acquired (either definitely or in all probability)

22 through NHS treatment with contaminated blood

23 products, whole blood or through tissue transfer'."

24 Then he goes on to refer in the next paragraph

25 to there being:

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1 Now, it might be said that that's imposing

2 a higher threshold than just more likely than not,

3 which is what the balance of probabilities is usually

4 understood to refer to. Do you have any observation

5 in relation to that?

6 **A.** So in this case definitely in a small percentage of

7 cases we had a look back letter that the patient had

8 received from the NHS informing them that the batch of

9 blood they had received was infected with hepatitis C.

10 So that was one of the cases that is would be

11 definite. Also people who receive factor concentrate,

12 we now know there was a 100% chance they would have

13 been exposed to hepatitis C. So they would be the

14 definite cases. Then the all probability cases, he

15 must be referring to one-off transfusions, where it

16 wasn't known that batch was infected with hepatitis C

17 but, on the balance of probabilities, it should be

18 deemed it was the source.

19 **Q.** Do you understand there to be any difference between

20 "in all probability" and "balance of probabilities",

21 or did you not apply your mind to that at the time?

22 **A.** I didn't think that was significant. I took it to

23 mean the same.

24 **MS RICHARDS:** Sir, I am going to come on to --

25 **SIR BRIAN LANGSTAFF:** I think, if I may comment, as

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1 "... some aspects of ... processing ... that

2 have developed through experience of tricky cases."

3 Then he says, he concludes that:

4 "... the 'balance of probabilities' emerged

5 during 2003/2004 as our thinking about operational

6 issues developed; it would have been shared with, and

7 accepted by, the officials ..."

8 But he says he can't recall anything further in

9 relation to that.

10 Can I ask you, first of all, what the context

11 for this enquiry was? It appears there was some

12 concern or difficulty in understanding how balance of

13 probabilities should be applied; is that correct?

14 **A.** Yes. I think the Appeal Panel wanted to know what we

15 had been told by the Department of Health about how to

16 assess applications. So I think they wanted the

17 background of how the scheme came about and how we

18 were asked to consider claims.

19 **Q.** We can obviously ask Professor Mildred about that

20 later this week but, if we just look at the third

21 paragraph on the screen, the reference to the phrase

22 used by Martin Harvey, we see there in brackets the

23 terms:

24 "... (either definitely or in all probability)

25 ..."

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1 a matter of language it is not simply saying

2 "probably" or "on balance of probabilities". The word

3 "all" may simply be an expression which people do use

4 in ordinary conversation but it is a word of

5 emphasis --

6 **A.** I accept that.

7 **SIR BRIAN LANGSTAFF:** -- and I think if you look -- you

8 didn't read it this way, I am sure, but it does seem

9 to me to suggest or hint at, at any rate, a higher

10 standard than just "probable". You can't help with

11 anything other than how you saw things and did things.

12 As a matter of expression, that's my current view, for

13 what it is worth.

14 **A.** No. I would agree that it should have said "on

15 balance of probabilities" or "is probable".

16 **MS RICHARDS:** Sir, I note the time. Mr Fish has obviously

17 been giving evidence since 10.00. If we take a break,

18 that would enable those who wish to observe the

19 minute's silence at 12 o'clock to do so.

20 **SIR BRIAN LANGSTAFF:** We will do so and come back at

21 12.05. So a break now until 12.05.

22 **MS RICHARDS:** Thank you, sir.

23 (11.35 am)

24 (Short break)

25 (12.05 pm)

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1 **SIR BRIAN LANGSTAFF:** Yes.

2 **MS RICHARDS:** Mr Fish, I am going to ask you about some of

3 the kinds of reasons application would not succeed

4 next and I am going to ask you first about the

5 approach taken to the applications based upon receipt

6 of anti-D immunoglobulin.

7 So if we could have SKIP0000031_071. This is

8 a letter written to your predecessor, Mr Foster,

9 February 2005. I think you had been employed by the

10 Skipton Fund for only two or three months at this

11 stage. It is from Dr Patricia Hewitt, at the National

12 Blood Service, and it sets out various matters

13 relating to anti-D immunoglobulin. Now, I am not

14 going to go through the detail of the report. We have

15 seen a further report obtained from her in 2010. Can

16 you assist us with this: what was your understanding

17 of the report and to what extent did you rely upon it

18 when you were considering applications.

19 **A.** So it was my understanding that anti-D was used when

20 I think there was a difference in a particular part of

21 the blood group of mother and baby -- it was quite

22 commonly given during pregnancy and child birth and

23 this report that we had been provided with confirmed

24 in our view that it was not a possible source of

25 hepatitis C, unless it was a specific, exceptional

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1 root of transmission was said to be receipt of anti-D

2 immunoglobulin?

3 **A.** No, not as far as I recall. We didn't have all that

4 many anti-D applications but I don't recall previewing

5 one, no.

6 **Q.** If an applicant had received gamma globulin rather

7 than anti-D immunoglobulin, was there any particular

8 policy or approach in assessing the risk of hepatitis

9 transmission in relation to such a product that you

10 can recall?

11 **A.** That's quite technical. So, at the time, I would have

12 known more about the differences or similarities but,

13 unfortunately, now I can't recall.

14 **Q.** Was a copy of Dr Hewitt's letter provided usually to

15 applicants whose applications had been objected so

16 they could understand the basis for that and if they

17 wanted to challenge it?

18 **A.** No. I think our letter said that we had been informed

19 by the National Blood Service that anti-D wasn't

20 a risk factor for hepatitis C. I don't think as

21 a matter of course we provided a copy of that letter.

22 **Q.** Do you think it might have been good idea to do so, at

23 least in the interests of transparency, so the

24 individual could understand the reasons why their

25 application had not succeeded?

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1 circumstance where it was a different type of product

2 that was given intravenously.

3 **Q.** If you had an application from someone whose

4 application was based upon receipt of anti-D

5 immunoglobulin, did the application essentially

6 automatically get refused or were steps taken to

7 investigate the individual circumstances of the

8 applicant and what product she had specifically

9 received?

10 **A.** So, yes, normally it would be something mentioned in

11 the medical records. From that it would be seen

12 whether or not it was one of those exceptional

13 circumstances or if it was a sort of routine anti-D

14 injection. If there wasn't information to that

15 effect, we would obviously ask for the records that

16 mentioned the anti-D.

17 **Q.** Was it, as far as you can recall, usually possible to

18 determine, on the basis of typical medical records,

19 which anti-D product an individual had received?

20 **A.** Yes, as far as I recall. It would have been obvious

21 if there was something unusual about the way it is

22 mentioned, anti-D. I believe that was only used

23 incredibly rarely on a named-patient basis for quite

24 a different purpose.

25 **Q.** Do you recall ever approving an application where the

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1 **A.** Possibly. It is quite a technical letter. It is

2 quite difficult to understand some of it but, I mean,

3 if someone requested further information, we happily

4 would have provided it. Yes, I guess we would have

5 had to have sought the permission of Dr Hewitt as

6 well. So, yes, we could have paraphrased but I am not

7 sure we could have just shared that letter. Yes, we

8 could and did provide further information on request.

9 **Q.** Dr Hewitt was, I think, appointed to the Appeal Panel

10 in October 2006; is that right?

11 **A.** Yes, she was one of the original members.

12 **Q.** Maybe this may be more a question for

13 Professor Mildred or indeed in due course Dr Hewitt,

14 but were you ever concerned that effectively she'd be

15 assessing the value of her own expert opinion if she

16 was considering appeals in anti-D immunoglobulin

17 cases?

18 **A.** I think maybe the Panel shared that view and they

19 sought literature review from Bioproducts

20 Laboratories. So they got an independent person to

21 provide their view as well. I'm not sure if that was

22 because of the conflict that you mentioned but that is

23 something they did.

24 **Q.** We can take that up perhaps with Professor Mildred

25 later this week.

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1 Now, intravenous drug use. If we go to
2 SKIP0000031_221, that's your letter. This is a letter
3 written by you to Dr Ramsay, Health Protection Agency,
4 asking for an opinion about use of IV drugs as
5 an alternative cause of infection to blood
6 transfusion. Do we correctly understand from this
7 that this was something the Appeal Panel was seeking
8 rather than something you and the directors had
9 decided to obtain yourselves?

10 A. Yes, that's right.

11 Q. If we then go to the report which is SKIP0000031_217,
12 this is the report that you received. If we go to the
13 conclusions, perhaps, on page 4, we can see in the
14 "Summary" Dr Ramsay says:

15 "Overall, the risk of hepatitis C infection with
16 short time injecting in the UK is poorly documented
17 and is likely to have varied geographically and over
18 time. Although data on one-off casual injectors is
19 absent, evidence from many countries supports the
20 belief that the risk of acquiring hepatitis C in the
21 early period of injecting is high. The estimated
22 probability of transmission from single episodes of
23 needle and syringe sharing also appears to be
24 substantially higher than the risks associated with
25 a single transfusion of unscreened blood. On

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1 a history of intravenous drug use, this would be
2 considered a more probable transmission route for
3 hepatitis C infection than treatment with an NHS blood
4 transfusion. So is this right, that was the guidance
5 or instruction you were given at an early stage of
6 your employment with the Skipton Fund?

7 A. Yes, for one-off transfusions.

8 Q. Did --

9 SIR BRIAN LANGSTAFF: May I just ask you this? The risk
10 of transmission of hepatitis C comes with the risk of
11 blood being transferred, does it not?

12 A. Yes, blood to blood.

13 SIR BRIAN LANGSTAFF: So if a needle is the source of the
14 entry of the blood into the body, it has first to be
15 used on someone else?

16 A. Yes, but not just a needle. The paraphernalia, the
17 spoons and the associated equipment can have traces of
18 the blood as well. I believe that's documented.

19 SIR BRIAN LANGSTAFF: I see. So the source may be from
20 blood which is on a spoon, heating the drug?

21 A. Potentially, yes. Yes. So it would have had to have
22 been blood from someone who had hepatitis C but, yes,
23 it could have been on the needle or any of the
24 associated equipment. But, obviously, if everything
25 was sterile and clean, then there'd be no risk.

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1 an individual basis, it will be difficult to assess
2 the risks associated with single episodes of injecting
3 where sharing is denied, but recent studies suggest
4 that the incidence of hepatitis C in injectors who
5 deny sharing is around half of that observed in those
6 who do report such behaviour."

7 What was your understanding of the significance
8 of Dr Ramsay's report for your decision-making
9 processes?

10 A. I believe it backs up what I had been taught when
11 I first started with the Skipton Fund, that the risks
12 from intravenous drug use were far higher than one-off
13 transfusion. Obviously different blood products, for
14 instance I mentioned clotting factor earlier, we know
15 that is 100% chance of that being infected with
16 hepatitis C, so if someone had received clotting
17 factor and had a history of intravenous drug use, they
18 still would have been approved, but for one-off
19 transfusions we believed this just backed up our view
20 that it was much more likely that the intravenous drug
21 use would have been the source of infection.

22 Q. You said in your witness statement -- I don't think we
23 need to put it on screen, it is your second statement,
24 I think -- that during your training period you were
25 told that for any application where there was

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1 SIR BRIAN LANGSTAFF: So if someone says honestly in their
2 application form "Yes, I have used intravenous drugs
3 on one occasion, I had a fresh needle", that would be
4 more likely to give them hepatitis than an injection,
5 would it?

6 A. Yes. It is obviously difficult to assess, but I am
7 not sure if people who inject intravenous drugs for
8 the first time do so on their own with sterile
9 equipment but if there was somehow proof that that was
10 the case, then it couldn't be considered a risk
11 factor.

12 SIR BRIAN LANGSTAFF: There are quite a lot of assumptions
13 involved in this conclusion, would you agree?

14 A. I don't recall anyone or any doctor saying the person
15 had used intravenous drugs on one occasion on their
16 own with clean equipment and brand new equipment.
17 I don't think we ever assessed such an application.

18 SIR BRIAN LANGSTAFF: The reason I ask is that yesterday
19 I was reading a statement from someone, who remains
20 anonymous, who said, "I used drugs once, I used it on
21 my own and I used a fresh needle; I was rejected by
22 Skipton". That's what they said. Now, that's why
23 I am asking you these questions.

24 A. Yes. I don't recall an application where that was
25 something we had to decide upon.

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

2 **MS RICHARDS:** To what extent when deciding applications

3 did you place reliance upon Dr Ramsay's report?

4 **A.** So it did back up what we had as our view already, so

5 I wouldn't say we relied upon it because we had

6 already been making decisions on the same basis but,

7 yes, it was certainly something we could refer to and

8 make available to applicants or appellants on request.

9 **Q.** If we just go to SKIP0000048_332, this is an e-mail

10 from Professor Mildred to you, 2nd April 2007. If we

11 just look at the second paragraph:

12 "Will the Fund now use the Ramsay report when

13 dealing with applications involving [intravenous drug

14 use]? The Panel thinks it is important for

15 consistency that it should."

16 Can you recall whether in light of this e-mail

17 setting out the panel's view it became your practice

18 to expressly rely upon the Ramsay report in decision

19 letters?

20 **A.** Yes, we certainly changed our wording of the decision

21 letters. I think it said "The Skipton Fund has

22 an expert report setting out the risk factors". So

23 yes, we did amend our letters accordingly.

24 **Q.** Is this right: you didn't provide a copy of the expert

25 report, at least not unless it was expressly requested

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1 **Q.** Presumably that incidence of hepatitis C and injectors

2 who deny sharing is explained by that being

3 an inaccurate denial of sharing, because if the person

4 had not, as a matter of fact shared, they couldn't

5 contract hepatitis C from drug use, could they?

6 **A.** I mentioned about the paraphernalia. So it could well

7 be that what they said -- this was part of a study,

8 not something we did, obviously. But, yes, perhaps

9 they honestly said that they didn't share needles, not

10 knowing that there was a risk associated with sharing

11 other equipment.

12 **Q.** Did you ever consider the significance of the dates of

13 transfusion compared with dates at which the

14 intravenous drug use took place to ascertain if

15 a person had been transfused before --

16 **A.** Yes, it's certainly something -- we did look out for

17 that.

18 **Q.** Did that make any difference to the success or

19 otherwise of applications?

20 **A.** It would have done if there was a positive hep C

21 result before the incident of sharing needles or IV

22 drug use. I can't remember every specific thing.

23 That may have happened in one or two.

24 **Q.** In the absence of a case of the kind you just

25 described, so where there is a positive hepatitis C

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1 by the applicant?

2 **A.** Yes. I'd like to think we sent that out with every --

3 I mean, there weren't all that many IV drug *(unclear:*

4 *audio distortion)* -- I think we sent it out, but we

5 certainly did send it on request. It wasn't

6 classified or a secret report. We could share it and

7 did share it.

8 **Q.** Dr Ramsay's report -- I don't think we need to go back

9 to it, but she talks about risk being poorly

10 documented. She talks about geographical variations

11 in relation to risks and says it is difficult to

12 assess risks associated with single episodes of

13 injecting where sharing is denied.

14 Did you understand Dr Ramsay's report as

15 excluding IVDU, intravenous drug use -- excluding

16 transfusion in any case of intravenous drug use, or

17 did you understand it to be more nuanced and requiring

18 individual assessment?

19 **A.** I think in that paragraph you showed me, it did say

20 that even if there was a denial of sharing needles or

21 equipment, there was still half the risk of people who

22 admitted to sharing the equipment, which would still

23 be a much greater risk than a one-off transfusion.

24 So, yes, in my view, it did exclude even a single

25 episode of intravenous drug use.

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1 result before any evidence of intravenous drug use,

2 did you ever, as far as you can recall, approve

3 an application in which there was evidence of

4 intravenous drug use?

5 **A.** Not that I recall. I don't think so.

6 **Q.** Would it be right to say that very much as reflected

7 in what you've told us your training was that there

8 was an effective blanket policy to regard intravenous

9 drug use as the more likely cause in all cases?

10 **A.** Yes, unless the person had a look-back letter or had

11 received factor concentrate where we know that that

12 was the source. Sorry. Not just Factor VIII; any

13 factor.

14 **Q.** If an application was received from someone who had

15 had, they said, some very limited exposure to

16 intravenous drugs but had had repeated transfusions --

17 so leave aside factor concentrates because you have

18 told us what the position would be in relation to

19 that -- would the policy still have been to reject the

20 application without further investigation?

21 **A.** No. We would have perhaps found out more information

22 if that was the case, *(unclear)* the transfusions, for

23 instance.

24 **Q.** You can't recall, and I appreciate you won't

25 necessarily recall all individual cases, Mr Fish --

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1 I don't want this to be an unfair question at all.
 2 You can't recall allowing any applications in which
 3 there was intravenous drug use as a potential
 4 contributing cause?
 5 **A.** No. I guess because IV drug use was quite rare, as
 6 were conditions requiring multiple blood transfusions,
 7 so I don't remember the two coinciding.
 8 **Q.** When the case of someone whose application was being
 9 rejected on the basis of intravenous drug use, when
 10 you wrote to them to tell them the position, were they
 11 given the same information about the possibility of
 12 making an appeal, or were they told that an appeal was
 13 also likely to be unsuccessful because the panel would
 14 place the same reliance on the Ramsay report as the
 15 fund did?
 16 **A.** Yes. We didn't tell them the likelihood of success,
 17 but we certainly informed them that they had the right
 18 to appeal.
 19 **Q.** What was the approach, if this ever arose, in relation
 20 to non-intravenous drug use; for example, intranasal
 21 routes of administration of drugs?
 22 **A.** It is a bit more difficult because there wasn't as
 23 much information about the prevalence of hepatitis C
 24 amongst cocaine use, but there is -- for instance,
 25 even on the Hep C Trust website, you can see that it

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1 **A.** No. That was something established by the time
 2 I started.
 3 **Q.** Was the test for determining whether someone had
 4 cleared hepatitis C in a six-month acute stage
 5 determined on the balance of probabilities?
 6 **A.** Yes. So we relied on the doctor to say whether or not
 7 they had evidence of chronic infection. So, yes, it
 8 was still -- the balance of probabilities was applied
 9 to that.
 10 **Q.** How straightforward or easy was it to consider the
 11 applications from people who might fall into that
 12 category and make a decision?
 13 **A.** So the majority of applications would have just said
 14 the doctor said there is no evidence they are PCR
 15 positive, but there is evidence of antibodies. And
 16 the next question was: is there any evidence of
 17 chronic infection before naturally clearing it? So
 18 they would have said yes or no to that.
 19 So the majority of cases would have just been
 20 a straightforward section -- I think it was two.
 21 They've had just said yes, they have had antibodies
 22 which shows previous exposure, and then "no" to the
 23 next three questions. So, yes, those were
 24 straightforward to consider.
 25 **Q.** Mr Stevens in his witness statement to the Inquiry

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1 does say that sharing straws when snorting cocaine,
 2 because of the delicate blood vessels in the nose,
 3 there is a chance, if you are sharing a straw with
 4 someone who's got hepatitis C, there is a chance of
 5 infection through that route.
 6 **Q.** Did you have such cases which were rejected for those
 7 reasons?
 8 **A.** I think one. I can recall one that was rejected.
 9 There may have been more, but I do remember one,
 10 certainly.
 11 **Q.** Did you have any understanding as to whether this
 12 approach to IV drug use and the policy that you've
 13 described being taught in your training period, did
 14 you have any understanding as to whether that was
 15 dictated or determined by the Department of Health, or
 16 was that Skipton's own assessment of the evidence?
 17 **A.** I'm not sure. Some of the documents you made
 18 available about when they were discussed in the
 19 application process -- I think it was mentioned there,
 20 wasn't it -- so I think it is something the Department
 21 of Health no doubt had an opinion or guidance on.
 22 **Q.** I'm going to move to ask you next about another cohort
 23 of cases, natural clearers, if I can call them that.
 24 Were you ever involved in any discussions about
 25 the exclusion of natural clearers from the scheme?

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1 referred to the approach of Elizabeth Boyd and
 2 suggested her approach was not to approve stage 1
 3 applications for people who were shown as having being
 4 hepatitis C positive after the acute phase but not
 5 currently hepatitis C positive as shown by a PCR test
 6 because that was the approach that the Royal Free,
 7 where she had worked, took to deciding whether to
 8 validate applications or not.
 9 Do you have any recollection of Ms Boyd's
 10 approach in that regard?
 11 **A.** No, I don't. I mean, a lot of these -- because
 12 I think my predecessor had to one side the
 13 applications where the answer was "yes" to antibodies,
 14 "no" to PCR positive, and then "yes" to evidence of
 15 chronic infection beyond the acute phase, so they were
 16 all put to one side.
 17 I think there was back and forth discussions
 18 with the Department of Health, and then a lot of those
 19 in bulk were dealt with while I was still the scheme
 20 assistant. But, no, I didn't remember Elizabeth
 21 dealing with them particularly differently.
 22 **Q.** Could we next go to NHBT0090734_001. So this is in
 23 relation to cases where third party infections, sexual
 24 transmission cases. It is a note from you dated
 25 November 2006. You say:

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1 "I have reviewed all of the sexual transmission
2 third party infection cases that I was able to locate
3 from our files, and it would seem that we began
4 requesting genotypes from both parties as a matter of
5 course in early 2006. The reason for this has been
6 covered in one of the e-mails from the Chairman
7 included in the case papers -- 'The directors of
8 Skipton have a job to do, which includes the proper
9 management of a scheme that was not fully defined when
10 it was started up. The requirement for genotyping
11 applies to a tiny number of cases and is a detail that
12 those drawing up the scheme and its operating
13 procedures did not, and probably could not, have been
14 expected to foresee'. Before this time, I found
15 a couple of cases where the genotypes were included on
16 the application form but the doctor had provided the
17 information without us requesting it. In most other
18 early cases, it would seem that no request for
19 genotypes was made."

20 The first question, Mr Fish, is: the passage
21 sets out in italics from the Chair refers to the
22 proper management of a scheme that was not fully
23 designed when it was started up. Do you understand
24 what he meant by that?

25 A. Yes. I think he meant that things such as genotypes

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1 involving haemophilia.

2 If we then go to your response, so we go to the
3 third page, bottom of the page, so this is your
4 response. You say:

5 "The criterion is that a payment can be made to
6 somebody 'who before September 1991, was treated with
7 NHS blood, blood products or tissue' ..."

8 Et cetera, et cetera. And then you say:

9 "So the treatment needn't have been in an NHS
10 clinic but the blood products must have been from the
11 NHS."

12 If we go up the page, Professor Mildred says in
13 response:

14 "We needed clarity on the question whether the
15 concentrate had to be NHS made as well as delivered."

16 Then if we go to the second page before I ask
17 a question, bottom half of the page is an e-mail from
18 Dr Hewitt to you and to Professor Mildred:

19 "We can agree that anyone treated with clotting
20 factor concentrates (whether NHS or commercial) would
21 have a close to 100% probability of hepatitis C
22 infection, and the majority would have had chronic
23 infection ..."

24 Et cetera, et cetera.

25 It would appear from this that as late as

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1 to help back up a third party claim hadn't been
2 considered or thought of. It must be referring to
3 that sort of oversight.

4 Q. Why was it you -- had you been asked by the Chair or
5 the directors to review all sexual transmission third
6 party infection cases, and if so, why?

7 A. Yes. So I think it was Elizabeth who wanted us to ask
8 for genotypes to just help back up the third party
9 claims. So, yes, it must have been something that the
10 Board asked me to review.

11 Q. Could we next go to NHBT0091224_007. These are some
12 e-mail communications between you and, first of all,
13 Dr Hewitt and Professor Mildred and then to Mr Stevens
14 and Ms Boyd.

15 So if we pick it up on the third page, bottom
16 half of the page -- actually, I think we should go to
17 the fourth page to put it in context.

18 There is an e-mail from Mark, that's Mark
19 Mildred, to you, August 2011, asking this question:

20 "The haemophilia cases have made us think again
21 about the scheme. Is the proper criterion simply
22 treatment with blood or blood products in NHS clinics,
23 or must that treatment also be with NHS blood or blood
24 products?"

25 Then there is a specific question about cases

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1 August 2011, which is a number of years after the
2 scheme had been set up and been operating, there
3 seemed to be some doubt, at least in the Chair of the
4 Appeal Panel's mind, as to whether the scheme was
5 limited to products made by the NHS or not.

6 Can you assist us with why -- which would have
7 excluded then those infected through the use of
8 commercial concentration -- commercially produced
9 concentrates. Can you assist us with how this issue
10 came to arise in 2011?

11 A. It may have been -- obviously, we considered thousands
12 of applications. They only considered a few hundred.
13 Perhaps an occurrence hadn't -- because they didn't
14 actually consider many haemophilia applications, if
15 any, because most of them were approved by the
16 Skipton Fund itself. So maybe it wasn't an issue that
17 had cropped up from the Appeal Panel before.

18 But from our point of view, if commercial factor
19 was purchased by the NHS, that becomes an NHS product.
20 It didn't have to be manufactured by the NHS.

21 Q. It may be we can pick that up again with
22 Professor Mildred, but if we go to the first --

23 SIR BRIAN LANGSTAFF: There is also, I think, an ambiguity
24 in the phrase which Mr Fish quoted. "NHS blood",
25 that's obviously NHS blood, "blood products", et

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1 cetera.
 2 So the question is whether the NHS also
 3 qualifies the blood products?
 4 **A.** Yes. Any products --
 5 **SIR BRIAN LANGSTAFF:** It is one of these linguistic,
 6 grammatical questions. It is ambiguous on that basis.
 7 **A.** So, yes, any blood or blood products that were
 8 administered by the NHS we would have considered as
 9 qualified.
 10 **SIR BRIAN LANGSTAFF:** That's a different question. If the
 11 question of whether NHS, meaning origin or NHS
 12 production, that's one thing; NHS administered, that's
 13 another, but "NHS blood, blood products", that could
 14 mean -- I don't think it is likely, but it could mean
 15 broad products which are not NHS.
 16 **A.** Yes, could be, but I am not sure what they would --
 17 *(over-speaking)* --
 18 **SIR BRIAN LANGSTAFF:** Anyway, it's, I think, a rather
 19 esoteric dispute.
 20 **MS RICHARDS:** Yes. It is just rather curious that it had
 21 arisen in 2011.
 22 Can I ask you to look at the first page and
 23 assist with what you meant in your e-mail to
 24 Mr Stevens and Ms Boyd. You refer to the e-mail
 25 exchange, and then you say in the second paragraph:

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1 those claims where the person died so long ago there
 2 were just no records available.
 3 **Q.** Thank you. That may assist in understanding why the
 4 issues were arising there. Thank you.
 5 **A.** Yes. It was about those pre-'03 cases I think.
 6 **Q.** Then the next category of cases I wanted to ask you
 7 about is cases that turned on the September 1991
 8 cut-off date. Was this your understanding, that as
 9 far as the Skipton Fund was concerned, there was no
 10 flexibility to that date because the agency agreement
 11 essentially pinned eligibility to pre-September 1991
 12 infection.
 13 **A.** Yes. That was the *(unclear)* date that we had to use
 14 with no flexibility.
 15 **Q.** Then if we could go to SKIP0000030_009, so these are
 16 the minutes of the Board of Directors, February 2014.
 17 If we go to page 4, please, if you look at the
 18 paragraph that bears the number 168 next to it, so it
 19 is towards the top of the page:
 20 "Exclusion of applicants who have already been
 21 compensated for their HCV infection through the NHS.
 22 "The Scheme Administrator reported that the DH
 23 had indicated in a recent telephone call that it was
 24 their intention to exclude people from the scheme who
 25 had already received compensation for hepatitis C

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1 "If we are all in agreement, it would seem that
 2 we can start to approve applications where
 3 an individual was known to have been treated with
 4 clotting factor concentrates before screening began
 5 and where there are no records which suggest that they
 6 might have been one of the minority who naturally
 7 cleared HCV without experiencing a period of chronic
 8 infection."
 9 Can you assist us with what you mean there by
 10 "starting to approve applications" because, again,
 11 it --
 12 **A.** Sorry. I think this is referring to people who died
 13 before 29 August 2003 who were originally excluded
 14 from the scheme. So I was essentially saying that
 15 they were put to one side until this was clarified.
 16 I think this was in 2011 when the changes occurred to
 17 the scheme.
 18 We were saying that if there was -- the
 19 haemophilia centre had them on their database as
 20 someone who had received clot clotting factor, we are
 21 saying that they would have been exposed to
 22 hepatitis C, even if we didn't have explicit records
 23 showing that they received a particular batch
 24 *(inaudible)* -- if they were on that database, we know
 25 that they would have done. So it helps us to assess

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1 infection through litigation. At the moment it was
 2 unclear if this would be limited to future applicants
 3 being asked to confirm that they had not already been
 4 compensated, or include existing applicants who were
 5 receiving regular payments."
 6 Then it refers to you having submitted some
 7 draft wording on the application form and guidance
 8 notes to the Department of Health and Department of
 9 Health lawyers now considering it.
 10 Can you recall how that issue was resolved,
 11 Mr Fish?
 12 **A.** Yes. We certainly didn't look at applications and ask
 13 if they had received compensation. So it must have
 14 been dropped by the Department of Health but I don't
 15 ever remember them asking us to check if someone had
 16 been compensated.
 17 **Q.** I am going to come back now to the question of medical
 18 records and the approach when there were no medical
 19 records. If I can start by taking you to
 20 DHSC0004510_045, this is a letter from you dated 26th
 21 January 2006 to somebody in the blood policy group at
 22 the Department of Health. If we go to the third
 23 paragraph, we can see it says:
 24 "As the scheme guidelines set out by the
 25 Department of Health currently stand it is necessary

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for the clinicians completing application forms to have seen medical records which confirm blood or blood products were administered to their patient through the NHS prior to September 1991. As you are aware this is unfortunately not the case with Mr [X]'s application and the Fund therefore had no choice but to decline his application."

Now, this would suggest it was your understanding, at least in January 2006, that the existence of confirmatory medical records, at that point seen by the clinician rather than sent to you, but the existence of them was a necessary pre-requisite with the fund having no choice but to decline the application in the absence of such records; is that correct? Was that your understanding at the time?

A. Yes.

Q. Did that change?

A. Only I think that we didn't need the records to explicitly mention a blood transfusion. If there was good evidence that a blood transfusion would have been probable then we could still assess those. So I'm not sure if that's a difference. Yes, I guess that is a slight difference.

Q. If we go to ARCH0002318, this is the written material

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blood products the Directors of SFL exercise discretion where appropriate."

Then we have the three examples that we saw in that footnote to your annual report, Mr Fish, so where a transfusion would definitely have been needed or where there is a disease for which treatment would have involved the use of blood products, and then there is the example given of the elderly applicant and the clinician with no doubts of the source of infection and a strong letter of support. Then it says this at paragraph 8.3:

"If there are no records available and the treatment with blood products is simply in the applicant's memory then the application must be declined and referred to the Appeal Panel if the applicant so wishes."

Is that an accurate reflection of the approach which the fund took to applications where there were no medical records?

A. Yes. I think you mentioned that there was nowhere on the form for people to give their personal accounts. So that was a design at the outset of the scheme. So, no, we weren't able to make applications where someone had hepatitis C and they recall having a blood transfusion but that's the extent of the evidence.

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submitted to the Archer Inquiry on behalf of the Board of Directors of the Skipton Fund by Mr Stevens and Mr Harvey. If we go to the third page, we can see, bottom of the page, section 8:

"Level of evidence necessary to qualify for payment.

"SFL [Skipton Fund Limited] considers applications on the balance of probabilities where, firstly, there is evidence of an applicant receiving blood or blood products through the NHS prior to September 1991, but not necessarily identifying a batch of blood that was infected with HCV, and, secondly, there is an absence of other significant risk factors."

Now, that would appear to suggest that if there were other significant risk factors, that would be essentially -- exclude the application from succeeding; is that correct?

A. Yes, if it was a significant risk factor or significant enough that that was felt to have been the probable source of the infection.

Q. Then Mr Stevens and Mr Harvey come on to the question of records:

"In cases where there are no medical records which confirm the applicant was treated with blood or

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That was not something we were told we could approve.

Q. I want to look with you at a document I think you almost certainly wouldn't have seen at the time you worked for the Skipton Fund, but I hope has been sent to you in advance of your evidence. It is DHSC0014979_004. Now, you will see from this, Mr Fish, this is headed "HIV Blood and Tissue Transfer Scheme". It is a determination of the panel in two particular cases. It is the Inquiry's current understanding that this is effectively in relation to the scheme for those who were infected with HIV through blood or tissue and who would then, if accepted as eligible, would then be able to receive financial support from the Eileen Trust.

If we go to the next page and I want to ask you about the general approach which was taken and whether it was ever considered by the Skipton Fund. Various matters are set out in respect of an appellant diagnosed as HIV positive and his deceased wife who had also died of the AIDS virus. We can see in the first paragraph:

"... both claims having been rejected on the ground that blood transfusions given to the Deceased were not the cause of the infection."

If we go to the next page, please --

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1 A. Sorry, who was that rejected by, do you know? By the
2 Department of Health?

3 Q. It may have been rejected by the Department of Health
4 and then effectively allowed by the Panel. I think
5 that's right.

6 Then we can see paragraph 4 says there is
7 a suggestion of a transfusion of fresh frozen plasma,
8 no record in the hospital notes of any such
9 transfusion. Then we see the determinations set out
10 as follows:

11 "There are, it seems to us, only four
12 possibilities ..."

13 The four possible routes of transmission are set
14 out. Paragraph 6 then says:

15 "On the face of it, none of these four
16 possibilities is a likely one; indeed, on the
17 available evidence each is unlikely. We must
18 therefore consider the evidence and conclude which of
19 the four is the least unlikely."

20 Then that's precisely what the determination
21 then does, and the conclusion, if we go to page 7,
22 Soumik, paragraph 21, is:

23 "Balancing the unlikelihoods, we have therefore
24 concluded that the least unlikely, by some margin, is
25 an unrecorded transfusion of infected plasma in 1984."

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1 A. Yes, and I think we may have written to a hospital to
2 request records and we would have got a response
3 saying that they need the applicants to request them
4 in person -- not in person, personally. I don't think
5 we had the authority to request people's records.

6 Q. What was the Skipton Fund's approach to the costs
7 implications for applicants, many of whom may have
8 been living in poverty, in trying to obtain copies of
9 their medical records?

10 A. So, occasionally, we'd hear of or receive an invoice
11 from a GP. It was almost always a GP. I don't think
12 specialist doctors in hospitals ever sent such letters
13 but they would say there's a fee for the completion of
14 a form or for the records. So the Department of
15 Health's instructions were that we couldn't cover
16 those, but we did write back a letter explaining that
17 this is nothing like an insurance request form and
18 such fees should not be levied by the GPs or the
19 hospitals. Whether or not they listened to our advice
20 I am not sure but that's certainly what we told them:
21 they shouldn't be charging applicants.

22 Q. Can you recall if you ever approved an application,
23 leaving aside bleeding disorder cases, whether you
24 ever approved an application in the absence of medical
25 records confirming a transfusion?

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1 Now, I am not inviting you to comment obviously
2 on the individual case, about which you would have had
3 no direct knowledge at all, Mr Fish, but was this kind
4 of approach ever suggested by the Department of Health
5 to you or contemplated by you or the directors, where
6 there was a range of possible causes, examination of
7 which was the least unlikely?

8 A. No, that was never suggested to me.

9 Q. We can take that down, thank you. We have heard
10 again, just sticking briefly with the Eileen Trust,
11 some evidence that there was a caseworker at the
12 Eileen Trust who was able to assist applicants with
13 tracking down medical records. Did the Skipton Fund
14 ever offer such assistance to applicants?

15 A. We offered advice of who they should approach and how
16 to request the records but I am not sure we had that
17 level of -- so it was the caseworker that would meet
18 them or -- yes, I think the Eileen Trust at its
19 maximum had 100 beneficiaries. Obviously, at the
20 Skipton Fund we dealt with thousands of applications.
21 So that might be why the Department of Health set it
22 up slightly differently or very different.

23 Q. So the Skipton Fund would not itself take steps to
24 obtain records? It would expect either the applicant
25 or the clinician completing the form to provide them?

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1 A. Yes. Certainly once it didn't confirm a definition
2 transfusion but, yes, I don't think we approved any
3 where there was literally no medical records at all.
4 But, yes, there could have been or certainly were ones
5 that there were records that describe treatments and
6 injuries but didn't specifically mention blood. We
7 were aware that discharge summaries didn't always
8 routinely refer to blood transfusions. So, yes, we
9 did approve applications where it didn't explicitly
10 mention a blood transfusion.

11 Q. I know you have seen the report prepared by the
12 Inquiry, Mr Fish, which includes reference to the
13 numbers of cases declined on the basis of lack of
14 medical records or lack of other evidence and also
15 gives some case summaries. I am not going to go to
16 the details of any of them, but a theme which seems to
17 emerge from that is that it was fairly common for
18 applications to be rejected because of an absence of
19 medical records. Are you able to assist us in
20 understanding more about that?

21 A. Yes, it was probably about a quarter of applications.
22 About half are natural clearers. In fact, I noticed
23 in your numbers you might be missing three lever-arch
24 folders' worth of natural clearer rejections. The
25 solicitor should have those if you request them. They

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1 were stored in lever-arch folders instead of box
 2 files. So that was half of the declines were natural
 3 clearers, then about a half again, or maybe slightly
 4 more than half, were a lack of evidence of a probable
 5 transfusion and then the other quarter would have been
 6 other reasons: IV drug use, anti-D, et cetera.

7 **Q.** If we have a look at your witness statement, so if we
 8 go back to WITN4466002, please, and we go to page 14,
 9 we can see there you were asked questions about the
 10 extent to which the Skipton Fund sought medical advice
 11 and you refer in the bottom of the page to Elizabeth
 12 Boyd. I have asked you about that. You have referred
 13 to Professor Mutimer and I will come back to that when
 14 I ask you a handful of questions about stage 2
 15 payments, but if we go to the top of the next page,
 16 you then refer to the appointment of Professor Thomas
 17 and, picking it up about halfway down that paragraph,
 18 you say this:

19 "Rather than reject an application where the
 20 medical records didn't explicitly mention the use of
 21 blood or blood products, it was felt that it would be
 22 fairer that a medical director within the Fund
 23 consider what medical evidence was available so that
 24 they could make an informed judgment of whether they
 25 believed treatment with blood or blood products was

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1 hepatologists but would have arisen in the context of
 2 surgery, sometimes cancer treatment, childbirth and
 3 other medical interventions, including emergency
 4 medical interventions.

5 Did the fund ever consider having a panel of
 6 clinicians with a broader range of expertise that you
 7 could go to to say, you know, "In the course of
 8 orthopaedic surgery or ear, nose and throat surgery
 9 for this condition, is it plausible that a blood
 10 transfusion might have been given?"

11 **A.** Yes. I am not sure to what extent that was
 12 considered, but obviously their expertise does go
 13 beyond just hepatology, and I think on occasion they
 14 did seek the opinion from colleagues who were experts
 15 in other fields, but in terms of whether or not we
 16 ever considered getting any more medical directors
 17 in-house, I am not sure we ever formally did that.

18 **Q.** I come on then to ask you a handful of questions --
 19 I note the time. I was going to move to stage 2, but
 20 it is almost 1 o'clock. It might make more sense to
 21 do that after lunch, sir.

22 **SIR BRIAN LANGSTAFF:** Okay. We will take a break now then
 23 until 2 o'clock. The same rules apply that I
 24 mentioned this morning about talking to others about
 25 what you have been saying or what you think you might

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1 probable, ie more likely than not, and the application
 2 could proceed as such."

3 Then you refer to it being beneficial for
 4 Professor Thomas to have another medical director to
 5 discuss such cases because they were not always
 6 straightforward.

7 Is it an accurate inference from what you have
 8 set out in that paragraph that, prior to
 9 Professor Thomas' appointment in late 2012, early
 10 2013, there would have been or were a number of
 11 applications rejected by the Skipton Fund because they
 12 were not straightforward cases. There weren't medical
 13 records and there was a dearth of medical expertise to
 14 accommodate this?

15 **A.** Yes, although they would have presumably have been
 16 considered by a doctor via Elizabeth Boyd. Obviously
 17 I don't have access to the files now, so I can't say
 18 that's what happened in every case. It was
 19 essentially saying it was better to bring in the
 20 expertise in house.

21 **Q.** Now, Professor Thomas's area of expertise was
 22 hepatology and Professor Dusheiko, who was then
 23 appointed a little later, likewise, but the
 24 transfusions that many Skipton Fund applicants would
 25 have received would not have been administered by

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1 yet have to say. I look forward to seeing you back at
 2 2 o'clock.

3 **A.** Thank you.

4 **(12.59 pm)**

5 **(Luncheon adjournment)**

6 **(2.00 pm)**

7 **MS RICHARDS:** Mr Fish, I am going to ask you next about
 8 the process in terms of applications for stage 2
 9 payments. Could we look at CVHB0000009_118, please?
 10 So you will see from this, Mr Fish, this is guidance
 11 notes for those making an application. If we look
 12 about a third of the way down the page at the question
 13 "How do I know if I qualify for the additional
 14 payment?" it says this:

15 "In order to qualify, you must first have
 16 received the basic £20,000 payment from the Skipton
 17 Fund. Provided this is the case, you should then
 18 automatically qualify for the additional payment if
 19 ..."

20 There are three categories of case: liver
 21 transplant, waiting for a liver transplant, liver
 22 cancer. Then it says this:

23 "Alternatively, if you and your specialist
 24 doctor suspect or have confirmation that you have an
 25 advanced stage of liver damage called cirrhosis, you

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1 may also qualify."

2 What was your understanding of what was required

3 in terms of cirrhosis in order to qualify?

4 **A.** Evidence in whatever form that might be that cirrhosis

5 was probable, so various blood tests and later

6 Fibroscans, just anything that the clinician could

7 provide to assess whether or not cirrhosis was

8 probable rather than fibrosis.

9 **Q.** Can you assist us as to why these guidance notes say

10 that "the individual may also qualify", rather than

11 say "you will qualify if you have advanced stage of

12 liver cirrhosis"?

13 **A.** I didn't word that originally. It was my

14 understanding if they had cirrhosis, they would

15 definitely qualify.

16 **Q.** There wasn't an extra area of discussion?

17 **A.** Yes. Maybe it is just because it is not quite as

18 clear-cut a diagnosis as the other. Obviously, if you

19 either have or haven't had a liver transplant, you

20 either are or are not on the waiting list, and the

21 same with cancer: you either have or haven't been

22 diagnosed. Whereas with cirrhosis, because it is

23 a degree of fibrosis leading up to cirrhosis, I think

24 that's probably why it was worded that way.

25 **Q.** So is this right, your approach was provided you were

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1 "If your specialist is satisfied that test

2 results you have had in the past will be sufficient to

3 complete the application form, you will not need to

4 have any tests. If you have had a liver biopsy in the

5 past that confirms you have cirrhosis, that will be

6 sufficient, but the Skipton Fund does not require that

7 you have one."

8 Then there's further reference to potential

9 risks involved in liver biopsies. The next paragraph

10 says:

11 "... if information from a liver biopsy is not

12 available, the results of certain blood tests may be

13 sufficient."

14 This, I think, is pre-Fibroscans routine. Then

15 it is suggested that:

16 "You will need the results from more than one

17 set of tests ..."

18 I will come on to Fibroscans in a moment, but in

19 terms of blood tests what would satisfy the Skipton

20 Fund in terms of proof of probable cirrhosis?

21 **A.** It's been a number of years since I was dealing with

22 these applications but there were certain enzymes that

23 would be raised or were more likely to be raised if

24 you had cirrhosis and others that would be likely to

25 be low, amongst other things. So it was all to do

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1 satisfied that the applicant on the balance of

2 probabilities had cirrhosis, they would, assuming they

3 had qualified at the stage 1 basic payment stage, then

4 qualify for the additional payment?

5 **A.** Yes, definitely.

6 **Q.** If we look at the bottom of the page, we can see it

7 says:

8 "... how do I get the evidence ...?"

9 "A specialist doctor must provide evidence of

10 the extent of your liver disease if you are to qualify

11 for the additional payment. The specialist will be

12 asked to complete the application form on your behalf

13 by providing evidence based on tests or your medical

14 history."

15 Then if we go over the page, I don't think

16 I need to go through the detail of it, but under the

17 heading "The application form", it explains how that's

18 going to be completed by the doctor. Before I ask you

19 about one particular part of these notes, were

20 applications for stage 2 payments largely decide on

21 the basis of the clinician's opinions as set out in

22 the application form?

23 **A.** Yes, we did rely on their opinion a lot.

24 **Q.** Then if we go at the heading "The tests" and go

25 a little further down the page, it says:

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1 with the liver function tests and particular markers

2 within those. There was another section, two or

3 three, of the application form, there was a formula

4 that could be worked out using a blood test and if it

5 was above a certain number, based on these markers,

6 then we would accept that as evidence. You have

7 probably got a copy of the application form, so you

8 would be able to see that I mean.

9 **Q.** Prior to you having either Professor Thomas or

10 Professor Dusheiko to whom you could turn from 2013

11 onwards, was there anyone else with any specialist

12 knowledge of hepatology to whom you were able to turn

13 in order to seek advice in assessing stage 2

14 applications?

15 **A.** So similar to stage 1 it would have been via Elizabeth

16 Boyd and the Royal Free and liver specialists there.

17 **Q.** Before the widespread availability of Fibroscan

18 results how common was it that stage 1 registrants

19 couldn't demonstrate the criteria for stage 2 because

20 without a biopsy the extent of their liver damage

21 couldn't be determined?

22 **A.** Without access to the statistics I am not sure. We

23 certainly had some deferrals but I wouldn't be able to

24 say how frequently they were deferred, as opposed to

25 approved.

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1 Q. As and when Fibrosan technology became more
 2 widespread, was there any proactive effort on the part
 3 of the Fund to get back in contact with applicants
 4 whose stage 2 applications had not been allowed in
 5 order to encourage them to make a further application?
 6 A. Because they were only ever deferred, we said in the
 7 letter "if anything changes, if you have further
 8 tests, you are welcome to re-apply" and if they were
 9 deferred, presumably they would have been at
 10 an advanced stage of fibrosis, so they would have been
 11 in hopefully regular contact with their specialist.
 12 So if a Fibrosan was done as part of their treatment
 13 that showed progression to cirrhosis, they would have
 14 re-applied.
 15 Q. Is this right, and I don't mean this as a pejorative
 16 question, Mr Fish, but the Skipton Fund itself didn't
 17 take proactive steps to get back in contact with
 18 individuals and say "Now might be the time to
 19 reactivate your stage 2 application, because we know
 20 Fibrosans are being used". You made the assumption
 21 they would be under the care of a specialist who would
 22 be able to undertake those tests for them?
 23 A. I mean, it didn't mean they had access to Fibrosan.
 24 Obviously, it started in some hospitals and then
 25 became more widespread. So we might have been telling

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1 has cirrhosis. As the value increases, so does the
 2 likelihood of cirrhosis."
 3 Then he gives some specific data and then in the
 4 last sentence says:
 5 "If we are to use Fibrosan results, then the
 6 Skipton Fund would need to decide what likelihood
 7 ratio or positive predictive value would be sufficient
 8 to justify second payment."
 9 Did the Skipton Fund subsequently decide what
 10 likelihood ratio or positive predictive value would be
 11 sufficient?
 12 A. Yes. I actually had a lower score of 12.5. I am not
 13 sure now exactly how we got that, whether that was
 14 from different advice from a different doctor. But
 15 that wasn't a hard and fast 12.5 and above is "yes,
 16 12.5" and below is "no" but that was a marker we used
 17 and then we looked at everything else that was
 18 submitted in connection with the application, in
 19 conjunction with that Fibrosan score. So it wasn't
 20 a hard and fast cut-off that we used but over 12.5 is,
 21 sort of, in the realms where cirrhosis was probable.
 22 I seem to remember that was the number we used.
 23 Q. If we then go back to your witness statement, please,
 24 WITN4466002 and if we could go to page 16, please,
 25 Soumik, picking it up at the bottom of the page in

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1 people "You can now get a Fibrosan", whereas the
 2 reality was they couldn't.
 3 Q. If we could then look at SKIP0000076_013, please, we
 4 can see at the bottom of the page is an e-mail from
 5 you to Dr Mutimer. You say:
 6 "We are seeing an increasing number of 2nd stage
 7 applications where the test results on which the
 8 degree of liver damage is being based from
 9 a Fibrosan. As I understand it this is a fairly new
 10 test and is not available at every hospital.
 11 "In your opinion what is the minimum Fibrosan
 12 result which indicates that cirrhosis is present? Do
 13 you have any other information about Fibrosans which
 14 you think may be useful?"
 15 Then if we can go to the top of the page and see
 16 Dr Mutimer's response, he says:
 17 "I wish that there was an easy answer ...
 18 "Fibrosan is being used in a few places around
 19 the UK, but there is no real way to assess the quality
 20 of the results ..."
 21 Then he says:
 22 "... the results are fairly reproducible and it
 23 seems valid that people are using it to assess the
 24 amount of fibrosis in the liver ... it is hard to
 25 define an acceptable cut-off to identify which patient

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1 paragraph 31.4, you refer to a model being identified
 2 to ascertain likely dates of progression of disease.
 3 If we go to the next page, we pick it up about halfway
 4 down that long paragraph. It says:
 5 "With the help of Professor Thomas the Fund
 6 created a model using evidence from a medical study
 7 that estimated the speed of fibrotic progression in
 8 people with hepatitis C and the speed of progression
 9 in people co-infected with HIV and hepatitis C."
 10 Were the results of that fibrotic progression
 11 study used solely to consider applications that
 12 related to haemophiliacs with hepatitis C or were they
 13 used to consider applications of non-haemophiliacs as
 14 well?
 15 A. Yes. So in this case it was primarily people with
 16 haemophilia because, even though they passed away many
 17 years ago and there were no records available, we
 18 would have known from databases that they had
 19 haemophilia and received treatment over particular
 20 years, whereas with one-off blood transfusions we
 21 wouldn't have had that information. So yes, this was
 22 predominantly people who had haemophilia a bleeding
 23 disorder who passed away.
 24 Q. If we can next look at an exchange of correspondence
 25 you had with Dr Makris, SKIP0000031_103, please,

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1 Soumik. This is a letter to you from
 2 Professor Makris, November 2013 and he says:
 3 "I am writing to you for clarification about
 4 a policy decision."
 5 He refers to having recently submitted a form on
 6 behalf of one of our patients with a very high
 7 Fibroscan score and that being returned to him, asking
 8 for information about other causes for high Fibroscan
 9 measurements.
 10 Then if we go to the next paragraph:
 11 "In the past you have accepted that if the
 12 patient has hepatitis C and cirrhosis they were
 13 eligible for the payment, irrespective of their
 14 alcohol intake. Can you clarify whether the rules
 15 have changed? As far as I know, I have never provided
 16 information about alcohol intake and this has never
 17 been questioned previously."
 18 Then he poses the question in the next
 19 paragraph:
 20 "... I wonder how the question about whether the
 21 patient had diabetes was relevant? If the patient has
 22 chronic hepatitis C and was diabetic, would that have
 23 precluded them from payment?"
 24 Then before I ask you about this, if we just
 25 look at your reply, SKIP0000030_101. So you

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1 a basis for rejecting applications. Are you able to
 2 comment on that and explain why this information was
 3 being sought?
 4 A. Yes, it was nothing to do with the cause of cirrhosis.
 5 So, if somebody had developed cirrhosis having already
 6 reached stage 1 due to alcohol intake, they could
 7 still have been approved if there was evidence of
 8 cirrhosis. If the blood tests weren't suggestive of
 9 cirrhosis and the only piece of evidence we had was
 10 a raised Fibroscan, the reason to ask about alcohol
 11 was because that could cause inflammation in the liver
 12 which causes an increased Fibroscan score. So that
 13 was basically to weigh up what was causing the
 14 increase in the Fibroscan score where the blood tests
 15 weren't indicative of cirrhosis.
 16 Q. Then if we could look at one further letter on
 17 a similar topic, but a year later, from the
 18 Haemophilia Society, SKIP0000031_100. So this is
 19 a letter from Ms Carroll, the Chief Executive of the
 20 Haemophilia Society, to you. She is expressing
 21 a concern in the first paragraph about there being
 22 a significant difference in the number of people
 23 differed or rejected from the bleeding disorder
 24 community. Then she says in the second paragraph
 25 this:

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1 responded, this says 6th December 2012 but I suspect
 2 that might be an error and it should have been 2013,
 3 because if we look just up the page there is
 4 a handwritten note "e-mailed to Howard 5/12/13", and
 5 it seems to be responding to Professor Makris's
 6 letter. You say in the second paragraph:
 7 "The reason we ask such questions is not to
 8 ascertain whether outside influences have caused
 9 cirrhosis, as the scheme does not distinguish between
 10 cirrhosis caused by hepatitis C or, for instance,
 11 alcohol abuse, rather they are to ascertain whether or
 12 not the Fibroscan result was increased by other
 13 factors rather than cirrhosis."

14 Then you go on in the next paragraph to refer,
 15 I think, to a request that Professor Thomas had asked
 16 you to raise this issue because someone with fibrosis
 17 or fat deposits in the liver might have a Fibroscan
 18 reading within the cirrhotic range, and there is the
 19 reference to 12.5, even though they do not have
 20 cirrhosis.

21 Now, some Core Participants have asked me to ask
 22 you about this in particular because you will
 23 appreciate there is a concern that the Skipton Fund
 24 may have been looking for other potential causes of
 25 liver damage, such as alcohol intake or obesity, as

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1 "You say, for example, that someone with a high
 2 BMI or alcohol intake can have their application
 3 deferred if their platelets and other tests are
 4 normal, even if their Fibroscan score is higher than
 5 normal. However within our community if someone has
 6 received contaminated blood, has haemophilia and lives
 7 their life in fairly constant pain and with a major
 8 disability due to joint damage from their haemophilia,
 9 it wouldn't be unusual for them to have a high BMI and
 10 possibly due to pain, isolation and the fact that they
 11 have lost large numbers of friends to contaminated
 12 blood, they may also drink larger amounts of alcohol
 13 than those without a bleeding disorder. How is this
 14 taken into account and weighed in your decision making
 15 process? This should not exclude them from receiving
 16 payment. If there is any possibility they have
 17 cirrhosis we believe they should be accepted for stage
 18 two payment, using the balance of probability, rather
 19 than the beyond doubt principle."

20 Can you recall, first of all, how this issue
 21 arose that was being raised by the Haemophilia
 22 Society?

23 A. So it looks as if it was to do with Fibroscan and us
 24 asking about if there is anything else affecting the
 25 Fibroscan score, but, like I say, if somebody drank

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1 excessive amounts of alcohol and had a high BMI but
 2 there was evidence of cirrhosis, we would approve the
 3 application. They weren't excluded for having a high
 4 BMI and drinking alcohol, certainly not. We weighed
 5 up all of the information we had available and, as you
 6 said, used the balance of probabilities, that sort of
 7 thing.

8 **Q.** If we then, moving to a different topic, but still on
 9 stage 2 applications --

10 **A.** Sorry. Can I just mention on the next paragraph about
 11 the statistics, where she says "every one of the
 12 contaminated blood population will have had their
 13 infection for ... 30 years". Obviously the stats
 14 would have been skewed by people who cleared the virus
 15 with interferon. So what she is saying is if the
 16 person had not cleared with interferon, then that may
 17 have been the progression rate, but this statistic --
 18 or X% who had cleared with interferon treatment.

19 **Q.** I think we might have missed a few words then. I just
 20 want to check I have understood what you are saying.
 21 If we look at the next paragraph, she is expressing
 22 concern that only 18% of applicants, presumably from
 23 the bleeding disorder community, are accepted as
 24 having cirrhosis, which would suggest 82% rejected.
 25 Are you able to assist with understanding that figure?

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1 **A.** Yes. It sounds as if ones that would normally have
 2 been deferred due to the blood test results before
 3 Fibroscan was available, we were then getting ones
 4 where the blood test results would have suggested
 5 deferral but the Fibroscan results were suggesting
 6 possible cirrhosis. So if Fibroscan hadn't existed
 7 they would have been deferred on the blood tests
 8 results and the other tests available on the form. So
 9 I think it was to raise that issue.

10 **Q.** Do you recall now how the Department of Health
 11 responded?

12 **A.** We certainly added Fibroscan onto the form. So
 13 I think they accepted we should be taking everything
 14 available to us into account.

15 **Q.** Then if we could look at SKIP000030_085, please,
 16 these are the minutes of a meeting of the Skipton Fund
 17 Directors, 11th March 2013, with you in attendance.
 18 If we go to the second page, please, we can see at the
 19 bottom of page the issue there is:
 20 "Stage 2 applications from the estates of people
 21 who were co-infected ... who died before
 22 29 August 2003 and whose records have been destroyed."
 23 Then if we go to the next page, there's
 24 reference to discussion from the Panel, I think that's
 25 the Appeal Panel, and a suggestion by Dr Mutimer.

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1 **A.** Yes. I think 18% have been accepted but that doesn't
 2 take into account those who hadn't applied because
 3 they cleared hepatitis C and their liver damage was
 4 not progressing at the same rate as she indicated
 5 above. So it assumes everyone still has chronic
 6 hepatitis C. It doesn't take into account the
 7 clearers either.

8 **Q.** Can we then look at SKIP000030_013? These are the
 9 minutes of a meeting of Skipton Board of Directors,
 10 17th February 2011, at which you are present, and if
 11 we look at the bottom half of the page, last
 12 paragraph, it says:
 13 "The Board agreed that the Scheme Administrator
 14 and the Chairman should raise the issue of borderline
 15 stage two applications at their meeting with the
 16 Department of Health ... on Friday 18 February."
 17 Then there is reference to the anticipated
 18 increase in stage 2 payments to £50,000 and the
 19 regular annual payment and the suggestion that's going
 20 to result in a surge of applications, many of which
 21 would be borderline, and then a reference to referring
 22 to Fibroscan on the application form.

23 What was it you were proposing to raise with the
 24 Department of Health, can you recall? Why were they
 25 being asked about borderline applications at all?

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1 Then the next paragraph refers to the model of
 2 fibrotic progression created by Professor Thomas which
 3 I asked you about a few moments ago then it says this:
 4 "The Scheme Administrator summarised the model,
 5 the values and dates that had been used ... and the
 6 reasons why these figures had been used. Around 40
 7 declined applications from the estates of co-infected
 8 people would need reviewing on the basis of this
 9 model. The Scheme Administrator confirmed that the
 10 Department, who were satisfied with the model, had
 11 asked that the review be deferred until the start of
 12 the upcoming financial year."

13 Do you know why the Department was requesting
 14 that you defer reviewing the 40 or so declined
 15 applications?

16 **A.** It must have been to do with their budgets. I hadn't
 17 remembered that but, yes, it must have been to do with
 18 their budgets.

19 **Q.** That could potentially lead to a delay in individuals
 20 or their families receiving the payment if the
 21 application upon review was successful.

22 Do you recall you or the Chair or anyone else
 23 expressing concern that people's payments should not
 24 be delayed?

25 **A.** I'm sure we did. I can't remember those meetings,

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1 though. Sorry, what was the date of these minutes?
 2 **Q.** The date of this is 11 March 2013.
 3 **A.** Okay. So it was only -- I mean, it's maybe not
 4 acceptable. It was only three weeks until the next
 5 financial year, but that's still three weeks, isn't
 6 it? But, yes, I am sure we would have mentioned it.
 7 **Q.** Do you know whether, once the new financial year
 8 started, whether that review was undertaken swiftly?
 9 **A.** Yes. It is quite possible we started the review
 10 straightaway and didn't communicate responses until
 11 1 April. But, yes, we wouldn't have used that to stop
 12 us from reviewing the applications.
 13 **Q.** Do you recall the Department of Health ever expressing
 14 a concern that increasing the payment to £50,000 might
 15 encourage people not to accept treatment because there
 16 would be a substantial financial incentive to allow
 17 their condition to worsen?
 18 **A.** That's probably something they considered internally,
 19 but it is not something that -- we weren't party to.
 20 **Q.** Prior to the widespread availability of Fibroskans,
 21 are you confident that it was never necessary for
 22 an applicant to provide biopsy evidence in order to
 23 succeed in a stage 2 application?
 24 **A.** Yes, we definitely never asked someone to have
 25 a biopsy.

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1 **A.** I think medical records. We could have accepted
 2 medical records that suggested it was a contributing
 3 cause of death.
 4 **Q.** Can you recall whether you looked for an actual
 5 reference to hepatitis C on the death certificate, or
 6 liver cancer, or liver disease?
 7 **A.** All of those plus many others, but I can't recall the
 8 specific list. It is quite long. There are lots of
 9 things I hadn't heard of before.
 10 **Q.** We can take that down. Thank you, Soumik.
 11 **A.** Yes, certainly all the terms you just mentioned would
 12 be evidence.
 13 **Q.** In terms of the regular payments that commenced, was
 14 any choice given to applicants about how frequently
 15 they could receive their payments: monthly,
 16 quarterly --
 17 **A.** Yes, quarterly or monthly. We gave that option.
 18 **Q.** Was it ever part of the services or facilities offered
 19 by the Skipton Fund to make available financial advice
 20 for applicants on how to use their money?
 21 **A.** Not by the Skipton Fund. I think it was something
 22 that Caxton offered. Caxton Foundation.
 23 **Q.** If we then look, please, at DHSC0004063_002, please,
 24 Soumik. If we could go to the second page, we can see
 25 this is an e-mail from an individual to Ailsa Wight at

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1 **Q.** If we could then go back to your witness statement,
 2 please, so WITN4466002. And if we can go to page 18.
 3 If we look at paragraph 33.2, towards the bottom of
 4 the page, this is about bereavement payments, Mr Fish.
 5 You talk about how:
 6 "A few years later the DHSC introduced regular
 7 payments (at a lesser level than the stage 2 regular
 8 payments) for living applicants who'd qualified for a
 9 stage 1 payment and a bereavement payment of £10,000
 10 for the partners of deceased applicants where
 11 hepatitis C had been a contributing cause of death."
 12 Was the question of whether hepatitis C had been
 13 a contributing cause of death a balance of
 14 probabilities test, as far as you can recall?
 15 **A.** Yes, essentially, and I think with the help of the
 16 Department of Health, they came up with quite good
 17 guidance about what we needed to look out for on the
 18 death certificate, which would have enabled us to make
 19 the payment. And then if we came across a death
 20 certificate that had a term that hadn't been mentioned
 21 that we weren't sure of, we would run that by the
 22 Department of Health for clarification.
 23 **Q.** If you didn't have evidence on a death certificate,
 24 what other evidence, if any, was capable of satisfying
 25 you that the bereavement payment should be made?

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1 the Department of Health, 17 April 2013.
 2 It refers to having been infected with hepatitis
 3 C and having cirrhosis of the liver and having had
 4 a liver transplant. It refers to receiving stage 1
 5 and stage 2 payments.
 6 If we go to the next page, the applicant says
 7 this:
 8 "Last Friday, I received a phone call from the
 9 Skipton Fund to let me know that I was entitled to
 10 a further lump sum payment of £25,000. I later
 11 discovered through the SF website that I was also
 12 entitled to a flat-rate regular payment of £14,000 per
 13 annum and that these payments have been available
 14 since 2011. I phoned the Skipton Fund to confirm the
 15 availability of this regular payment and to enquire
 16 about backdating to 2011. I spoke to Nick Fish,
 17 scheme administrator, who told me that he was unable
 18 to backdate the payment and that I would need to apply
 19 to the Department of Health for any backdating."
 20 The next paragraph also says that you told this
 21 individual he couldn't backdate the payment as over
 22 two years had elapsed since the original announcement.
 23 So that's what you are recorded as saying. If
 24 we then go to the first page of this document, I just
 25 want to show you the reply before asking you about it.

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1 So bottom of the page. So the response from Ailsa
2 Wight starts here. If we go to the top of the next
3 page, she says this:
4 "With regard to your request for backdating,
5 this is not automatic, but the Skipton Fund is
6 responsible for assessing such requests as they arise
7 and making a decision about whether to backdate. We
8 have spoken with the fund, and they will let you know
9 of their decision shortly."

10 This appears to suggest that you're saying it
11 was for the Department of Health to make decisions on
12 backdating. The Department of Health are saying it's
13 for the Skipton Fund to make decisions on backdating.
14 What was the policy and practice in relation to
15 backdating?

16 **A.** So, yes, it definitely was their decision at first.
17 I think I was quite surprised by this letter. But
18 following receipt of this letter, we happily backdated
19 everyone, which we felt was fairer in any case, and we
20 backdated everyone who was due backdated payments.

21 **Q.** So does it follow that prior to this individual
22 raising the issue with Dr Wight, with Ailsa Wight, at
23 the Department of Health in April 2013, you, as in the
24 Skipton Fund, wouldn't have been backdating any
25 payments because you understood that to be something,

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1 or capital. You will be aware that capital and income
2 paid through the fund does not impact on means-tested
3 benefits paid through DWP. It was recognised that in
4 the majority of cases, investigations start because of
5 data matching carried out between Government
6 departments, and there is no way that matches relating
7 to beneficiaries can be separated out. We agreed
8 that, between our organisations, we will do all we can
9 to minimise the risk of beneficiaries being called to
10 a fraud investigation interview. Internal processes
11 are being created to make this happen. If you are
12 called to such an interview, please feel free to quote
13 or show this letter. The investigator will then know
14 what action to take."

15 What can you recall about the background or
16 events that led to you having this meeting with the
17 Department for Work and Pensions?

18 **A.** Yes. So we were hearing of people who were being
19 interviewed under caution and being investigated for
20 fraud because they had received payments from the
21 Skipton Fund which should have been disregarded when
22 they were assessed for means-tested benefits.
23 Obviously this is unacceptable. So even though we
24 didn't have much in our power we could do to prevent
25 the DWP from investigating these cases, obviously we

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1 as it were, in the gift of the department, rather than
2 for you to be able to do?

3 **A.** I think that two years might have been significant.
4 So we certainly were backdating when the changes to
5 the scheme were made. It obviously took us a while to
6 find some of the people. There must have been some
7 sort of cut-off date where we were told we can no
8 longer backdate, and then following this letter, we
9 did backdate everyone again.

10 So as far as I am aware, there was no-one that
11 we ever didn't backdate. If it was our choice, we
12 would obviously happily backdate, and that's the right
13 thing to do.

14 **Q.** I want to ask you now about a separate and discrete
15 topic. If we go to WITN4466004, please. This is
16 a joint letter from you and from Dave White, head of
17 the Department for Work and Pensions Fraud
18 Investigation Service. It is not dated, but it refers
19 to a meeting that you had had in August 2011. So it
20 is presumably produced at some point after that.

21 The second paragraph says:

22 "The Skipton Fund wanted to establish whether
23 beneficiaries of the fund could be excluded from such
24 fraud investigations [so DWP fraud investigations] as
25 a result of their apparent non-declaration of income

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1 wanted it to stop, so we raised the issue with the DWP
2 and said, "What can you do to stop this from
3 happening? Because obviously it is not right that
4 people are put through that."

5 **Q.** It seems to have been the DWP's position that in terms
6 of what was referred to as data matching, there was no
7 way that matches relating to beneficiaries could be
8 separated out.

9 Can you assist us with what that refers to, data
10 matching carried out between Government departments?

11 **A.** I think, although I don't work and never have worked
12 for the DWP, I think they had ways of seeing income or
13 at least interest on income that people were
14 receiving, and if that didn't match up with the
15 answers they were providing about savings, I think
16 that would flag that potentially there's undeclared
17 savings that the person has. I think it's regarding
18 that. I don't know how it all worked in practice.

19 **Q.** Is it right to understand that one of the purposes in
20 sending this letter was that it would then enable the
21 recipients of the letter, if they were called for
22 interview by the DWP, to show this letter and explain
23 that they shouldn't be interviewed?

24 **A.** Yes, definitely.

25 **Q.** Can you recall to what extent this problem continued

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1 over the following years?

2 **A.** I can't. I am not sure, unfortunately. We didn't

3 always hear about somebody who was called to interview

4 in the first place. So, yes, we wouldn't have known,

5 but I like to think it did help.

6 **Q.** There is a rather earlier letter I just wanted to ask

7 you about --

8 **SIR BRIAN LANGSTAFF:** Just before you do that, if we just

9 look at the top paragraph on the screen, the third or

10 fourth sentence from last begins "we agreed that".

11 Those are the three words at the end of the

12 line:

13 "We agreed that, between our organisations, we

14 will do all we can to minimise the risk of

15 beneficiaries being called to a fraud investigation

16 interview."

17 Then this is said:

18 "Internal processes are being created to make

19 this happen."

20 What can you tell us about any internal

21 processes so far as Skipton was concerned?

22 **A.** I can't recall, I am afraid.

23 **SIR BRIAN LANGSTAFF:** This presumably then just refers to

24 DWP, does it?

25 **A.** Yes. It was certainly down to them to stop

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1 money should be taken into account. I can't remember

2 if there was other advice we gave at the time.

3 **Q.** Do you recall ever being contacted by an individual

4 and then yourself contacting the DWP, as it were, on

5 behalf of that individual to suggest that they should

6 cease their investigation?

7 **A.** I believe I had -- yes, I may well have written

8 letters of support. I can't recall how often or any

9 specific examples, but it was certainly something

10 I was willing to do if it would have helped. And,

11 yes, I am fairly sure I did on occasion.

12 **Q.** That was 2011. I just want to ask you about

13 an earlier letter on the subject of benefits. It's at

14 HSOC0027883.

15 This is a letter to an individual,

16 2 February 2007. You say:

17 "In response to your request, please accept this

18 letter as confirmation that any benefits that

19 recipients of Skipton Fund payments are receiving will

20 not be affected by their payment from the Skipton

21 Fund.

22 "The benefit waiver number that should be quoted

23 to benefits agencies in order to allow the payment to

24 be disregarded is: 2004/1141.

25 "I hope this letter answers your question ..."

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1 investigating people. There is not much we could have

2 done to influence them, other than highlight this

3 issue and expect them to do all they could to stop it

4 from happening.

5 I wrote to every DWP centre explaining the

6 schemes, so if they saw payments from any of the named

7 trusts, they should not take that money into

8 account --

9 **SIR BRIAN LANGSTAFF:** Thank you very much.

10 **A.** -- and then investigate it.

11 **MS RICHARDS:** I think it is right, if you go to the top of

12 the next page, in terms of action by the Skipton Fund,

13 all that's set out is here:

14 "In the event you are asked to attend

15 an interview in connection with your payments, you

16 should first contact the Skipton Fund before doing

17 anything. Do not attend the interview until you have

18 obtained our advice."

19 What was going to be the purpose of someone

20 contacting the Skipton Fund, and what kind of advice

21 would you expect to give if they had done so?

22 **A.** I think it was to reassure them that no payments they

23 had received from the Skipton Fund or any of the other

24 trusts should be taken into account for their savings.

25 So it was just to make it clear that none of that

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1 So it sounds as though you had been contacted by

2 an individual recipient of Skipton Fund payments

3 asking for assistance, and this was your response.

4 What was the significance of the benefit waiver

5 number; can you recall?

6 **A.** Yes. I think that's in reference to a piece of

7 legislation where it sets out that the monies from the

8 Skipton Fund should be disregarded. So some piece of

9 Government legislation. But that number was attached

10 to it.

11 **Q.** We can take that down. Thank you.

12 Now, you have made clear in your statement, in

13 terms of the appeal process, that could not be used to

14 challenge the parameters of the scheme itself, and you

15 have said in your statement if applicants were

16 dissatisfied with the eligibility rules themselves,

17 you provided the contact details of the Department of

18 Health so they could make a complaint to the

19 Department of Health.

20 Were you ever made aware of any such complaints

21 being made to the Department about eligibility rules

22 and how the department responded?

23 **A.** We certainly handed out their contact details on a few

24 occasions. So I wouldn't know the ins and outs of

25 what complaint was raised or what was written in the

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1 correspondence. But, yes, we definitely gave out
 2 their contact details on a number of occasions for
 3 people to use.
 4 **Q.** I am going to move on from the Skipton Fund now and
 5 ask you just a handful of questions about the
 6 Macfarlane Trust and the Caxton Foundation.
 7 Starting with the Macfarlane Trust as being the
 8 first in time that you would have worked for, what
 9 were your roles and responsibilities at the Macfarlane
 10 Trust?
 11 **A.** So initially whilst I was a temp, it was to assist the
 12 finance department with various things. One thing
 13 I can remember, they wanted to see if the level of
 14 mileage that trustees claimed was in line with other
 15 charities, things like that.
 16 And then later, I became the assistant to the
 17 Chief Executive, and as part of that role, it
 18 was minute-taking. If there was a policy that the
 19 trustees were considering, I would analyse how much it
 20 would cost using spreadsheets. I would design the
 21 spreadsheets based on the number of beneficiaries we
 22 had and then, yes, they could see how much the
 23 policies they were discussing would cost and how much
 24 that would -- (inaudible) overall budget they had for
 25 disbursements.

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1 beneficiaries in general or using any derogatory
 2 language to describe them?
 3 **A.** No.
 4 **Q.** What was the relationship like between the Board of
 5 Trustees and the Chief Executive, either Mr Harvey or
 6 then Ms Barlow, during the time you were involved with
 7 the Macfarlane Trust?
 8 **A.** It seemed fine. I don't recall any major issues or
 9 any issues.
 10 **Q.** Did your role change at all when Ms Barlow took over
 11 in early 2013?
 12 **A.** Yes. So my involvement -- I stopped attending
 13 meetings. I did very little work for either of the
 14 Caxton Foundation or Macfarlane Trust after that time.
 15 **Q.** Why was that?
 16 **A.** I think she hired her own assistant. So there was
 17 essentially no need for my small role within the
 18 charities.
 19 **Q.** Do you have any observations to make either about
 20 the -- as a longstanding employee of both Skipton and
 21 Macfarlane Trust, and perhaps for a shorter period of
 22 time Caxton, any observations about the management
 23 style of either Mr Harvey or Ms Barlow?
 24 **A.** Do you mean towards employees?
 25 **Q.** Yes.

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1 **Q.** Did you have any role in developing the substantive
 2 content of policies at the Macfarlane Trust?
 3 **A.** Not at all, no.
 4 **Q.** Did you have any role in the taking of decisions about
 5 either regular payments or single grants?
 6 **A.** No. Not involved at all.
 7 **Q.** To what extent, if at all, did you have any direct
 8 interactions with beneficiaries of the Macfarlane
 9 Trust?
 10 **A.** So I attended the events. There were a couple of
 11 events each year; one that was for male people with
 12 bleeding disorders. Everyone was invited to attend,
 13 and it was a chance for them to meet up with everyone,
 14 and certain workshops they had throughout the day, and
 15 then socialised in the evenings. So I attended that
 16 on an annual basis.
 17 Then I think there was another larger event that
 18 was for everyone, every beneficiary of the Trust that
 19 could attend, so I think (inaudible) -- attended once,
 20 I think. Then there were other ones for women with
 21 bleeding disorders, which obviously I wasn't invited
 22 to.
 23 **Q.** You worked for most -- for the first few years that
 24 you were involved under Martin Harvey. Do you recall
 25 him ever expressing any views to you about

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1 **A.** No. It was always a fairly good working relationship.
 2 Nothing unusual.
 3 **Q.** Did you pick up anything about the relationship
 4 between the Chief Executive, either Mr Harvey or then
 5 Ms Barlow, and the beneficiary community during your
 6 employment there?
 7 **A.** I think because Martin was involved for so many years,
 8 he knew many of them I wouldn't say personally, but he
 9 certainly had grown to know them over the years. So
 10 he had, like I say, not a personal relationship, but
 11 he seemed to have a rapport with some of the
 12 beneficiaries. Whereas Jan coming in, I am not sure
 13 she had enough time to develop that. That was
 14 probably the biggest difference.
 15 **Q.** There's just one document I want to ask you about in
 16 relation to the Macfarlane Trust. It is at
 17 AHOH0000064. It is a document entitled "Possible
 18 reasons why the Board may not wish for Russell
 19 Mishcon's dissertation to be published".
 20 The Inquiry's current understanding is that this
 21 is a document that you produced; is that correct?
 22 **A.** I don't think so.
 23 **Q.** You don't think so?
 24 **A.** No.
 25 **Q.** Okay. You have no recollection of being asked to go

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1 through Mr Miscon's dissertation and identify reasons
2 why it shouldn't be published?
3 **A.** No, I don't think so.
4 **Q.** In that case, I don't think I can sensibly ask --
5 **A.** Sorry. I read this when you made it available, and it
6 didn't sound like it was something I would have
7 written, to be honest. I can't say 100% that
8 I didn't, but it really didn't look like something I'd
9 done.
10 **Q.** Do you recall being present at any meetings at which
11 the question of Mr Mishcon's dissertation being
12 published and its contents were discussed?
13 **A.** Only that he was unhappy that it wasn't able to be
14 published, but I wasn't obviously party to the
15 decision that it shouldn't be.
16 **Q.** Moving then to the Caxton Foundation, again, what were
17 your roles and responsibilities in relation to the
18 Caxton Foundation?
19 **A.** So in the very early days, I attended the board
20 meetings. I think I may have taken the minutes for
21 those meetings, and again analysing policy, potential
22 policies, so costing them out essentially.
23 **Q.** And do we understand that your involvement with the
24 Caxton Foundation reduced to little or nothing after
25 Ms Barlow took over in early 2013?

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1 Why was it that the Department of Health
2 sign-off was being sought for claim forms for a new
3 charitable foundation?
4 **A.** I am not sure what that's -- what claim forms they
5 would be. Yes, I am not -- I can't recall now.
6 **Q.** Okay. Then if we go to CAXT0000108_017, please.
7 **A.** Sorry. I am just reading 4(b) and it was mentioning
8 about the claim forms. It seems it was in connection
9 to the Skipton Fund.
10 **Q.** Shall we just go back to that because I don't want
11 to --
12 **A.** I just caught the first line as you were changing
13 slides.
14 **Q.** Can we go back to the last document, please, Soumik,
15 the HCPT0000210_015 document. HPCT0000210_015.
16 So 4(b) "Accepting claims on the balance of
17 probabilities":
18 "GK [I think that's Graham Kent, Department of
19 Health] had concerns over question 4A on the claim
20 form, where a doctor had to say when and where they
21 'believed' an infection to have occurred ... he was
22 worried payments could be made below the balance of
23 probabilities. GK said that larger payments will be
24 a greater incentive for speculative applications."
25 So were claim forms in relation to the enhanced

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1 **A.** Yes, that's right.
2 **Q.** Did you have any direct interaction with beneficiaries
3 of the Caxton Foundation?
4 **A.** Whilst Martin was still the Chief Exec, I attended of
5 couple of -- I'm not sure if they were called
6 partnership group meetings, but they certainly had
7 five or six Caxton Foundation beneficiaries present in
8 the very early days where we would discuss how things
9 were working.
10 **Q.** But that's it, is it, in terms of interactions with
11 the Caxton beneficiaries?
12 **A.** Yes, although obviously every Caxton beneficiary was
13 also a Skipton Fund applicant, so I knew many of them
14 pretty well.
15 **Q.** Could we go to HPCT0000210_015. This is a meeting on
16 new contaminated blood payments and new hepatitis C
17 charity, 18 February. It seems likely that's probably
18 18 February 2011. It is a meeting with various
19 Department of Health representatives and then various
20 representatives of the trusts, including yourself.
21 Then if we go to the third page where it says:
22 "4. Claims.
23 "4A. Claim forms.
24 "NF handed out the new claim forms which he
25 wanted DH sign-off on."

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1 stage 2 payments. Was that your suggestion?
2 **A.** Yes. Maybe it was -- we had a separate form for the
3 top-up. So it must have been in relation to a Skipton
4 Fund top-up for the additional 25,000 --
5 **Q.** Thank you.
6 **A.** -- topping people up from 25 to 50. So, yes,
7 I thought it sounded odd there wouldn't have been
8 a specific claim form I designed for anything to do
9 with the Caxton Foundation. So I think this meeting
10 was not just about the new charity, it was also about
11 the 2011 changes to the Skipton Fund.
12 **Q.** Thank you. That's useful. If we then go on to
13 CAXT0000108_017, we can see it is a meeting on 4th
14 August 2011 of the Caxton Foundation. If we go to
15 page 7, bottom of the page, so we can see there's
16 a presentation by Professor Thomas and then at the
17 very bottom:
18 "Disbursement Policies -- Preliminary
19 Considerations.
20 "The Chairman invited Mr Nicholas Fish ... to
21 give a presentation on the likely number of Caxton
22 beneficiaries based on past current and past
23 historical date."
24 Then it says this --
25 **SIR BRIAN LANGSTAFF:** That must be data presumably?

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1 **MS RICHARDS:** I think it must be data.
 2 **A.** Yes, it is.
 3 **MS RICHARDS:** "Following a number of questions that were
 4 concerned with garnering publicity for the Foundation
 5 and how parity of the payment of disbursements with
 6 the HIV charities might be achieved, the Chairman
 7 thanked Mr Fish for his exposition."
 8 Can you recall anything about the discussions
 9 referred to there, so first of all the question of
 10 garnering publicity for the Caxton Foundation?
 11 **A.** So I remember, it was primarily a presentation on
 12 numbers. I actually remember that -- maybe I raised
 13 the issue that because the Macfarlane Trust had been
 14 running for so many years, obviously setting up this
 15 new Trust with discretionary payments from 2011, there
 16 would have been a number of years where people didn't
 17 have access to these payments. In terms of garnering
 18 publicity, as well as however the Department of Health
 19 advertised it, obviously we advertised it on our
 20 website and added it into our application forms and
 21 guidance notes.
 22 **Q.** If we go to CAXT0000110_134, please, Soumik, this is
 23 a Caxton Foundation report from 2014, October 2014,
 24 from the Chief Executive, so Ms Barlow. I just want
 25 to ask you about the first paragraph:

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1 available?
 2 **A.** No, because similar to when we had the stage 2 look
 3 back in 2011, we had means of getting around that. So
 4 when we telephoned people, would he had to ensure we
 5 were speaking to the correct person before mentioning
 6 the Skipton Fund. So obviously if you Google the
 7 Skipton Fund the first thing that comes up is
 8 hepatitis C. So it would have been a bit different to
 9 do that for stage 1 as we did for stage 2.
 10 **Q.** Could we then look at -- this is the last document for
 11 now, I think -- SKIP0000031_051, please? This is
 12 an exchange of e-mails. I think we can probably pick
 13 it up just by looking at the bottom half of the page.
 14 So it is an e-mail to you saying:
 15 "We are very concerned that the regular payments
 16 made to those in Wales may be stopped and do not wish
 17 this to happen. I can therefore confirm that the
 18 Welsh Government will underwrite any payments made by
 19 the Skipton Fund to Welsh recipients until the revised
 20 Agency Agreement has been put in place and any
 21 consequential amendments made. We would therefore
 22 like to confirm that we would like the Skipton Fund to
 23 continue to make regular payment to recipients in
 24 Wales."

Then there is a similar confirmation at the top

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1 "Towards the end of August 2014, the Department
 2 of Health asked the Skipton Fund to attempt to make
 3 contact with everyone who had received a Skipton stage
 4 1 payment, but with whom there had been no subsequent
 5 contact. This involved making contact with
 6 approximately 2000 people, a large proportion of whom
 7 had received their stage 1 payments before the Caxton
 8 Foundation was established ... DH provided funding for
 9 2 temporary members of staff to work on the project",
 10 et cetera, et cetera.
 11 Can you assist with this: had there been
 12 requests to the Skipton Fund prior to August 2014 for
 13 the Skipton Fund to take proactive steps to contact
 14 the recipients of Skipton payments to alert them to
 15 the Caxton Foundation?
 16 **A.** No. So anything the Department of Health asked us to
 17 do in that regard we would have done so. If that was
 18 the first date that this was mentioned then we
 19 certainly wouldn't have refused to do that at
 20 a previous date.
 21 **Q.** Can you recall whether concerns had been expressed
 22 prior to this by the Skipton Fund about either data
 23 protection as a reason for not assisting with this
 24 exercise or inadequate staffing as a reason for not
 25 assisting prior to additional staff being made

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1 of the page in relation to Northern Ireland and also a
 2 confirmation in relation to Scotland. Can you recall
 3 what prompted the discussion about payments in respect
 4 of the devolved administrations?
 5 **A.** Yes. I think we were contacted by the Department of
 6 Health who said we shouldn't be making the regular
 7 payments yet to people in Wales, Scotland and Northern
 8 Ireland because they hadn't signed up to the changes
 9 to this scheme by way of, I think, the revised agency
 10 agreement that you mentioned. We had already been
 11 paying them regular payments, so we were in
 12 a situation where we might have had to have stopped
 13 the regular payments to people who had now come to
 14 depend on them, which obviously is unacceptable. So
 15 as a way around this, a workaround until those
 16 documents were finalised, we had to get consent from
 17 Scotland, Wales and Northern Ireland that they would
 18 underwrite the payments.
 19 **Q.** We can take that down. Just three final questions
 20 from me, Mr Fish, before we may then need to break to
 21 ask for Core Participants to suggest any further
 22 questions.

23 The first is this. Skipton beneficiary files,
 24 you observed earlier, I think by reference to the
 25 Inquiry's report of its investigations so far, that

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1 there may be files that the Inquiry doesn't have, and
 2 you described three lever-arch files of natural
 3 clearer applications.
 4 **A.** Yes.
 5 **Q.** Other than those files, the Inquiry, you are right,
 6 certainly doesn't have all the applicant beneficiary
 7 files. Are you able to assist with what may have
 8 happened to the missing applicant beneficiary files or
 9 why some of the files -- indeed I think most of the
 10 files -- that we have are incomplete?
 11 **A.** So, like I say, there was a large number of natural
 12 clearers. That's some over 300, I think, that were
 13 stored. Obviously, if you hadn't had access to those,
 14 you would be thinking there was a massive gap or lots
 15 of applications missing. In terms of approvals I had
 16 to go through every application myself to ascertain
 17 which country of infection, and which scheme would be
 18 taking on the payments for the individual. So I think
 19 there are only one or possibly two approved
 20 applications I couldn't find out of thousands. I am
 21 not sure what happened to those. Any that I approved
 22 would have been filed. So I can only assume there
 23 were a couple of applications that were before my
 24 time.
 25 In terms of rejections, again any rejections

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1 support schemes and, if so, what was it?
 2 **A.** Not particularly. It was all fairly standard meetings
 3 really. I know that with the charities the trustees
 4 always felt that they were underfunded. So there
 5 would have been a tone of them saying, "We require
 6 more money to do the work we would like to be able to
 7 do", but with the Skipton Fund there was never any
 8 hint that they were going to sort of cut the funding
 9 to us or -- there was never really any issue with us
 10 putting our forecasts in and then receiving invoices
 11 on that basis. So yes, I suppose the only thing was
 12 with the charities that they were always asking for
 13 increased funding, which wasn't always forthcoming.
 14 **MS RICHARDS:** Sir, those are the questions I have for
 15 Mr Fish but we need, obviously, to give Core
 16 Participants and their legal representatives the
 17 opportunity to suggest any further lines of
 18 questioning. So can I invite you to take a break at
 19 this stage?
 20 **SIR BRIAN LANGSTAFF:** Yes. We will take a break until
 21 3.35. That gives counsel an opportunity to field the
 22 questions which other participants may have for you.
 23 So be back here, please, by 3.35.
 24 **MS RICHARDS:** Thank you, Sir.
 25 **A.** Thank you.

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1 that I made, I would have taken a copy of the form,
 2 stapled all the supporting information to it and filed
 3 it away in a box file. So certainly by the time
 4 I left the Skipton Fund I don't consider there were
 5 any missing applications. If there were, I wasn't
 6 involved.
 7 **Q.** You told us one of your responsibilities in relation
 8 to Macfarlane and Caxton was to make notes of meetings
 9 or minutes of meetings. Were you ever asked to change
 10 the minutes of a meeting to a content that you felt
 11 did not accurately reflect the content of that
 12 meeting?
 13 **A.** No. So depending on which chairman, they would make
 14 revisions to my minutes. Generally it was the wording
 15 rather than the content, but I don't ever remember
 16 thinking "how has that been put in" or "why has that
 17 been changed?" It was more to do with the wording.
 18 **Q.** Finally, you attended meetings at the Department of
 19 Health in your capacity as administrator for the
 20 Skipton Fund. You also attended, I think, not all but
 21 at least some meetings with the Department of Health
 22 in the early days of Caxton Foundation and some
 23 meetings in relation to the Macfarlane Trust. Did you
 24 gain any particular impression of the Department of
 25 Health's interest in or attitude towards the financial

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1 (3.04 pm)

(Short break)

3 (3.35 pm)

4 **MS RICHARDS:** Mr Fish, I have a few questions that I have
 5 been asked to raise with you by Core Participants and
 6 their legal representatives. The first concerns the
 7 payments that were made to the estates of those who
 8 had died.

9 First of all, is this correct, that the fund
 10 was -- the payment was made to the estates of the
 11 deceased rather than to any specific type of relative?

12 **A.** Lump sums went to the estates but the bereavement
 13 payment was specifically to a cohabiting partner.

14 **Q.** So what kind of enquiries would the Skipton Fund make
 15 before making a payment where there was someone who
 16 was claiming to act on behalf of an estate?

17 **A.** So we'd ask for a copy of probate I believe, a copy of
 18 the death certificate and any other evidence to
 19 confirm they were the executor.

20 **Q.** In terms of the bereavement payments, were parents
 21 excluded from bereavement payments?

22 **A.** Yes, I think so. I think it was just cohabiting
 23 partners.

24 **Q.** Do you know why that was the case?

25 **A.** No. That was Department of Health policy.

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1 Q. I asked you this morning about the steps taken by the
2 Skipton Fund to advertise its existence and you made
3 reference to making contact with the Macfarlane Trust
4 to ask the Macfarlane Trust to pass on information to
5 its beneficiaries.
6 Did you or anyone else at the Skipton Fund, to
7 your knowledge, ever consider writing to UKHCDO and
8 asking them to inform all those on their database
9 about the Skipton Fund and the scheme?
10 A. I am sure that may have happened in the early days of
11 the fund. I don't recall us ever writing to them
12 specifically. That might have been something that the
13 Department of Health did when the scheme was set up.
14 I believe they probably had meetings with them. They
15 will be able to confirm.
16 Q. Fibroskans. We discussed this afternoon the reliance
17 based on Fibroskan results in and determining whether
18 an applicant qualified for stage 2 payments. What
19 consideration was given to the accuracy or lack of
20 accuracy of Fibroskan results?
21 A. We never relied solely on Fibroskan. So yes, we would
22 always get as much information as was available, make
23 an informed decision based on taking account of
24 everything. So yes, on occasion there would be
25 reasons why a reliable Fibroskan couldn't be taken, in

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1 remember how that was resolved, whose decision it was,
2 which scheme they were appointed to. But, yes,
3 I don't think in every single case it was clear-cut.
4 Q. You told us about what reasons there might have been
5 for concluding that an applicant was not eligible for
6 a stage 1 payment. You have told us also about the
7 policy or practice towards deceased haemophiliacs
8 considered to have been at 100% risk or close to of
9 HCV infection. I am not asking about any individual
10 case here, but can you think of any reason why a claim
11 from the estate of a severe haemophiliac who had
12 received treatment with NHS blood products and died
13 before 2003 would have been refused?
14 A. Only if there was evidence of naturally clearing the
15 virus but that would have been unlikely to have
16 existed either way, but that could have been a reason
17 why. If there was evidence still available which did
18 suggest they had not had a chronic infection.
19 Q. But you can't think of any other reason why that kind
20 of category of case might not succeed?
21 A. No. If we knew that they had received clotting
22 factor, then we knew they were definitely exposed to
23 hepatitis C. So it then just comes down to
24 chronicity.
25 Q. Leaving aside the question of chronicity or natural

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1 which case we would rely more heavily on whatever
2 evidence was available.
3 Q. Did those reasons why a Fibroskan result might not be
4 reliable include particular medical conditions that
5 an applicant might suffer from, as far as you can
6 recall?
7 A. I can't recall. All I remember was an incident where
8 it kept piercing a rib. So they could only get
9 a reading of the density of the rib. I am not
10 entirely sure why that was the case. No, I don't
11 think there were specific medical conditions that
12 prevented it from being useful. There may be, I'm not
13 an expert.
14 Q. That's not something you recall considering?
15 A. No.
16 Q. During the winding down of Skipton and the transfer
17 over to the NHS Business Services Authority were you
18 aware of registrants having problems being recognised
19 by the Scottish Infected Blood Support Scheme and
20 being registered with the English Infected Blood
21 Support Scheme instead?
22 A. I think there were a couple where it wasn't clear
23 which country the infection occurred in. So, yes,
24 I do vaguely remember there was maybe one or two cases
25 where it wasn't clear which country it was. I can't

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1 clearance, is it correct to say that the
2 Skipton Fund's approach, based on its understanding of
3 the Department of Health's requirements, was that
4 where there was evidence of an individual with a
5 bleeding disorder having received a concentrate any
6 time prior to September 1991, that was deemed to be
7 the cause of their hepatitis C infection with no need
8 for further enquiries?
9 A. Yes.
10 Q. You made, I think, some reference that before
11 seeking -- in your evidence earlier that before
12 seeking medical input on medical questions you might
13 carry out your own research. What kind of research
14 would you undertake?
15 A. Just to see if I could find any literature, medical
16 literature online that might help. Obviously, we
17 would only consider recognised studies. It wouldn't
18 just be Wikipedia, for instance. But just to see if
19 we could find any of our own information that's
20 already widely available in the public domain.
21 Q. Would you ever rely upon the products of your own
22 research as a basis for refusing an application?
23 A. Not without discussing it with a medical director or a
24 specialist.
25 Q. In cases where intravenous drug use was a possible

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1 cause of infection based upon information or records
2 provided by the medical practitioner, is it correct to
3 say that the applicant would not see the application
4 before it got to you because, as we discussed, it came
5 straight from the doctor, and so the applicant would
6 have had no opportunity to dispute the accuracy of the
7 intravenous drug use entry?

8 **A.** Yes. I think typically they came direct from the
9 doctor. I mean, the doctor probably would have phoned
10 them or given them a copy if they had asked before it
11 was sent, but I think, generally speaking, most came
12 direct from the doctor.

13 **Q.** If you received evidence of an entry in medical
14 records which suggested intravenous drug use, would
15 you, before taking a decision on the application, go
16 back to the applicant and ask if that entry was
17 accepted as correct?

18 **A.** No. I think we did take what the doctor said as the
19 fact.

20 **Q.** If that was then disputed by the applicant, so an
21 entry in the medical record asserting intravenous drug
22 use was disputed by the applicant as being wrong as
23 a matter of fact, either at the application stage or
24 on appeal, what approach was taken to that? How would
25 that be resolved?

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1 would write that lightly in their medical records.
2 But, yes, it would be a difficult situation where it's
3 the doctor's word or record's word against the
4 applicant's.

5 **Q.** Do you recall ever deciding an application on those
6 facts? I think we have seen evidence to suggest that
7 there might have been such a case, but I appreciate
8 you may not recall individual cases.

9 **A.** Yes, I can't remember that specifically happening.
10 But, yes, in the summaries you provided, I think three
11 of the appeals where intravenous drug use was the
12 reason we rejected it were overturned because they
13 denied intravenous drug use. So, yes, if we had have
14 had scope to consider personal statements, that may
15 have helped.

16 **Q.** Did you ever come across a situation in relation to
17 medical records where a doctor was able to say, "There
18 was previously a transfusion record and, therefore,
19 I can confirm that I have seen a medical record
20 vouching transfusion," but by the time the application
21 to the Skipton Fund was made, that record had been
22 destroyed or lost?

23 **A.** I can't recall a specific case of that, but it sounds
24 like something that we could take into account. If
25 the doctor was adamant they'd seen it and for whatever

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1 **A.** So we would certainly have asked the doctor why it was
2 mentioned on the form, what was the basis for their
3 assertion or their mentioning it to try and find out
4 why it was written by the doctor.

5 **Q.** Would you at that stage invite the applicant to set
6 out their account, or was that something that would
7 only become an option at the appeals stage?

8 **A.** Yes. So, as you mentioned before, the form doesn't
9 have an area where the applicant can give their
10 personal statement, but then if they had written back
11 to dispute what the doctor had said, they presumably
12 would have explained why they thought that that was
13 inaccurate. So the fact that we then went back to the
14 doctor would have been because of having received
15 further information from the applicant.

16 **Q.** If you had an applicant saying, "The reference to
17 intravenous drug use in my medical records is just
18 wrong as a matter of fact. I have never taken
19 intravenous drugs," and a doctor saying, "Well,
20 I don't know, but all I am doing is providing you with
21 the medical records which contain a reference to
22 intravenous drug use," how would you resolve
23 an application in those circumstances?

24 **A.** I can't recall. It would be an unusual thing to be
25 written if there was no basis. I don't think a doctor

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1 reason it was no longer available, then, yes, that
2 would hold weight, obviously.

3 **Q.** You've told us in relation to stage 2 decisions that
4 you relied on the opinion of the doctor completing the
5 stage 2 application form a lot, or quite a lot, and
6 that their opinion could form the basis for
7 a successful stage 2 application. Why was a different
8 approach taken then to stage 1 when you would look
9 behind what the clinician was saying?

10 **A.** With stage 2, it is always an option for further test
11 results and tests to be done, or wait for more routine
12 bloods to be done. There was always that option of
13 building up a better picture of the evidence.

14 **Q.** Sorry. My fault. I don't think I put the question
15 sufficiently clearly.

16 At both stage 1 and stage 2, you would have
17 a form completed by a clinician, and presumably
18 a local clinician or a clinician who had some direct
19 knowledge of the applicant. Would that be right as
20 a matter of generality?

21 **A.** Yes.

22 **Q.** In relation to stage 2 decisions, as I understand your
23 evidence earlier, the primary basis for allowing
24 an application for stage 2 would be what the doctor
25 told you in the application form. Not always but as

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1 a matter of generality?

2 **A.** Yes, but we would also have all of the test results

3 available, whereas with stage 1 applications it would

4 presumably be based on cases where there were no

5 medical records that we could see ourselves. With

6 stage 2 we actually could see what they were basing

7 their decision on, whereas with stage 1 that wasn't

8 always possible.

9 **Q.** So it comes back to this key question of there being

10 available medical records to demonstrate either at

11 stage 1 the transfusion --

12 **A.** Yes.

13 **Q.** -- or at stage 2 the state of liver disease; is that

14 right?

15 **A.** Yes, yes.

16 **Q.** Was it impossible for an application to the Skipton

17 Fund to be made by an applicant acting without

18 a supporting medical professional?

19 **A.** Yes, I think we did insist it had to be a medical

20 professional who completed their form.

21 **Q.** Just going back to the evidence you gave about

22 Elizabeth Boyd and her informally seeking advice on

23 cases from the Royal Free or from clinicians at the

24 Royal Free Hospital, I think you have mentioned your

25 understanding that advice may have come from liver

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1 **Q.** Were concerns ever raised with you about issues

2 relating to confidentiality or stigma, because, as you

3 said, if you Googled Skipton Fund it would come up

4 with hepatitis C?

5 **A.** Yes. Not with the Skipton Fund. But I think it may

6 have been raised by the Macfarlane Trust beneficiaries

7 and I think most of their payments would be shown as

8 MFET, which I am not sure if you Google that what it

9 would necessarily disclose.

10 **Q.** The Inquiry certainly had evidence that hepatitis C

11 carried its own stigma, not least because of other

12 possible routes of transmission associated with drug

13 use and the like. Was that an issue that was ever

14 considered by the Board of Directors in the context of

15 how payments were made and what they might reveal?

16 **A.** No. So in the two or so years before I became the

17 administrator I don't think it was something that was

18 raised and neither after I started. So I am sure if

19 a beneficiary or applicant had raised that issue, we

20 would have explored it, but I don't remember it being

21 an issue with Skipton Fund.

22 **Q.** You have acknowledged, Mr Fish, in your evidence that

23 at the initial application stage you and whichever

24 director was concerned was not routinely considering

25 the potential totality of available evidence because

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1 specialists, and you gave us, I think,

2 Professor Dusheiko's name as one of those. Other than

3 Professor Dusheiko, did you ever know the name of the

4 individual clinicians who Ms Boyd was consulting?

5 **A.** At the time quite probably, but I can't recall,

6 because she was involved in the haemophilia

7 department. So the people she knew best would have

8 been haematologists but she also had access to the

9 hepatology department. So, at the time, I probably

10 did know which doctors but I can't recall their names

11 now.

12 **Q.** Were there ever occasions, as far as you can recall,

13 where the medical advice received through this

14 indirect route from the Royal Free Hospital was later

15 contradicted by the opinion of the medical member or

16 members of the Appeal Panel?

17 **A.** I can't recall that, no.

18 **Q.** When I asked you about the issue relating to the DWP

19 and fraud investigations, you talked about benefits

20 authorities being told to disregard payments from

21 named funds. As a matter of fact, did payments from

22 the Skipton Fund appear upon bank statements as

23 emanating from the Skipton Fund, to the best of your

24 recollection?

25 **A.** I think so, yes.

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1 you had looked at the form and the records rather than

2 personal statements and the like. You told us that

3 your understanding is that's what the Department of

4 Health required or expected of you.

5 Are you able to assist us with understanding

6 where we might see that kind of instruction or

7 guidance from the Department of Health, because

8 I don't think the Agency Agreement itself casts any

9 further light on that?

10 **A.** No. I mean, the Department of Health should be able

11 to assist with that, but one thing to note is that the

12 English Infected Blood Support Scheme has almost the

13 exact same application form as we had. There is no

14 area on there where people can give personal

15 statements. So, obviously, following major reforms,

16 transferring it to the NHSBSA, it was essentially

17 still being run in the same way as we did it. So that

18 is almost a clear statement of their intentions to

19 continue it as it was.

20 **Q.** I think we have seen from some of the documents we

21 have looked at and your evidence that the Department

22 of Health had an involvement in either approving or

23 signing off application forms and guidance notes for

24 the Skipton Fund; is that right?

25 **A.** Yes, through changing forms or content of the website,

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1 we would quite often run it by the Department of
2 Health to make sure they were happy with the way we
3 had worded it to make sure it reflected how they saw
4 the changes. For instance, the 2011 changes, we gave
5 them a chance just to check the wording, that they
6 were happy with it on the forms and literature.

7 **Q.** My apologies if I have already asked this question,
8 Mr Fish, and you have already answered it, but did you
9 ever raise with the Department of Health or, to your
10 knowledge, did any of the directors ever raise with
11 the Department of Health this particular issue of the
12 application process not allowing you to consider all
13 potential available evidence and that only being
14 something that could be looked at at the appeal stage?

15 **A.** It may have been something that was discussed when we
16 presented the appeals panel statistics. They may have
17 asked what they thought or what we thought was causing
18 circa 50%. I am sure we would have given that as the
19 reasons why.

20 **Q.** Did the Department ever say to you, "There is no need
21 for you to take that approach, you can redesign the
22 application process to allow everything to be
23 considered at the first stage"?

24 **A.** No. If they had done that, we would have been happy
25 to do that.

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1 **SIR BRIAN LANGSTAFF:** -- and the person who did that first
2 up at Skipton for many years was you?

3 **A.** Not first up, but yes, from early -- well, 2006
4 onwards. It was initially Mr Foster.

5 **SIR BRIAN LANGSTAFF:** Yes. For many years it was you?

6 **A.** Yes, yes.

7 **SIR BRIAN LANGSTAFF:** Now, how to do, how to make that
8 decision, that was a matter really for you, wasn't it,
9 apart from knowing that it had to be applying the
10 standard of the balance of probabilities and it had to
11 begin --

12 **A.** Yes.

13 **SIR BRIAN LANGSTAFF:** -- with an application form.

14 **A.** Yes, and, as we have mentioned, there was no area on
15 the form that the Department of Health helped design
16 where personal statements were sought.

17 **SIR BRIAN LANGSTAFF:** Yes. Now, the difference between
18 what is operational and what is government policy is
19 drawn by the Agency Agreement. How to evaluate
20 a claim, would you not say that was operational?

21 **A.** Yes. Although, I mentioned about the EIBSS
22 application process. They have been operating for,
23 what, two years now and they still don't have an area
24 where people can give personal statements --

25 **SIR BRIAN LANGSTAFF:** That may be. I just want to

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1 **Q.** Was it ever a concern this was a policy rather than
2 operational issue or did that issue never cross your
3 mind?

4 **A.** Yes. I felt it was always something -- this was the
5 way that the scheme -- the Department of Health wanted
6 the scheme to operate and they certainly never gave
7 any indication that they wanted us to start taking
8 personal statements or photographing scars.

9 **MS RICHARDS:** Those are the questions, sir, I have from
10 Core Participants that I am proposing to ask Mr Fish.
11 Do you have any questions?

Questions from SIR BRIAN LANGSTAFF

13 **SIR BRIAN LANGSTAFF:** Yes. Just really on one general
14 topic, which is the relationship between the
15 Department of Health and Skipton. Can I start by
16 asking you this very broad question. Essentially the
17 job, the task of Skipton, as I understand it, was to
18 decide who qualified for the scheme, if somebody
19 qualified for the scheme against the qualifications
20 which the Department of Health had set out; is that
21 right?

22 **A.** Yes. Yes.

23 **SIR BRIAN LANGSTAFF:** So your job was to evaluate whether
24 someone qualified, essentially --

25 **A.** Yes. Yes.

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1 concentrate on Skipton and what is truly operational
2 and what is truly government policy. I think you have
3 answered it. You have said how to decide that someone
4 was or wasn't, on balance of probabilities, qualifying
5 within the scheme, whether for stage 1 or stage 2, was
6 a matter essentially for Skipton. That's what they
7 were there to do.

8 **A.** Yes.

9 **SIR BRIAN LANGSTAFF:** No doubt, from time to time, you
10 would want to make sure that the Department you were
11 an agent for was reasonably happy with how you were
12 doing thing, so you might refer how you did things to
13 them. That's as I have understood it; am I right?

14 **A.** Yes, but it was always my impression that we weren't
15 to consider anything other than the medical
16 information that was made available to us.

17 **SIR BRIAN LANGSTAFF:** I see. That wasn't written down
18 anywhere?

19 **A.** Maybe, but I started months after the scheme began and
20 then I was trained on how to consider applications.
21 So it may have been something that was written down
22 somewhere, but I have not seen it.

23 **SIR BRIAN LANGSTAFF:** So you never said to any one, to the
24 Chief Executive, for instance, or the new Chief
25 Executive when she took over, "Well, I think I need

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1 help to evaluate this. I want to do it this way. Can
 2 I do that?" because evaluation is part of the
 3 operational side of affairs, you have just agreed.
 4 **A.** Yes. I think I had been there so long and it had
 5 never been questioned by the Department of Health --
 6 (over-talking) --
 7 **SIR BRIAN LANGSTAFF:** So, basically, you went on doing
 8 what you had always done.
 9 **A.** Essentially, although once we did have the medical
 10 director on board, we were able to look more closely
 11 at records where it didn't explicitly mention the use
 12 of blood or blood products but we could weigh up the
 13 probability that such products would have been
 14 necessary.
 15 **SIR BRIAN LANGSTAFF:** The other aspect which I want to ask
 16 you about in respect of the relations between Skipton
 17 and the Department of Health, in the question of
 18 what's operational and what's policy, arises out of
 19 what you were saying this morning when you said that
 20 Government would come, the Department of Health, would
 21 have a number of meetings, particularly more meetings
 22 than the regular annual review if they were thinking
 23 of making changes to the scheme, and you said they
 24 would come and discuss the options.
 25 **A.** Yes. They obviously didn't tell us everything that

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1 **A.** No. I accept that. It was the wrong word.
 2 **SIR BRIAN LANGSTAFF:** When you were discussing how you did
 3 things, the operational side of the evaluation part of
 4 the job -- essentially what Skipton were up to -- did
 5 you discuss that, or did the Department of Health tell
 6 you how to do it?
 7 **A.** When changes were made to the scheme, is that?
 8 **SIR BRIAN LANGSTAFF:** Well, throughout. At any stage.
 9 **A.** No. I just accepted they knew how we were considering
 10 applications. And they were part of the initial
 11 design of the form, and it was never sort of
 12 questioned since then.
 13 **SIR BRIAN LANGSTAFF:** Yes. So you really assumed that
 14 because you had been doing it that way and they hadn't
 15 objected that it was okay to go on doing it that way.
 16 **A.** Yes. They were happy with the way it was being
 17 administered. Like I mentioned, the current schemes
 18 do it, as I gather, in the same way. They certainly
 19 did the year I was there.
 20 **SIR BRIAN LANGSTAFF:** You say "happy with the way they
 21 were doing it". I think you mean probably not
 22 unhappy. They never expressed unhappiness with it.
 23 **A.** Yes.
 24 **SIR BRIAN LANGSTAFF:** That's all that I have to ask.
 25 Thank you very much.

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1 they were considering. For instance, when they
 2 increased stage 2 from 25,000 to 50,000, we knew that
 3 was under consideration, but we didn't know that they
 4 would be introducing regular payments. So that's
 5 something that hadn't been mentioned to us. And they
 6 added a new qualifying condition to stage 2 based on
 7 non-Hodgkin's lymphoma. Until the day of the
 8 announcement, we hadn't heard that that was under
 9 consideration either. The meetings were more to get
 10 a sense of the number of different types of
 11 applicants.
 12 **SIR BRIAN LANGSTAFF:** You used the expression that they
 13 would discuss the options with you, with Skipton. The
 14 word "discussion" suggests that there is a to and fro
 15 of ideas. Was that the way it was?
 16 **A.** No. That was a bad choice of words. They would tell
 17 us what was under consideration.
 18 **SIR BRIAN LANGSTAFF:** So it wasn't a discussion; it was
 19 telling you.
 20 **A.** Yes.
 21 **SIR BRIAN LANGSTAFF:** I see. Well, that answers that part
 22 of the question, because if there had been
 23 a discussion, then it would be impossible to say that
 24 Skipton had no influence at all on what the Department
 25 of Health was doing.

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Further questions from MS RICHARDS

1 **MS RICHARDS:** Just one question, Mr Fish, further question
 2 from me.
 3 We talked about the changes to the Skipton
 4 procedures that were implemented following the fraud
 5 by Mr Foster, and I asked you about the NHS counter
 6 fraud service. Skipton obviously wasn't itself an NHS
 7 body, although it was administering funds that came
 8 within the budget of the Department of Health.
 9 Who was it who either requested or required the
 10 involvement of the NHS counter fraud service?
 11 **A.** That was the Department of Health who sent them in to
 12 review the Skipton Fund in totality.
 13 **Q.** There's reference in the minutes of the meeting that
 14 we looked at, which was the meeting between you and
 15 members of the counter fraud team, that there was
 16 going to be further discussions -- they don't seem to
 17 have contemplated the further discussions involved you
 18 directly -- with the Department of Health about the
 19 proposed change to procedures.
 20 Did you ever have any discussions with the
 21 Department of Health about the changes to the
 22 procedural requirements that were implemented in light
 23 of Mr Foster's fraud?
 24 **A.** I think after their review, they sent us a document of

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1 what they believed should be done, and we pushed back
 2 on a couple of things because they would have been
 3 impractical. I can't now recall exactly which things
 4 we pushed back on. But at that stage, yes, we gave
 5 our feedback on the recommendations they wanted us to
 6 implement. We didn't just accept them all.
 7 **Q.** You did feel able to raise some concerns about how
 8 applications should be considered?
 9 **A.** At that stage, yes, after that route.
 10 **MS RICHARDS:** Sir, unless there is anything further you
 11 have, Mr Fish, is there anything that you would like
 12 to add?
 13 **A.** No. I think you have covered a lot of what I used to
 14 do at the Skipton Fund.
 15 **MS RICHARDS:** Sir.
 16 **SIR BRIAN LANGSTAFF:** I imagine when you came as temp in
 17 November 2004 to work for Skipton, you never imagined
 18 that 15 years later you would be still be working,
 19 doing basically the same job, albeit be it now for
 20 EIBSS, and that was going to be the next 15 years of
 21 your life of becoming the administrator.
 22 **A.** Certainly not.
 23 **SIR BRIAN LANGSTAFF:** But it has been a great advantage to
 24 us that you were in that position, because we were
 25 able to hear from the one person who was at the hub at

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1 least of the initial evaluation of both the stage 1
 2 and stage 2 payments, and you have described how you
 3 inherited the scheme and how you operated that and
 4 been, as far as I can see, entirely open about the way
 5 in which you yourself went about those things and the
 6 relations you had and how you operated the discretion,
 7 such as you saw yourself as having.
 8 So I would just like to thank you for that and
 9 for giving us a day of your time in order to do so,
 10 and obviously crafting your statements beforehand, all
 11 of which I have read with considerable interest. So
 12 thank you very much.
 13 **A.** Thank you. It is a pleasure. Happy to help.
 14 **MS RICHARDS:** Sir, tomorrow we have the evidence of
 15 Professor Howard Thomas.
 16 **SIR BRIAN LANGSTAFF:** Yes. 10 o'clock. So 10 o'clock
 17 tomorrow. Thank you very much.
 18 **(4.10 pm)**

(Adjourned until 10.00 am the following day)

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