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.

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?

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

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.

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

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

Q. If he if we look towards the bottom of the page, paragraph 13.1, you set out there what being scheme administrator and company secretary entailed. You say you were:

"... responsible for administering the scheme as set out by the DHSC which included liaising with applicants and doctors regarding their applications ..."

I will come back to the application process, Mr Fish:

"... making decisions on application jointly with one of the directors ..."

Again, I'm going to ask you about that in more detail:

"... managing scheme assistants ..."

How many scheme assistants were there and what was their role?
A. That fluctuated depending on if there had been changes to the scheme. Usually it was just one. The maximum I think we had at any one time were four. That was around 2011 when the major changes came in. So generally it was between one and four and their role was similar to my role had been previously, writing letters, answering telephone calls, dealing with e-mails and just generally gathering information for

the application process.
Q. Was it ever the function of the scheme assistants, reporting to you as the administrator, to themselves take decisions on eligibility?
A. No.
Q. Then you refer next to providing feedback, statistics and forecasts to the Department of Health. What kind of feedback, statistics or forecasts were you required to provide to the Department of Health?
A. So monthly statistics about the total number of applications received, number paid, number declined, number that had gone to appeal. So basically the summary of all of the application statuses and that was on a monthly basis, and forecasts. We used to get money, I think it was quarterly, in advance, so I would do a forecast for the number of applications we expected to pay for that upcoming quarter and the Department of Health would then pay that money over so that we had it ready to make payments.
Q. Top of the next -- oh, we have got it on screen. Thank you:

"... general admin duties associated with administering a scheme ... keeping the application form and guidance notes up to date ... content of the website ..."

Company Secretary responsibilities. Then you say:

"I also became the secretariat to the independent Appeals Panel ..."

I will come back later to the panel itself but what, in broad terms, was your function as the secretariat to that panel?

A. If somebody requested an appeal I would create their appeal file, so I would make copies of all the documents that we had received for distribution to the panel members in advance of their meeting, so obviously they had a full record of what the Skipton Fund had received. Then, if there was further information, quite often the chairman would do a preliminary look at cases and if he thought there was further information that might help with the application, I would send those letters out to the appellants asking them to provide the additional information. Also, after me, I think it was the same.

Q. Did you attend the meetings of the Appeal Panel?

A. No.

Q. Were you responsible for drafting the decisions of the Appeal Panel?

A. No, they were drafted by the chairman and they would be posted for me and I would take a copy for the file

as well.

Q. In terms of your role in determining eligibility, the Inquiry understands that it was also a requirement that one of the directors of the Skipton Fund sign off on the decision, if I can put it that way; is that correct?

A. Yes, that's right.

Q. Prior to the appointment of a medical director, and I think the first medical director was Professor Thomas from whom we are hearing tomorrow, how did that sign off process work? What was the director's role in the decision-making process?

A. So they would visit the office usually once every week or two. We would have a pile of applications to consider. On the front of each one I would usually summarise the key points as I saw them and then we would discuss together whether or not we could approve the application.

Q. So is this right, the decisions on eligibility were usually joint decisions as between you and the director, rather than you taking the decision and then it simply being approved by the director?

A. Yes, definitely. I mean, we had obviously straightforward cases and difficult cases. So if it was a straightforward case that was declined, that

wouldn't necessarily need to be seen by the director. For instance, the natural clearer where the doctor had ticked "yes", they were antibody positive and "no" to the next three questions, so they were not currently PCR positive and there was no evidence they had been chronically infected, so those ones wouldn't need to be seen by a director. But, yes, any borderline ones and approvals, it was a joint decision.

Q. Was there any guidance as to the kind of cases that would need to have a more detailed discussion with the director or was that very much left to your judgment?

A. Yes, that was left to my judgment.

Q. In your witness statement -- I don't think we need to put it back on screen -- you said that in the more difficult cases the views of the medical directors were very important. In the years prior to the Skipton Fund having a medically qualified director, what would happen in those more difficult cases? What would the process be?

A. So one of our directors, Elizabeth Boyd had contacts with the Royal Free. I believe she used to work there. So she would be able to refer any new cases to medical experts at the Royal Free Hospital and then she would bring back the advice to the fund.

Q. How did that work? Did you ever learn which doctors

at the Royal Free Hospital were being asked to express a view?

A. No, not specifically. I think it was Professor Dusheiko, I believe, but he was a liver specialist. I think she worked in the haematology department. So, no, I didn't know exactly which doctor had been spoken to in every case.

Q. There would be no way, would there, if you didn't even know who the doctor was that Ms Boyd was going to, of testing that doctor's opinion or no way of ensuring accountability? Did that not give you cause for concern that you were relying on the views of an unknown clinician?

A. So this was the process that I inherited and it had been going on for a year and a half by the time I took over as scheme administrator. So, to me, it seemed to be working well. The opinions seemed to be sound. So it didn't particularly cause me concern.

Q. Do you know what information about individual cases Ms Boyd supplied to those she was contacting at the Royal Free Hospital?

A. I believe she took an anonymised copy of the application form and any supporting evidence, but they would have had access to the same information as us.

Q. What is the basis for your view that the information

she provided was anonymised?
A. There wasn't much personal information on the application form. So pages 1 and 2 were where the patient's -- the applicant's -- name and address were, so provided she didn't copy page 1 and 2, then it would be anonymous.
Q. Do you know whether that's what she did or is that your assumption that's what she did because it would have been the right thing to do?
A. I mean, it is a long time ago. I believe that's what she did but, yes, I can't say 100%.
Q. Now, you attended meetings from time to time in your capacity as administrator for the Skipton Fund with the Department of Health.
SIR BRIAN LANGSTAFF: Just changing the subject here a little, can I just ask, you said a moment ago that the medical opinions or the opinions that Ms Boyd brought back seemed to you to be sound. How did you judge that they were sound?
A. Well, I trust the judgment of a clinician, so I had no reason to think they wouldn't be sound.
SIR BRIAN LANGSTAFF: So, in other words, you assumed they were sound, rather than made that decision for yourself?
A. Well, yes. Nothing was unusual about the decisions

that they had made to me.
Q. Well, it would be a "yes" or a "no", in effect, wouldn't it?
A. Yes.
SIR BRIAN LANGSTAFF: So whatever they decided, whether it was "yes, this person qualifies" or "no, they don't", you would regard that as sound?
A. Well, there was usually some background information given about how they'd reached the decision that Ms Boyd would have explained to me. And, yes, nothing -- I didn't ever think anything sounded unusual.
SIR BRIAN LANGSTAFF: Yes. So, essentially, it was because you thought a doctor who was expressing that view that you thought it was sound?
A. Yes. An independent medical expert.
SIR BRIAN LANGSTAFF: Yes, I see. Thank you.
MS RICHARDS: You attended meetings with the Department of Health in your capacity as administrator of the Skipton Fund. Indeed, I think you also attended meetings with the Department of Health in your capacity as assistant to the Chief Executive of Macfarlane and Caxton.

Do you recall there ever being any discussion with the Department of Health or within the

Skipton Fund about broadening its remit to include people who had been infected with hepatitis B?
A. That was never mentioned as an option.
Q. Now, I am going to ask you a little about the agency agreement which was signed as between the Skipton Fund and the Department of Health.

Soumik, could we have SKIP0000033_066. You will see that the date of that is 22 May 2007, so that's nearly three years since the 5 July 2004 date when the Skipton Fund began operating.

Did you gain any understanding as to why it took so long for there to be a concluded agency agreement?
A. No. I know it is to do with the lawyers, back and forth between solicitors, but I am not entirely sure what could have caused such a huge delay. It was always a source of frustration. Didn't know why it was taking so long.
Q. Do you recall you having any direct involvement in the drafting of the agency agreement or in discussions as to what it should contain?
A. No, just proofreading before final sign-off. But, no, not the content. I wasn't involved in that.
Q. If we go to -- Soumik, it is page 7, I think. Yes. If we look at paragraph 2.5, bottom half of the page, we can see at 2.5.4 the agreement provided that:

"Skipton acknowledges that it may only alert DH to operational issues and may not make proposals to amend Government policy."

What was your understanding of the kind of operational issues that could be raised and the kind of policy issues that couldn't?
A. Operational issues would be things like if we thought we needed more staff. For instance, if there had been a change to the scheme and we felt we were understaffed. So that would be the sorts of operational issues we could raise.

Government policy would have been if we felt that natural clearers should have been included, we weren't able to make that suggestion. So it would have been obviously a major change to the scheme. So anything like that, we were unable to make recommendations or even give our opinion.
Q. Did you know or ever gain an understanding as to what had been the genesis of this provision?
A. No, not really. I guess maybe they considered it was the scheme that they'd designed, and we were the agent company to administer the scheme as they designed it. So perhaps they didn't want us making recommendations about the scheme, as it was ultimately their decision what the rules were.

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

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

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

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

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

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

leading up to changes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

communication with hospitals or relevant medical bodies or societies, or relevant patient bodies or societies?

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

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

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

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

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

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

SKIP0000030_027, please, Soumik. These are minutes of the meeting of the Board of Directors of Skipton Fund, 5 October 2006. We can see that you're in attendance. At that point, you're the acting scheme administrator, so Mr Foster has been dismissed, and this is before, I think, your permanent appointment was confirmed.

If we look just a little further down the page, we see a heading there, "Administrator's statistics":

"Gordon Clarke asked if there was any way of knowing the proportions of haemophiliacs paid from each of the four areas of the UK to highlight any areas where the existence of the Skipton Fund needs promoting. It was noted that there was no way for this to be done and that there is no media budget in place for the Skipton Fund to promote itself in any case."

Did that ever change? Was there ever a media budget in place for the Skipton Fund to promote itself?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Yes.

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

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

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

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

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

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

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

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

A. I think it was to look at the application process; find out how this happened and how it could be prevented in future.

Q. If we look at the bottom of the page, there's a heading "Implementation of CFSMS suggestions". We see Mr Harvey stating objections to a redesign of the application forms because it would seem from this the impact that might have on previously unsuccessful applicants.

Then it says:

"After discussion, the following alterations were decided."

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

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

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

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

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

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

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

Q. If we go to SKIP --

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

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

SIR BRIAN LANGSTAFF: Thank you.

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

under the heading "Keith Foster" the amount he was found to have misappropriated, around £400,000 -- £400,000, "around 0.5% of total funds disbursed". Then it says:

"To date we have recovered £267,321.91 ..."

The details are then set out as to the sources from which those have been recovered. Did the Skipton Fund ever recover any more than that?

A. No, not as far as I am aware. I think that was the extent of the recoveries.

Q. Did the fraud and the inability to recover the entirety of the monies defrauded have any impact upon the amount of money available to the Skipton Fund for distribution to beneficiaries?

A. No, definitely not, because we received our finance based on my forecasts for the upcoming quarters. So we were never short of funds. If we had been, we would have put our invoice in earlier, to ensure we did have enough.

Q. If we go to the next page --

SIR BRIAN LANGSTAFF: Just pausing for a moment, if we may, do you know anything or did you learn anything about the circumstances in which Mr Foster misappropriated money from his previous employer, the British Association of Hand Therapists?

A. I am not sure. That was before I started.

MS RICHARDS: If we go to the next page, please, Soumik, we can see under "Procedural Alterations", a number of alterations made to the scheme following the discovery of the fraud: provision by the applicant of their NHS number; and then the second bullet point is putting dates and initials of the applicant on all application forms. There is then the declaration that I have asked you about previously, but if we go over the page, in the top half of the page, we can see a more substantive change to the process. The top paragraph says:

"The forms also request that the completing medical practitioner encloses copies of medical records which confirm the HCV status of the applicant and that they received contaminated blood or blood products within the NHS prior to September 1991 (there is still a degree of flexibility regarding records)."

We will look at the footnote in a moment. Do we correctly understand that a change that was instituted was that the medical practitioner completing the form now had to actually provide the patient's medical records, both in relation to their hepatitis C diagnosis and medical records confirming receipt of contaminated blood or blood products?

A. I think he was just writing cheques to himself. I think he was in charge of writing cheques. I am not sure how he managed to get away with that, but that's what I believe he was doing.

SIR BRIAN LANGSTAFF: Did you discover how that came to light?

A. Yes, I think the way that we discovered the Foster fraud is because his previous employer was finding it very suspicious that they were getting regular sums of money that he was paying back to them after they discovered that he had been stealing money from them, and then they looked up, I think, where he was currently working and saw it was a payment scheme. So they put two and two together and informed the police, who then contacted us, and I think that's the reason the BAHT paid the money back to us because they had not reported the crime to the police that he committed under their employment.

I think they had said to him, provided he paid the money back, they wouldn't inform the police. That's my understanding.

SIR BRIAN LANGSTAFF: I see. Do you happen to know, because you may have seen the files, whether any reference was obtained by Skipton from his previous employer before he started employment?

A. Yes, so whereas before they just had to say "Yes, I have seen a copy of records confirming the hep C status", they have now asked for a photocopy of that document and likewise for the blood transfusion.

Q. In practice, did you receive selections from patient's medical records made by the completing medical practitioner or did you receive a whole bundle of medical records from which you were expected to try to identify the relevant parts?

A. 90% of the time it was the relevant page. Occasionally, the doctor would supply more comprehensive record *(unclear: audio distortion)* then we would try and find. Then as we requested it was the specific page relating to the qualifying treatment.

Q. We can see the footnotes. It says:

"... (there is still a degree of flexibility regarding records)."

If we go to the footnote at the bottom of the page, it says:

"The Directors are still able to exercise discretion where deemed appropriate. For example in a case where an applicant's records show the extent of their injuries were such that a transfusion would definitely have been needed although this was not

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

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

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

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

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 administrational 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

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

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.

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

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

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

A. Yes, that's right.

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

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

It says:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. I have moved the microphone.

SIR BRIAN LANGSTAFF: Okay. Right.

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

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

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

7, photographic evidence of the operation or

injury scar.

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

A. Yes. Uh-huh.

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

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

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

A. Yes, that's my understanding.

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

and see if you agree or have any comment.

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

A. Yes, it is possible.

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

A. Yes, I would.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. No. I have not seen this before.

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

page, it says:

"Evidence is defined as --

"information ... on an application form;

"authentic documentation (eg from any NHS establishment, the National Blood Service, et cetera);

"opinion, confirmation or signed authority from a practising clinician; or

"attestation by an authorising signatory that the claimant has no history of intravenous drug misuse."

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

A. No. Exactly.

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

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

Q. If we then go down to the bottom of the page, andI am just going to take as an example what we see in Section Three of this document, which is said to be for non-haemophiliacs, there's a question:

"Is there any evidence to suggest that the

claimant's infection occurred because of exposure to NHS blood or blood products before September 1991?"

If the answer to that is no, then reject the application; if the answer is yes, then continue to the section.

Then we go over the page. We look at the top two questions:

"Is there evidence that a particular incident or course of treatment with any NHS blood product was responsible for the claimant's infection?

"Yes. Continue with this section.

"No. Reject application."

Now, that would seem to suggest that the applicant had to produce evidence of a particular incident or course of treatment. Although you didn't use this document, was that in practice your approach?

A. No. So there was another document that you made available to me where they were suggesting we would have had to have gone -- where someone had a blood transfusion, we would have had to have gone back and asked about the batch number and then the person who donated the blood, whether or not they were hepatitis C positive. So, at one point, it looks as if that level of detail was being considered by the Department of Health, but no, in practice, we didn't

need it to be a specific blood transfusion that we wanted linked to the hep C. It just had to have been treatment with blood or blood products prior to September 1991. So if there were two incidents, we didn't need to establish which of the transfusions was more likely.

Q. Then the next question is this:

"Is there evidence that a source of infection other than NHS blood or blood products could be responsible for the claimant's infection?"

Then if the answer to that is "Yes", "Reject application".

Was that as a matter of practice the approach that you took?

A. No. So if there was, for instance, a risk factor of a transfusion in another country as well as in England, we wouldn't exclude them from the scheme on that basis. Tattoos, we didn't tend to consider a greater risk factor than a one-off transfusion. So no, that's not ...

Q. Are you able to assist us at all then with what the purpose or role or use was of this document?

A. I am not sure if this was something that was under consideration or was supposed to have formed the basis of how we assessed applications. Like I say, I hadn't

seen it until yesterday.

Q. We can take that down. Thank you. In terms of the application process, was any assistance available to applicants, practical assistance, to help them complete their application form?

A. All they had to do was provide their name and address and signature on page 2. So their doctor would have assisted with anything else, presumably, but most of the application was done by their doctor. But, yes, we could offer advice to the questions about what they needed to do, and we did frequently.

Q. If we go to SKIP0000030_017, please, minutes of a Skipton Fund directors' meeting, 1st August 2007 and you are there. If we go to the bottom half of the page, you will see under the heading "Matters Arising", the second paragraph is headed "New Application Form". Then there is a reference to there having been further amendments requested by the Scottish Executive. Are you able to assist with what amendments had been requested by the Scottish Executive?

A. As far as I recall, that was all to do third party transmission. So there were specific requirements for if somebody who had received a payment themselves infected someone else. I think they added in some

additional conditions around that, cohabiting and something. I can't remember the specifics now, but I believe it was all to do with that, third party infections.

Q. We can take that down. Thank you, Soumik.

Was it ever part of the application and decision-making process for applicants to have to sign some kind of undertaking or waiver that they wouldn't sue the government or the NHS in respect of their infection?

A. No, definitely not for Skipton.

Q. In terms of the Appeal Panel, there was a delay in its establishment so its first meeting was not held until early October 2006. Do you know why that delay occurred?

A. No. The Panel was set up by the Department of Health. I am not sure why.

Q. Was it correct as a matter of fact, though, that meant there was effectively a backlog between July 2004 and October 2006? There would be no means of appeals being determined?

A. Yes. Definitely. There was about 90 cases, I think.

Q. You have told us what you did in your capacity as the Panel secretariat. Did you actually make recommendations to the Panel at all?

A. No. Just copied the file.
Q. There were no oral hearings held by the Panel. Do you have any understanding as to why that was the case?
A. No. I'm not sure whose decision that was.
Q. Then if we could go, please, to INQY000045, please. This is a report put together by the Inquiry, Mr Fish, that you have been provided with a copy of. If we could go, please, to page 11, in paragraph 42 you will see there the Inquiry's analysis:

"The Skipton Fund Appeal Panel overturned 49.6% of the Skipton Fund decisions."

Obviously that's decisions where there was an appeal. That's a fairly high proportion of decisions that are being set aside by the Appeal Panel, and we can see if we trace through the minutes and annual reports there is reference to numbers of cases being successful from time to time being discussed at directors' meetings. Was there ever any consideration as to why so many appeals were succeeding?
A. Yes, I think we were aware it must have been to do with the additional information that they requested. The Department of Health had access to these stats as well, but they didn't think to change the scheme, so ...

Q. If we go to SKIP0000030_027, please. We looked at this in the context of the absence of a media budget earlier this morning. If we go to the second page -- sorry, I should say for the transcript it is minutes of a meeting of a Board of Directors, 5th October 2006, second half of the page, under the heading "Appeal Panel", we can see reference there to the first meeting of the Panel having taken place on 3rd October. Then it refers to the number of cases being reviewed. Then it says:

"Peter Stevens ... reviewed the Panel's decisions ... and asked NF [that's you] to seek clarification of how the panel reached their decision on two particular cases."

Now, I am not expecting you to remember two individual cases, Mr Fish, but can you recall why you were being asked to seek clarification about the Panel's decision-making process at all?
A. No, not specifically, but it must have been to ascertain how they came to their decision to help us potentially with the way we considered similar cases. But, no, I can't remember the specifics, unfortunately.
Q. Then it continues:

"Overall he [that's Mr Stevens] was satisfied

that the Appeal Panel were reaching decisions by exercising judgment where the Skipton Fund could not."

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

remember specifically those discussions but I am sure it was mentioned. As I said a bit earlier, they were aware of the Appeals Panel's statistics of approvals and declines. I used to provide those on a monthly basis as well. So yes, they were aware.
Q. Would you agree it would have been a good idea to reform the scheme so that you and the directors could look at the wider range of information from the outset?
A. Yes, it would have been helpful. That's why we did get medical directors in the end.
Q. Can we then look at -- I am just going to check the reference, Mr Fish -- NHBT0090394_001, and if we go to the next page, we can see that at the top of the page is an e-mail from you dated 31st May 2007. Is that an e-mail addressed to some of the members of the Appeal Panel?
A. Yes, that's the five members at the time.
Q. It says:

"Please see below the response I received from the Chairman of the Skipton Fund regarding John's question of assessing applications on the balance of probabilities."

Then you refer to a document and reference the document having been amended to satisfy the Scottish

Executive.

If we look below, I think we see what is presumably the chairman's response to you. It refers in the first paragraph to the agency agreement referring to balance of probabilities. There is then a reference in the second paragraph to the guidance notes for the application form.

Third paragraph he says:

"I have not kept all my drafts so cannot show at what stage 'balance of probabilities' raised its head ..."

Then in the next paragraph, he says this:

"There are some quite detailed early notes dated 2 October 2003, written by Martin (a Skipton Fund Director) ..."

That was Mr Harvey, I think, is that right? He was a director of the Skipton Fund?

A. Yes.

Q. "... in which the following phrase occurs: 'This authorisation would confirm that the HCV infection was acquired (either definitely or in all probability) through NHS treatment with contaminated blood products, whole blood or through tissue transfer'."

Then he goes on to refer in the next paragraph to there being:

"... some aspects of ... processing ... that have developed through experience of tricky cases."

Then he says, he concludes that:

"... the 'balance of probablilities' emerged during 2003/2004 as our thinking about operational issues developed; it would have been shared with, and accepted by, the officials ..."

But he says he can't recall anything further in relation to that.

Can I ask you, first of all, what the context for this enquiry was? It appears there was some concern or difficulty in understanding how balance of probabilities should be applied; is that correct?

A. Yes. I think the Appeal Panel wanted to know what we had been told by the Department of Health about how to assess applications. So I think they wanted the background of how the scheme came about and how we were asked to consider claims.

Q. We can obviously ask Professor Mildred about that later this week but, if we just look at the third paragraph on the screen, the reference to the phrase used by Martin Harvey, we see there in brackets the terms:

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

Now, it might be said that that's imposing a higher threshold than just more likely than not, which is what the balance of probabilities is usually understood to refer to. Do you have any observation in relation to that?

A. So in this case definitely in a small percentage of cases we had a look back letter that the patient had received from the NHS informing them that the batch of blood they had received was infected with hepatitis C. So that was one of the cases that is would be definite. Also people who receive factor concentrate, we now know there was a 100% chance they would have been exposed to hepatitis C. So they would be the definite cases. Then the all probability cases, he must be referring to one-off transfusions, where it wasn't known that batch was infected with hepatitis C but, on the balance of probabilities, it should be deemed it was the source.

Q. Do you understand there to be any difference between "in all probability" and "balance of probabilities", or did you not apply your mind to that at the time?

A. I didn't think that was significant. I took it to mean the same.

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

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

a matter of language it is not simply saying "probably" or "on balance of probabilities". The word "all" may simply be an expression which people do use in ordinary conversation but it is a word of emphasis --

A. I accept that.

SIR BRIAN LANGSTAFF: -- and I think if you look -- you didn't read it this way, I am sure, but it does seem to me to suggest or hint at, at any rate, a higher standard than just "probable". You can't help with anything other than how you saw things and did things. As a matter of expression, that's my current view, for what it is worth.

A. No. I would agree that it should have said "on balance of probabilities" or "is probable".

MS RICHARDS: Sir, I note the time. Mr Fish has obviously been giving evidence since 10.00. If we take a break, that would enable those who wish to observe the minute's silence at 12 o'clock to do so.

SIR BRIAN LANGSTAFF: We will do so and come back at 12.05. So a break now until 12.05.

MS RICHARDS: Thank you, sir.

(11.35 am)

(Short break)

(12.05 pm)

SIR BRIAN LANGSTAFF: Yes.

MS RICHARDS: Mr Fish, I am going to ask you about some of the kinds of reasons application would not succeed next and I am going to ask you first about the approach taken to the applications based upon receipt of anti-D immunoglobulin.

So if we could have SKIP0000031_071. This is a letter written to your predecessor, Mr Foster, February 2005. I think you had been employed by the Skipton Fund for only two or three months at this stage. It is from Dr Patricia Hewitt, at the National Blood Service, and it sets out various matters relating to anti-D immunoglobulin. Now, I am not going to go through the detail of the report. We have seen a further report obtained from her in 2010. Can you assist us with this: what was your understanding of the report and to what extent did you rely upon it when you were considering applications.

A. So it was my understanding that anti-D was used when I think there was a difference in a particular part of the blood group of mother and baby -- it was quite commonly given during pregnancy and child birth and this report that we had been provided with confirmed in our view that it was not a possible source of hepatitis C, unless it was a specific, exceptional

circumstance where it was a different type of product that was given intravenously.

Q. If you had an application from someone whose application was based upon receipt of anti-D immunoglobulin, did the application essentially automatically get refused or were steps taken to investigate the individual circumstances of the applicant and what product she had specifically received?

A. So, yes, normally it would be something mentioned in the medical records. From that it would be seen whether or not it was one of those exceptional circumstances or if it was a sort of routine anti-D injection. If there wasn't information to that effect, we would obviously ask for the records that mentioned the anti-D.

Q. Was it, as far as you can recall, usually possible to determine, on the basis of typical medical records, which anti-D product an individual had received?

A. Yes, as far as I recall. It would have been obvious if there was something unusual about the way it is mentioned, anti-D. I believe that was only used incredibly rarely on a named-patient basis for quite a different purpose.

Q. Do you recall ever approving an application where the

root of transmission was said to be receipt of anti-D immunoglobulin?

A. No, not as far as I recall. We didn't have all that many anti-D applications but I don't recall previewing one, no.

Q. If an applicant had received gamma globulin rather than anti-D immunoglobulin, was there any particular policy or approach in assessing the risk of hepatitis transmission in relation to such a product that you can recall?

A. That's quite technical. So, at the time, I would have known more about the differences or similarities but, unfortunately, now I can't recall.

Q. Was a copy of Dr Hewitt's letter provided usually to applicants whose applications had been objected so they could understand the basis for that and if they wanted to challenge it?

A. No. I think our letter said that we had been informed by the National Blood Service that anti-D wasn't a risk factor for hepatitis C. I don't think as a matter of course we provided a copy of that letter.

Q. Do you think it might have been good idea to do so, at least in the interests of transparency, so the individual could understand the reasons why their application had not succeeded?

A. Possibly. It is quite a technical letter. It is quite difficult to understand some of it but, I mean, if someone requested further information, we happily would have provided it. Yes, I guess we would have had to have sought the permission of Dr Hewitt as well. So, yes, we could have paraphrased but I am not sure we could have just shared that letter. Yes, we could and did provide further information on request.

Q. Dr Hewitt was, I think, appointed to the Appeal Panel in October 2006; is that right?

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

Q. Maybe this may be more a question for Professor Mildred or indeed in due course Dr Hewitt, but were you ever concerned that effectively she'd be assessing the value of her own expert opinion if she was considering appeals in anti-D immunoglobulin cases?

A. I think maybe the Panel shared that view and they sought literature review from Bioproducts Laboratories. So they got an independent person to provide their view as well. I'm not sure if that was because of the conflict that you mentioned but that is something they did.

Q. We can take that up perhaps with Professor Mildred later this week.

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

A. Yes, that's right.

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

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

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

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

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

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

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

A. Yes, for one-off transfusions.

Q. Did --

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

A. Yes, blood to blood.

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

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

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

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

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

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

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

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

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

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

SIR BRIAN LANGSTAFF: Thank you.
MS RICHARDS: To what extent when deciding applications did you place reliance upon Dr Ramsay's report?
A. So it did back up what we had as our view already, so I wouldn't say we relied upon it because we had already been making decisions on the same basis but, yes, it was certainly something we could refer to and make available to applicants or appellants on request.
Q. If we just go to SKIP0000048_332, this is an e-mail from Professor Mildred to you, 2nd April 2007. If we just look at the second paragraph:

"Will the Fund now use the Ramsay report when dealing with applications involving [intravenous drug use]? The Panel thinks it is important for consistency that it should."

Can you recall whether in light of this e-mail setting out the panel's view it became your practice to expressly rely upon the Ramsay report in decision letters?
A. Yes, we certainly changed our wording of the decision letters. I think it said "The Skipton Fund has an expert report setting out the risk factors". So yes, we did amend our letters accordingly.
Q. Is this right: you didn't provide a copy of the expert report, at least not unless it was expressly requested

by the applicant?
A. Yes. I'd like to think we sent that out with every -- I mean, there weren't all that many IV drug *(unclear: audio distortion)* -- I think we sent it out, but we certainly did send it on request. It wasn't classified or a secret report. We could share it and did share it.
Q. Dr Ramsay's report -- I don't think we need to go back to it, but she talks about risk being poorly documented. She talks about geographical variations in relation to risks and says it is difficult to assess risks associated with single episodes of injecting where sharing is denied.

Did you understand Dr Ramsay's report as excluding IVDU, intravenous drug use -- excluding transfusion in any case of intravenous drug use, or did you understand it to be more nuanced and requiring individual assessment?
A. I think in that paragraph you showed me, it did say that even if there was a denial of sharing needles or equipment, there was still half the risk of people who admitted to sharing the equipment, which would still be a much greater risk than a one-off transfusion. So, yes, in my view, it did exclude even a single episode of intravenous drug use.

Q. Presumably that incidence of hepatitis C and injectors who deny sharing is explained by that being an inaccurate denial of sharing, because if the person had not, as a matter of fact shared, they couldn't contract hepatitis C from drug use, could they?
A. I mentioned about the paraphernalia. So it could well be that what they said -- this was part of a study, not something we did, obviously. But, yes, perhaps they honestly said that they didn't share needles, not knowing that there was a risk associated with sharing other equipment.
Q. Did you ever consider the significance of the dates of transfusion compared with dates at which the intravenous drug use took place to ascertain if a person had been transfused before --
A. Yes, it's certainly something -- we did look out for that.
Q. Did that make any difference to the success or otherwise of applications?
A. It would have done if there was a positive hep C result before the incident of sharing needles or IV drug use. I can't remember every specific thing. That may have happened in one or two.
Q. In the absence of a case of the kind you just described, so where there is a positive hepatitis C

result before any evidence of intravenous drug use, did you ever, as far as you can recall, approve an application in which there was evidence of intravenous drug use?
A. Not that I recall. I don't think so.
Q. Would it be right to say that very much as reflected in what you've told us your training was that there was an effective blanket policy to regard intravenous drug use as the more likely cause in all cases?
A. Yes, unless the person had a look-back letter or had received factor concentrate where we know that that was the source. Sorry. Not just Factor VIII; any factor.
Q. If an application was received from someone who had had, they said, some very limited exposure to intravenous drugs but had had repeated transfusions -- so leave aside factor concentrates because you have told us what the position would be in relation to that -- would the policy still have been to reject the application without further investigation?
A. No. We would have perhaps found out more information if that was the case, *(unclear)* the transfusions, for instance.
Q. You can't recall, and I appreciate you won't necessarily recall all individual cases, Mr Fish --

I don't want this to be an unfair question at all. You can't recall allowing any applications in which there was intravenous drug use as a potential contributing cause?

A. No. I guess because IV drug use was quite rare, as were conditions requiring multiple blood transfusions, so I don't remember the two coinciding.

Q. When the case of someone whose application was being rejected on the basis of intravenous drug use, when you wrote to them to tell them the position, were they given the same information about the possibility of making an appeal, or were they told that an appeal was also likely to be unsuccessful because the panel would place the same reliance on the Ramsay report as the fund did?

A. Yes. We didn't tell them the likelihood of success, but we certainly informed them that they had the right to appeal.

Q. What was the approach, if this ever arose, in relation to non-intravenous drug use; for example, intranasal routes of administration of drugs?

A. It is a bit more difficult because there wasn't as much information about the prevalence of hepatitis C amongst cocaine use, but there is -- for instance, even on the Hep C Trust website, you can see that it

does say that sharing straws when snorting cocaine, because of the delicate blood vessels in the nose, there is a chance, if you are sharing a straw with someone who's got hepatitis C, there is a chance of infection through that route.

Q. Did you have such cases which were rejected for those reasons?

A. I think one. I can recall one that was rejected. There may have been more, but I do remember one, certainly.

Q. Did you have any understanding as to whether this approach to IV drug use and the policy that you've described being taught in your training period, did you have any understanding as to whether that was dictated or determined by the Department of Health, or was that Skipton's own assessment of the evidence?

A. I'm not sure. Some of the documents you made available about when they were discussed in the application process -- I think it was mentioned there, wasn't it -- so I think it is something the Department of Health no doubt had an opinion or guidance on.

Q. I'm going to move to ask you next about another cohort of cases, natural clearers, if I can call them that.

Were you ever involved in any discussions about the exclusion of natural clearers from the scheme?

A. No. That was something established by the time I started.

Q. Was the test for determining whether someone had cleared hepatitis C in a six-month acute stage determined on the balance of probabilities?

A. Yes. So we relied on the doctor to say whether or not they had evidence of chronic infection. So, yes, it was still -- the balance of probabilities was applied to that.

Q. How straightforward or easy was it to consider the applications from people who might fall into that category and make a decision?

A. So the majority of applications would have just said the doctor said there is no evidence they are PCR positive, but there is evidence of antibodies. And the next question was: is there any evidence of chronic infection before naturally clearing it? So they would have said yes or no to that.

So the majority of cases would have just been a straightforward section -- I think it was two. They've had just said yes, they have had antibodies which shows previous exposure, and then "no" to the next three questions. So, yes, those were straightforward to consider.

Q. Mr Stevens in his witness statement to the Inquiry

referred to the approach of Elizabeth Boyd and suggested her approach was not to approve stage 1 applications for people who were shown as having being hepatitis C positive after the acute phase but not currently hepatitis C positive as shown by a PCR test because that was the approach that the Royal Free, where she had worked, took to deciding whether to validate applications or not.

Do you have any recollection of Ms Boyd's approach in that regard?

A. No, I don't. I mean, a lot of these -- because I think my predecessor had to one side the applications where the answer was "yes" to antibodies, "no" to PCR positive, and then "yes" to evidence of chronic infection beyond the acute phase, so they were all put to one side.

I think there was back and forth discussions with the Department of Health, and then a lot of those in bulk were dealt with while I was still the scheme assistant. But, no, I didn't remember Elizabeth dealing with them particularly differently.

Q. Could we next go to NHBT0090734_001. So this is in relation to cases where third party infections, sexual transmission cases. It is a note from you dated November 2006. You say:

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

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

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

involving haemophilia.

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

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

Et cetera, et cetera. And then you say:

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

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

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

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

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

Et cetera, et cetera.

It would appear from this that as late as

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

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

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

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

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

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

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

Then there is a specific question about cases

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

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

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

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

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

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

cetera.

So the question is whether the NHS also qualifies the blood products?

A. Yes. Any products --

SIR BRIAN LANGSTAFF: It is one of these linguistic, grammatical questions. It is ambiguous on that basis.

A. So, yes, any blood or blood products that were administered by the NHS we would have considered as qualified.

SIR BRIAN LANGSTAFF: That's a different question. If the question of whether NHS, meaning origin or NHS production, that's one thing; NHS administered, that's another, but "NHS blood, blood products", that could mean -- I don't think it is likely, but it could mean broad products which are not NHS.

A. Yes, could be, but I am not sure what they would -- *(over-speaking)* --

SIR BRIAN LANGSTAFF: Anyway, it's, I think, a rather esoteric dispute.

MS RICHARDS: Yes. It is just rather curious that it had arisen in 2011.

Can I ask you to look at the first page and assist with what you meant in your e-mail to Mr Stevens and Ms Boyd. You refer to the e-mail exchange, and then you say in the second paragraph:

"If we are all in agreement, it would seem that we can start to approve applications where an individual was known to have been treated with clotting factor concentrates before screening began and where there are no records which suggest that they might have been one of the minority who naturally cleared HCV without experiencing a period of chronic infection."

Can you assist us with what you mean there by "starting to approve applications" because, again, it --

A. Sorry. I think this is referring to people who died before 29 August 2003 who were originally excluded from the scheme. So I was essentially saying that they were put to one side until this was clarified. I think this was in 2011 when the changes occurred to the scheme.

We were saying that if there was -- the haemophilia centre had them on their database as someone who had received clot clotting factor, we are saying that they would have been exposed to hepatitis C, even if we didn't have explicit records showing that they received a particular batch (inaudible) -- if they were on that database, we know that they would have done. So it helps us to assess

those claims where the person died so long ago there were just no records available.

Q. Thank you. That may assist in understanding why the issues were arising there. Thank you.

A. Yes. It was about those pre-'03 cases I think.

Q. Then the next category of cases I wanted to ask you about is cases that turned on the September 1991 cut-off date. Was this your understanding, that as far as the Skipton Fund was concerned, there was no flexibility to that date because the agency agreement essentially pinned eligibility to pre-September 1991 infection.

A. Yes. That was the *(unclear)* date that we had to use with no flexibility.

Q. Then if we could go to SKIP0000030_009, so these are the minutes of the Board of Directors, February 2014.

If we go to page 4, please, if you look at the paragraph that bears the number 168 next to it, so it is towards the top of the page:

"Exclusion of applicants who have already been compensated for their HCV infection through the NHS.

"The Scheme Administrator reported that the DH had indicated in a recent telephone call that it was their intention to exclude people from the scheme who had already received compensation for hepatitis C

infection through litigation. At the moment it was unclear if this would be limited to future applicants being asked to confirm that they had not already been compensated, or include existing applicants who were receiving regular payments."

Then it refers to you having submitted some draft wording on the application form and guidance notes to the Department of Health and Department of Health lawyers now considering it.

Can you recall how that issue was resolved, Mr Fish?

A. Yes. We certainly didn't look at applications and ask if they had received compensation. So it must have been dropped by the Department of Health but I don't ever remember them asking us to check if someone had been compensated.

Q. I am going to come back now to the question of medical records and the approach when there were no medical records. If I can start by taking you to DHSC0004510_045, this is a letter from you dated 26th January 2006 to somebody in the blood policy group at the Department of Health. If we go to the third paragraph, we can see it says:

"As the scheme guidelines set out by the Department of Health currently stand it is necessary

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

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

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.

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 --

A. Sorry, who was that rejected by, do you know? By the Department of Health?
Q. It may have been rejected by the Department of Health and then effectively allowed by the Panel. I think that's right.
Then we can see paragraph 4 says there is a suggestion of a transfusion of fresh frozen plasma, no record in the hospital notes of any such transfusion. Then we see the determinations set out as follows:
"There are, it seems to us, only four possibilities ..."
The four possible routes of transmission are set out. Paragraph 6 then says:
"On the face of it, none of these four possibilities is a likely one; indeed, on the available evidence each is unlikely. We must therefore consider the evidence and conclude which of the four is the least unlikely."
Then that's precisely what the determination then does, and the conclusion, if we go to page 7, Soumik, paragraph 21, is:
"Balancing the unlikelihoods, we have therefore concluded that the least unlikely, by some margin, is an unrecorded transfusion of infected plasma in 1984."

Now, I am not inviting you to comment obviously on the individual case, about which you would have had no direct knowledge at all, Mr Fish, but was this kind of approach ever suggested by the Department of Health to you or contemplated by you or the directors, where there was a range of possible causes, examination of which was the least unlikely?
A. No, that was never suggested to me.
Q. We can take that down, thank you. We have heard again, just sticking briefly with the Eileen Trust, some evidence that there was a caseworker at the Eileen Trust who was able to assist applicants with tracking down medical records. Did the Skipton Fund ever offer such assistance to applicants?
A. We offered advice of who they should approach and how to request the records but I am not sure we had that level of -- so it was the caseworker that would meet them or -- yes, I think the Eileen Trust at its maximum had 100 beneficiaries. Obviously, at the Skipton Fund we dealt with thousands of applications. So that might be why the Department of Health set it up slightly differently or very different.
Q. So the Skipton Fund would not itself take steps to obtain records? It would expect either the applicant or the clinician completing the form to provide them?

A. Yes, and I think we may have written to a hospital to request records and we would have got a response saying that they need the applicants to request them in person -- not in person, personally. I don't think we had the authority to request people's records.
Q. What was the Skipton Fund's approach to the costs implications for applicants, many of whom may have been living in poverty, in trying to obtain copies of their medical records?
A. So, occasionally, we'd hear of or receive an invoice from a GP. It was almost always a GP. I don't think specialist doctors in hospitals ever sent such letters but they would say there's a fee for the completion of a form or for the records. So the Department of Health's instructions were that we couldn't cover those, but we did write back a letter explaining that this is nothing like an insurance request form and such fees should not be levied by the GPs or the hospitals. Whether or not they listened to our advice I am not sure but that's certainly what we told them: they shouldn't be charging applicants.
Q. Can you recall if you ever approved an application, leaving aside bleeding disorder cases, whether you ever approved an application in the absence of medical records confirming a transfusion?

A. Yes. Certainly once it didn't confirm a definition transfusion but, yes, I don't think we approved any where there was literally no medical records at all. But, yes, there could have been or certainly were ones that there were records that describe treatments and injuries but didn't specifically mention blood. We were aware that discharge summaries didn't always routinely refer to blood transfusions. So, yes, we did approve applications where it didn't explicitly mention a blood transfusion.
Q. I know you have seen the report prepared by the Inquiry, Mr Fish, which includes reference to the numbers of cases declined on the basis of lack of medical records or lack of other evidence and also gives some case summaries. I am not going to go to the details of any of them, but a theme which seems to emerge from that is that it was fairly common for applications to be rejected because of an absence of medical records. Are you able to assist us in understanding more about that?
A. Yes, it was probably about a quarter of applications. About half are natural clearers. In fact, I noticed in your numbers you might be missing three lever-arch folders' worth of natural clearer rejections. The solicitor should have those if you request them. They

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Thank you.

(12.59 pm)

(Luncheon adjournment)

(2.00 pm)

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

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

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

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

may also qualify."

What was your understanding of what was required in terms of cirrhosis in order to qualify?

A. Evidence in whatever form that might be that cirrhosis was probable, so various blood tests and later Fibroscans, just anything that the clinician could provide to assess whether or not cirrhosis was probable rather than fibrosis.

Q. Can you assist us as to why these guidance notes say that "the individual may also qualify", rather than say "you will qualify if you have advanced stage of liver cirrhosis"?

A. I didn't word that originally. It was my understanding if they had cirrhosis, they would definitely qualify.

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

A. Yes. Maybe it is just because it is not quite as clear-cut a diagnosis as the other. Obviously, if you either have or haven't had a liver transplant, you either are or are not on the waiting list, and the same with cancer: you either have or haven't been diagnosed. Whereas with cirrhosis, because it is a degree of fibrosis leading up to cirrhosis, I think that's probably why it was worded that way.

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

satisfied that the applicant on the balance of probabilities had cirrhosis, they would, assuming they had qualified at the stage 1 basic payment stage, then qualify for the additional payment?

A. Yes, definitely.

Q. If we look at the bottom of the page, we can see it says:

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

"A specialist doctor must provide evidence of the extent of your liver disease if you are to qualify for the additional payment. The specialist will be asked to complete the application form on your behalf by providing evidence based on tests or your medical history."

Then if we go over the page, I don't think I need to go through the detail of it, but under the heading "The application form", it explains how that's going to be completed by the doctor. Before I ask you about one particular part of these notes, were applications for stage 2 payments largely decide on the basis of the clinician's opinions as set out in the application form?

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

Q. Then if we go at the heading "The tests" and go a little further down the page, it says:

"If your specialist is satisfied that test results you have had in the past will be sufficient to complete the application form, you will not need to have any tests. If you have had a liver biopsy in the past that confirms you have cirrhosis, that will be sufficient, but the Skipton Fund does not require that you have one."

Then there's further reference to potential risks involved in liver biopsies. The next paragraph says:

"... if information from a liver biopsy is not available, the results of certain blood tests may be sufficient."

This, I think, is pre-Fibroscans routine. Then it is suggested that:

"You will need the results from more than one set of tests ..."

I will come on to Fibroscans in a moment, but in terms of blood tests what would satisfy the Skipton Fund in terms of proof of probable cirrhosis?

A. It's been a number of years since I was dealing with these applications but there were certain enzymes that would be raised or were more likely to be raised if you had cirrhosis and others that would be likely to be low, amongst other things. So it was all to do

with the liver function tests and particular markers within those. There was another section, two or three, of the application form, there was a formula that could be worked out using a blood test and if it was above a certain number, based on these markers, then we would accept that as evidence. You have probably got a copy of the application form, so you would be able to see that I mean.

Q. Prior to you having either Professor Thomas or Professor Dusheiko to whom you could turn from 2013 onwards, was there anyone else with any specialist knowledge of hepatology to whom you were able to turn in order to seek advice in assessing stage 2 applications?

A. So similar to stage 1 it would have been via Elizabeth Boyd and the Royal Free and liver specialists there.

Q. Before the widespread availability of Fibroscan results how common was it that stage 1 registrants couldn't demonstrate the criteria for stage 2 because without a biopsy the extent of their liver damage couldn't be determined?

A. Without access to the statistics I am not sure. We certainly had some deferrals but I wouldn't be able to say how frequently they were deferred, as opposed to approved.

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

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

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

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

Soumik. This is a letter to you from Professor Makris, November 2013 and he says:

"I am writing to you for clarification about a policy decision."

He refers to having recently submitted a form on behalf of one of our patients with a very high Fibroscan score and that being returned to him, asking for information about other causes for high Fibroscan measurements.

Then if we go to the next paragraph:

"In the past you have accepted that if the patient has hepatitis C and cirrhosis they were eligible for the payment, irrespective of their alcohol intake. Can you clarify whether the rules have changed? As far as I know, I have never provided information about alcohol intake and this has never been questioned previously."

Then he poses the question in the next paragraph:

"... I wonder how the question about whether the patient had diabetes was relevant? If the patient has chronic hepatitis C and was diabetic, would that have precluded them from payment?"

Then before I ask you about this, if we just look at your reply, SKIP0000030_101. So you

responded, this says 6th December 2012 but I suspect that might be an error and it should have been 2013, because if we look just up the page there is a handwritten note "e-mailed to Howard 5/12/13", and it seems to be responding to Professor Makris's letter. You say in the second paragraph:

"The reason we ask such questions is not to ascertain whether outside influences have caused cirrhosis, as the scheme does not distinguish between cirrhosis caused by hepatitis C or, for instance, alcohol abuse, rather they are to ascertain whether or not the Fibroscan result was increased by other factors rather than cirrhosis."

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

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

a basis for rejecting applications. Are you able to comment on that and explain why this information was being sought?

A. Yes, it was nothing to do with the cause of cirrhosis. So, if somebody had developed cirrhosis having already reached stage 1 due to alcohol intake, they could still have been approved if there was evidence of cirrhosis. If the blood tests weren't suggestive of cirrhosis and the only piece of evidence we had was a raised Fibroscan, the reason to ask about alcohol was because that could cause inflammation in the liver which causes an increased Fibroscan score. So that was basically to weigh up what was causing the increase in the Fibroscan score where the blood tests weren't indicative of cirrhosis.

Q. Then if we could look at one further letter on a similar topic, but a year later, from the Haemophilia Society, SKIP0000031_100. So this is a letter from Ms Carroll, the Chief Executive of the Haemophilia Society, to you. She is expressing a concern in the first paragraph about there being a significant difference in the number of people differed or rejected from the bleeding disorder community. Then she says in the second paragraph this:

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

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

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

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

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

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

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

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

Q. Can we then look at SKIP0000030_013? These are the minutes of a meeting of Skipton Board of Directors, 17th February 2011, at which you are present, and if we look at the bottom half of the page, last paragraph, it says:

"The Board agreed that the Scheme Administrator and the Chairman should raise the issue of borderline stage two applications at their meeting with the Department of Health ... on Friday 18 February."

Then there is reference to the anticipated increase in stage 2 payments to £50,000 and the regular annual payment and the suggestion that's going to result in a surge of applications, many of which would be borderline, and then a reference to referring to Fibroscan on the application form.

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

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

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

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

Q. Then if we could look at SKIP0000030_085, please, these are the minutes of a meeting of the Skipton Fund Directors, 11th March 2013, with you in attendance. If we go to the second page, please, we can see at the bottom of page the issue there is:

"Stage 2 applications from the estates of people who were co-infected ... who died before 29 August 2003 and whose records have been destroyed."

Then if we go to the next page, there's reference to discussion from the Panel, I think that's the Appeal Panel, and a suggestion by Dr Mutimer.

Then the next paragraph refers to the model of fibrotic progression created by Professor Thomas which I asked you about a few moments ago then it says this:

"The Scheme Administrator summarised the model, the values and dates that had been used ... and the reasons why these figures had been used. Around 40 declined applications from the estates of co-infected people would need reviewing on the basis of this model. The Scheme Administrator confirmed that the Department, who were satisfied with the model, had asked that the review be deferred until the start of the upcoming financial year."

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

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

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

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

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

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

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

Q. If we could then go back to your witness statement, please, so WITN4466002. And if we can go to page 18. If we look at paragraph 33.2, towards the bottom of the page, this is about bereavement payments, Mr Fish.

You talk about how:

"A few years later the DHSC introduced regular payments (at a lesser level than the stage 2 regular payments) for living applicants who'd qualified for a stage 1 payment and a bereavement payment of £10,000 for the partners of deceased applicants where hepatitis C had been a contributing cause of death."

Was the question of whether hepatitis C had been a contributing cause of death a balance of probabilities test, as far as you can recall?
A. Yes, essentially, and I think with the help of the Department of Health, they came up with quite good guidance about what we needed to look out for on the death certificate, which would have enabled us to make the payment. And then if we came across a death certificate that had a term that hadn't been mentioned that we weren't sure of, we would run that by the Department of Health for clarification.
Q. If you didn't have evidence on a death certificate, what other evidence, if any, was capable of satisfying you that the bereavement payment should be made?

the Department of Health, 17 April 2013.

It refers to having been infected with hepatitis C and having cirrhosis of the liver and having had a liver transplant. It refers to receiving stage 1 and stage 2 payments.

If we go to the next page, the applicant says this:

"Last Friday, I received a phone call from the Skipton Fund to let me know that I was entitled to a further lump sum payment of £25,000. I later discovered through the SF website that I was also entitled to a flat-rate regular payment of £14,000 per annum and that these payments have been available since 2011. I phoned the Skipton Fund to confirm the availability of this regular payment and to enquire about backdating to 2011. I spoke to Nick Fish, scheme administrator, who told me that he was unable to backdate the payment and that I would need to apply to the Department of Health for any backdating."

The next paragraph also says that you told this individual he couldn't backdate the payment as over two years had elapsed since the original announcement.

So that's what you are recorded as saying. If we then go to the first page of this document, I just want to show you the reply before asking you about it.

So bottom of the page. So the response from Ailsa Wight starts here. If we go to the top of the next page, she says this:

"With regard to your request for backdating, this is not automatic, but the Skipton Fund is responsible for assessing such requests as they arise and making a decision about whether to backdate. We have spoken with the fund, and they will let you know of their decision shortly."

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

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

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

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

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

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

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

The second paragraph says:

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

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

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

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

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

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

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

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

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

A. Yes, definitely.

Q. Can you recall to what extent this problem continued

over the following years?
A. I can't. I am not sure, unfortunately. We didn't always hear about somebody who was called to interview in the first place. So, yes, we wouldn't have known, but I like to think it did help.
Q. There is a rather earlier letter I just wanted to ask you about --
SIR BRIAN LANGSTAFF: Just before you do that, if we just look at the top paragraph on the screen, the third or fourth sentence from last begins "we agreed that".
Those are the three words at the end of the line:
"We agreed that, between our organisations, we will do all we can to minimise the risk of beneficiaries being called to a fraud investigation interview."
Then this is said:
"Internal processes are being created to make this happen."
What can you tell us about any internal processes so far as Skipton was concerned?
A. I can't recall, I am afraid.
SIR BRIAN LANGSTAFF: This presumably then just refers to DWP, does it?
A. Yes. It was certainly down to them to stop

investigating people. There is not much we could have done to influence them, other than highlight this issue and expect them to do all they could to stop it from happening.
I wrote to every DWP centre explaining the schemes, so if they saw payments from any of the named trusts, they should not take that money into account --
SIR BRIAN LANGSTAFF: Thank you very much.
A. -- and then investigate it.
MS RICHARDS: I think it is right, if you go to the top of the next page, in terms of action by the Skipton Fund, all that's set out is here:
"In the event you are asked to attend an interview in connection with your payments, you should first contact the Skipton Fund before doing anything. Do not attend the interview until you have obtained our advice."
What was going to be the purpose of someone contacting the Skipton Fund, and what kind of advice would you expect to give if they had done so?
A. I think it was to reassure them that no payments they had received from the Skipton Fund or any of the other trusts should be taken into account for their savings. So it was just to make it clear that none of that

money should be taken into account. I can't remember if there was other advice we gave at the time.
Q. Do you recall ever being contacted by an individual and then yourself contacting the DWP, as it were, on behalf of that individual to suggest that they should cease their investigation?
A. I believe I had -- yes, I may well have written letters of support. I can't recall how often or any specific examples, but it was certainly something I was willing to do if it would have helped. And, yes, I am fairly sure I did on occasion.
Q. That was 2011. I just want to ask you about an earlier letter on the subject of benefits. It's at HSOC0027883.
This is a letter to an individual, 2 February 2007. You say:
"In response to your request, please accept this letter as confirmation that any benefits that recipients of Skipton Fund payments are receiving will not be affected by their payment from the Skipton Fund.
"The benefit waiver number that should be quoted to benefits agencies in order to allow the payment to be disregarded is: 2004/1141.
"I hope this letter answers your question ..."

So it sounds as though you had been contacted by an individual recipient of Skipton Fund payments asking for assistance, and this was your response.
What was the significance of the benefit waiver number; can you recall?
A. Yes. I think that's in reference to a piece of legislation where it sets out that the monies from the Skipton Fund should be disregarded. So some piece of Government legislation. But that number was attached to it.
Q. We can take that down. Thank you.
Now, you have made clear in your statement, in terms of the appeal process, that could not be used to challenge the parameters of the scheme itself, and you have said in your statement if applicants were dissatisfied with the eligibility rules themselves, you provided the contact details of the Department of Health so they could make a complaint to the Department of Health.
Were you ever made aware of any such complaints being made to the Department about eligibility rules and how the department responded?
A. We certainly handed out their contact details on a few occasions. So I wouldn't know the ins and outs of what complaint was raised or what was written in the

correspondence. But, yes, we definitely gave out their contact details on a number of occasions for people to use.

Q. I am going to move on from the Skipton Fund now and ask you just a handful of questions about the Macfarlane Trust and the Caxton Foundation.

Starting with the Macfarlane Trust as being the first in time that you would have worked for, what were your roles and responsibilities at the Macfarlane Trust?

A. So initially whilst I was a temp, it was to assist the finance department with various things. One thing I can remember, they wanted to see if the level of mileage that trustees claimed was in line with other charities, things like that.

And then later, I became the assistant to the Chief Executive, and as part of that role, it was minute-taking. If there was a policy that the trustees were considering, I would analyse how much it would cost using spreadsheets. I would design the spreadsheets based on the number of beneficiaries we had and then, yes, they could see how much the policies they were discussing would cost and how much that would -- (inaudible) overall budget they had for disbursements.

beneficiaries in general or using any derogatory language to describe them?

A. No.

Q. What was the relationship like between the Board of Trustees and the Chief Executive, either Mr Harvey or then Ms Barlow, during the time you were involved with the Macfarlane Trust?

A. It seemed fine. I don't recall any major issues or any issues.

Q. Did your role change at all when Ms Barlow took over in early 2013?

A. Yes. So my involvement -- I stopped attending meetings. I did very little work for either of the Caxton Foundation or Macfarlane Trust after that time.

Q. Why was that?

A. I think she hired her own assistant. So there was essentially no need for my small role within the charities.

Q. Do you have any observations to make either about the -- as a longstanding employee of both Skipton and Macfarlane Trust, and perhaps for a shorter period of time Caxton, any observations about the management style of either Mr Harvey or Ms Barlow?

A. Do you mean towards employees?

Q. Yes.

Q. Did you have any role in developing the substantive content of policies at the Macfarlane Trust?

A. Not at all, no.

Q. Did you have any role in the taking of decisions about either regular payments or single grants?

A. No. Not involved at all.

Q. To what extent, if at all, did you have any direct interactions with beneficiaries of the Macfarlane Trust?

A. So I attended the events. There were a couple of events each year; one that was for male people with bleeding disorders. Everyone was invited to attend, and it was a chance for them to meet up with everyone, and certain workshops they had throughout the day, and then socialised in the evenings. So I attended that on an annual basis.

Then I think there was another larger event that was for everyone, every beneficiary of the Trust that could attend, so I think (inaudible) -- attended once, I think. Then there were other ones for women with bleeding disorders, which obviously I wasn't invited to.

Q. You worked for most -- for the first few years that you were involved under Martin Harvey. Do you recall him ever expressing any views to you about

A. No. It was always a fairly good working relationship. Nothing unusual.

Q. Did you pick up anything about the relationship between the Chief Executive, either Mr Harvey or then Ms Barlow, and the beneficiary community during your employment there?

A. I think because Martin was involved for so many years, he knew many of them I wouldn't say personally, but he certainly had grown to know them over the years. So he had, like I say, not a personal relationship, but he seemed to have a rapport with some of the beneficiaries. Whereas Jan coming in, I am not sure she had enough time to develop that. That was probably the biggest difference.

Q. There's just one document I want to ask you about in relation to the Macfarlane Trust. It is at AHOH0000064. It is a document entitled "Possible reasons why the Board may not wish for Russell Mishcon's dissertation to be published".

The Inquiry's current understanding is that this is a document that you produced; is that correct?

A. I don't think so.

Q. You don't think so?

A. No.

Q. Okay. You have no recollection of being asked to go

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

A. Yes, that's right.
Q. Did you have any direct interaction with beneficiaries of the Caxton Foundation?
A. Whilst Martin was still the Chief Exec, I attended of couple of -- I'm not sure if they were called partnership group meetings, but they certainly had five or six Caxton Foundation beneficiaries present in the very early days where we would discuss how things were working.
Q. But that's it, is it, in terms of interactions with the Caxton beneficiaries?
A. Yes, although obviously every Caxton beneficiary was also a Skipton Fund applicant, so I knew many of them pretty well.
Q. Could we go to HPCT0000210_015. This is a meeting on new contaminated blood payments and new hepatitis C charity, 18 February. It seems likely that's probably 18 February 2011. It is a meeting with various Department of Health representatives and then various representatives of the trusts, including yourself.

Then if we go to the third page where it says:

"4. Claims.

"4A. Claim forms.

"NF handed out the new claim forms which he wanted DH sign-off on."

Why was it that the Department of Health sign-off was being sought for claim forms for a new charitable foundation?
A. I am not sure what that's -- what claim forms they would be. Yes, I am not -- I can't recall now.
Q. Okay. Then if we go to CAXT0000108_017, please.
A. Sorry. I am just reading 4(b) and it was mentioning about the claim forms. It seems it was in connection to the Skipton Fund.
Q. Shall we just go back to that because I don't want to --
A. I just caught the first line as you were changing slides.
Q. Can we go back to the last document, please, Soumik, the HCPT0000210_015 document. HPCT0000210_015.

So 4(b) "Accepting claims on the balance of probabilities":

"GK [I think that's Graham Kent, Department of Health] had concerns over question 4A on the claim form, where a doctor had to say when and where they 'believed' an infection to have occurred ... he was worried payments could be made below the balance of probabilities. GK said that larger payments will be a greater incentive for speculative applications."

So were claim forms in relation to the enhanced

stage 2 payments. Was that your suggestion?
A. Yes. Maybe it was -- we had a separate form for the top-up. So it must have been in relation to a Skipton Fund top-up for the additional 25,000 --
Q. Thank you.
A. -- topping people up from 25 to 50. So, yes, I thought it sounded odd there wouldn't have been a specific claim form I designed for anything to do with the Caxton Foundation. So I think this meeting was not just about the new charity, it was also about the 2011 changes to the Skipton Fund.
Q. Thank you. That's useful. If we then go on to CAXT0000108_017, we can see it is a meeting on 4th August 2011 of the Caxton Foundation. If we go to page 7, bottom of the page, so we can see there's a presentation by Professor Thomas and then at the very bottom:

"Disbursement Policies -- Preliminary Considerations.

"The Chairman invited Mr Nicholas Fish ... to give a presentation on the likely number of Caxton beneficiaries based on past current and past historical date."

Then it says this --
SIR BRIAN LANGSTAFF: That must be data presumably?

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

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

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

of the page in relation to Northern Ireland and also a confirmation in relation to Scotland. Can you recall what prompted the discussion about payments in respect of the devolved administrations?
A. Yes. I think we were contacted by the Department of Health who said we shouldn't be making the regular payments yet to people in Wales, Scotland and Northern Ireland because they hadn't signed up to the changes to this scheme by way of, I think, the revised agency agreement that you mentioned. We had already been paying them regular payments, so we were in a situation where we might have had to have stopped the regular payments to people who had now come to depend on them, which obviously is unacceptable. So as a way around this, a workaround until those documents were finalised, we had to get consent from Scotland, Wales and Northern Ireland that they would underwrite the payments.
Q. We can take that down. Just three final questions from me, Mr Fish, before we may then need to break to ask for Core Participants to suggest any further questions.
The first is this. Skipton beneficiary files, you observed earlier, I think by reference to the Inquiry's report of its investigations so far, that

there may be files that the Inquiry doesn't have, and you described three lever-arch files of natural clearer applications.

A. Yes.

Q. Other than those files, the Inquiry, you are right, certainly doesn't have all the applicant beneficiary files. Are you able to assist with what may have happened to the missing applicant beneficiary files or why some of the files -- indeed I think most of the files -- that we have are incomplete?

A. So, like I say, there was a large number of natural clearers. That's some over 300, I think, that were stored. Obviously, if you hadn't had access to those, you would be thinking there was a massive gap or lots of applications missing. In terms of approvals I had to go through every application myself to ascertain which country of infection, and which scheme would be taking on the payments for the individual. So I think there are only one or possibly two approved applications I couldn't find out of thousands. I am not sure what happened to those. Any that I approved would have been filed. So I can only assume there were a couple of applications that were before my time.

In terms of rejections, again any rejections

that I made, I would have taken a copy of the form, stapled all the supporting information to it and filed it away in a box file. So certainly by the time I left the Skipton Fund I don't consider there were any missing applications. If there were, I wasn't involved.

Q. You told us one of your responsibilities in relation to Macfarlane and Caxton was to make notes of meetings or minutes of meetings. Were you ever asked to change the minutes of a meeting to a content that you felt did not accurately reflect the content of that meeting?

A. No. So depending on which chairman, they would make revisions to my minutes. Generally it was the wording rather than the content, but I don't ever remember thinking "how has that been put in" or "why has that been changed?" It was more to do with the wording.

Q. Finally, you attended meetings at the Department of Health in your capacity as administrator for the Skipton Fund. You also attended, I think, not all but at least some meetings with the Department of Health in the early days of Caxton Foundation and some meetings in relation to the Macfarlane Trust. Did you gain any particular impression of the Department of Health's interest in or attitude towards the financial

support schemes and, if so, what was it?

A. Not particularly. It was all fairly standard meetings really. I know that with the charities the trustees always felt that they were underfunded. So there would have been a tone of them saying, "We require more money to do the work we would like to be able to do", but with the Skipton Fund there was never any hint that they were going to sort of cut the funding to us or -- there was never really any issue with us putting our forecasts in and then receiving invoices on that basis. So yes, I suppose the only thing was with the charities that they were always asking for increased funding, which wasn't always forthcoming.

MS RICHARDS: Sir, those are the questions I have for Mr Fish but we need, obviously, to give Core Participants and their legal representatives the opportunity to suggest any further lines of questioning. So can I invite you to take a break at this stage?

SIR BRIAN LANGSTAFF: Yes. We will take a break until 3.35. That gives counsel an opportunity to field the questions which other participants may have for you. So be back here, please, by 3.35.

MS RICHARDS: Thank you, Sir.

A. Thank you.

(3.04 pm)

(Short break)

(3.35 pm)

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

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

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

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

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

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

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

Q. Do you know why that was the case?

A. No. That was Department of Health policy.

Q. I asked you this morning about the steps taken by the Skipton Fund to advertise its existence and you made reference to making contact with the Macfarlane Trust to ask the Macfarlane Trust to pass on information to its beneficiaries.

Did you or anyone else at the Skipton Fund, to your knowledge, ever consider writing to UKHCDO and asking them to inform all those on their database about the Skipton Fund and the scheme?

A. I am sure that may have happened in the early days of the fund. I don't recall us ever writing to them specifically. That might have been something that the Department of Health did when the scheme was set up. I believe they probably had meetings with them. They will be able to confirm.

Q. Fibroscans. We discussed this afternoon the reliance based on Fibroscan results in and determining whether an applicant qualified for stage 2 payments. What consideration was given to the accuracy or lack of accuracy of Fibroscan results?

A. We never relied solely on Fibroscan. So yes, we would always get as much information as was available, make an informed decision based on taking account of everything. So yes, on occasion there would be reasons why a reliable Fibroscan couldn't be taken, in

which case we would rely more heavily on whatever evidence was available.

Q. Did those reasons why a Fibroscan result might not be reliable include particular medical conditions that an applicant might suffer from, as far as you can recall?

A. I can't recall. All I remember was an incident where it kept piercing a rib. So they could only get a reading of the density of the rib. I am not entirely sure why that was the case. No, I don't think there were specific medical conditions that prevented it from being useful. There may be, I'm not an expert.

Q. That's not something you recall considering?

A. No.

Q. During the winding down of Skipton and the transfer over to the NHS Business Services Authority were you aware of registrants having problems being recognised by the Scottish Infected Blood Support Scheme and being registered with the English Infected Blood Support Scheme instead?

A. I think there were a couple where it wasn't clear which country the infection occurred in. So, yes, I do vaguely remember there was maybe one or two cases where it wasn't clear which country it was. I can't

remember how that was resolved, whose decision it was, which scheme they were appointed to. But, yes, I don't think in every single case it was clear-cut.

Q. You told us about what reasons there might have been for concluding that an applicant was not eligible for a stage 1 payment. You have told us also about the policy or practice towards deceased haemophiliacs considered to have been at 100% risk or close to of HCV infection. I am not asking about any individual case here, but can you think of any reason why a claim from the estate of a severe haemophiliac who had received treatment with NHS blood products and died before 2003 would have been refused?

A. Only if there was evidence of naturally clearing the virus but that would have been unlikely to have existed either way, but that could have been a reason why. If there was evidence still available which did suggest they had not had a chronic infection.

Q. But you can't think of any other reason why that kind of category of case might not succeed?

A. No. If we knew that they had received clotting factor, then we knew they were definitely exposed to hepatitis C. So it then just comes down to chronicity.

Q. Leaving aside the question of chronicity or natural

clearance, is it correct to say that the Skipton Fund's approach, based on its understanding of the Department of Health's requirements, was that where there was evidence of an individual with a bleeding disorder having received a concentrate any time prior to September 1991, that was deemed to be the cause of their hepatitis C infection with no need for further enquiries?

A. Yes.

Q. You made, I think, some reference that before seeking -- in your evidence earlier that before seeking medical input on medical questions you might carry out your own research. What kind of research would you undertake?

A. Just to see if I could find any literature, medical literature online that might help. Obviously, we would only consider recognised studies. It wouldn't just be Wikipedia, for instance. But just to see if we could find any of our own information that's already widely available in the public domain.

Q. Would you ever rely upon the products of your own research as a basis for refusing an application?

A. Not without discussing it with a medical director or a specialist.

Q. In cases where intravenous drug use was a possible

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

a matter of generality?
A. Yes, but we would also have all of the test results available, whereas with stage 1 applications it would presumably be based on cases where there were no medical records that we could see ourselves. With stage 2 we actually could see what they were basing their decision on, whereas with stage 1 that wasn't always possible.
Q. So it comes back to this key question of there being available medical records to demonstrate either at stage 1 the transfusion --
A. Yes.
Q. -- or at stage 2 the state of liver disease; is that right?
A. Yes, yes.
Q. Was it impossible for an application to the Skipton Fund to be made by an applicant acting without a supporting medical professional?
A. Yes, I think we did insist it had to be a medical professional who completed their form.
Q. Just going back to the evidence you gave about Elizabeth Boyd and her informally seeking advice on cases from the Royal Free or from clinicians at the Royal Free Hospital, I think you have mentioned your understanding that advice may have come from liver

specialists, and you gave us, I think, Professor Dusheiko's name as one of those. Other than Professor Dusheiko, did you ever know the name of the individual clinicians who Ms Boyd was consulting?
A. At the time quite probably, but I can't recall, because she was involved in the haemophilia department. So the people she knew best would have been haematologists but she also had access to the hepatology department. So, at the time, I probably did know which doctors but I can't recall their names now.
Q. Were there ever occasions, as far as you can recall, where the medical advice received through this indirect route from the Royal Free Hospital was later contradicted by the opinion of the medical member or members of the Appeal Panel?
A. I can't recall that, no.
Q. When I asked you about the issue relating to the DWP and fraud investigations, you talked about benefits authorities being told to disregard payments from named funds. As a matter of fact, did payments from the Skipton Fund appear upon bank statements as emanating from the Skipton Fund, to the best of your recollection?
A. I think so, yes.

Q. Were concerns ever raised with you about issues relating to confidentiality or stigma, because, as you said, if you Googled Skipton Fund it would come up with hepatitis C?
A. Yes. Not with the Skipton Fund. But I think it may have been raised by the Macfarlane Trust beneficiaries and I think most of their payments would be shown as MFET, which I am not sure if you Google that what it would necessarily disclose.
Q. The Inquiry certainly had evidence that hepatitis C carried its own stigma, not least because of other possible routes of transmission associated with drug use and the like. Was that an issue that was ever considered by the Board of Directors in the context of how payments were made and what they might reveal?
A. No. So in the two or so years before I became the administrator I don't think it was something that was raised and neither after I started. So I am sure if a beneficiary or applicant had raised that issue, we would have explored it, but I don't remember it being an issue with Skipton Fund.
Q. You have acknowledged, Mr Fish, in your evidence that at the initial application stage you and whichever director was concerned was not routinely considering the potential totality of available evidence because

you had looked at the form and the records rather than personal statements and the like. You told us that your understanding is that's what the Department of Health required or expected of you.

Are you able to assist us with understanding where we might see that kind of instruction or guidance from the Department of Health, because I don't think the Agency Agreement itself casts any further light on that?
A. No. I mean, the Department of Health should be able to assist with that, but one thing to note is that the English Infected Blood Support Scheme has almost the exact same application form as we had. There is no area on there where people can give personal statements. So, obviously, following major reforms, transferring it to the NHSBSA, it was essentially still being run in the same way as we did it. So that is almost a clear statement of their intentions to continue it as it was.
Q. I think we have seen from some of the documents we have looked at and your evidence that the Department of Health had an involvement in either approving or signing off application forms and guidance notes for the Skipton Fund; is that right?
A. Yes, through changing forms or content of the website,

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

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

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

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

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

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

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

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

Questions from SIR BRIAN LANGSTAFF

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

A. Yes. Yes.

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

A. Yes. Yes.

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

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

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

A. Yes, yes.

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

A. Yes.

SIR BRIAN LANGSTAFF: -- with an application form.

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

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

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

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

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

A. Yes.

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

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

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

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

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

help to evaluate this. I want to do it this way. Can I do that?" because evaluation is part of the operational side of affairs, you have just agreed.

A. Yes. I think I had been there so long and it had never been questioned by the Department of Health -- (over-talking) --

SIR BRIAN LANGSTAFF: So, basically, you went on doing what you had always done.

A. Essentially, although once we did have the medical director on board, we were able to look more closely at records where it didn't explicitly mention the use of blood or blood products but we could weigh up the probability that such products would have been necessary.

SIR BRIAN LANGSTAFF: The other aspect which I want to ask you about in respect of the relations between Skipton and the Department of Health, in the question of what's operational and what's policy, arises out of what you were saying this morning when you said that Government would come, the Department of Health, would have a number of meetings, particularly more meetings than the regular annual review if they were thinking of making changes to the scheme, and you said they would come and discuss the options.

A. Yes. They obviously didn't tell us everything that

they were considering. For instance, when they increased stage 2 from 25,000 to 50,000, we knew that was under consideration, but we didn't know that they would be introducing regular payments. So that's something that hadn't been mentioned to us. And they added a new qualifying condition to stage 2 based on non-Hodgkin's lymphoma. Until the day of the announcement, we hadn't heard that that was under consideration either. The meetings were more to get a sense of the number of different types of applicants.

SIR BRIAN LANGSTAFF: You used the expression that they would discuss the options with you, with Skipton. The word "discussion" suggests that there is a to and fro of ideas. Was that the way it was?

A. No. That was a bad choice of words. They would tell us what was under consideration.

SIR BRIAN LANGSTAFF: So it wasn't a discussion; it was telling you.

A. Yes.

SIR BRIAN LANGSTAFF: I see. Well, that answers that part of the question, because if there had been a discussion, then it would be impossible to say that Skipton had no influence at all on what the Department of Health was doing.

A. No. I accept that. It was the wrong word.

SIR BRIAN LANGSTAFF: When you were discussing how you did things, the operational side of the evaluation part of the job -- essentially what Skipton were up to -- did you discuss that, or did the Department of Health tell you how to do it?

A. When changes were made to the scheme, is that?

SIR BRIAN LANGSTAFF: Well, throughout. At any stage.

A. No. I just accepted they knew how we were considering applications. And they were part of the initial design of the form, and it was never sort of questioned since then.

SIR BRIAN LANGSTAFF: Yes. So you really assumed that because you had been doing it that way and they hadn't objected that it was okay to go on doing it that way.

A. Yes. They were happy with the way it was being administered. Like I mentioned, the current schemes do it, as I gather, in the same way. They certainly did the year I was there.

SIR BRIAN LANGSTAFF: You say "happy with the way they were doing it". I think you mean probably not unhappy. They never expressed unhappiness with it.

A. Yes.

SIR BRIAN LANGSTAFF: That's all that I have to ask. Thank you very much.

Further questions from MS RICHARDS

MS RICHARDS: Just one question, Mr Fish, further question from me.

We talked about the changes to the Skipton procedures that were implemented following the fraud by Mr Foster, and I asked you about the NHS counter fraud service. Skipton obviously wasn't itself an NHS body, although it was administering funds that came within the budget of the Department of Health.

Who was it who either requested or required the involvement of the NHS counter fraud service?

A. That was the Department of Health who sent them in to review the Skipton Fund in totality.

Q. There's reference in the minutes of the meeting that we looked at, which was the meeting between you and members of the counter fraud team, that there was going to be further discussions -- they don't seem to have contemplated the further discussions involved you directly -- with the Department of Health about the proposed change to procedures.

Did you ever have any discussions with the Department of Health about the changes to the procedural requirements that were implemented in light of Mr Foster's fraud?

A. I think after their review, they sent us a document of

what they believed should be done, and we pushed back on a couple of things because they would have been impractical. I can't now recall exactly which things we pushed back on. But at that stage, yes, we gave our feedback on the recommendations they wanted us to implement. We didn't just accept them all.

Q. You did feel able to raise some concerns about how applications should be considered?

A. At that stage, yes, after that route.

MS RICHARDS: Sir, unless there is anything further you have, Mr Fish, is there anything that you would like to add?

A. No. I think you have covered a lot of what I used to do at the Skipton Fund.

MS RICHARDS: Sir.

SIR BRIAN LANGSTAFF: I imagine when you came as temp in November 2004 to work for Skipton, you never imagined that 15 years later you would be still be working, doing basically the same job, albeit be it now for EIBSS, and that was going to be the next 15 years of your life of becoming the administrator.

A. Certainly not.

SIR BRIAN LANGSTAFF: But it has been a great advantage to us that you were in that position, because we were able to hear from the one person who was at the hub at

least of the initial evaluation of both the stage 1 and stage 2 payments, and you have described how you inherited the scheme and how you operated that and been, as far as I can see, entirely open about the way in which you yourself went about those things and the relations you had and how you operated the discretion, such as you saw yourself as having.

So I would just like to thank you for that and for giving us a day of your time in order to do so, and obviously crafting your statements beforehand, all of which I have read with considerable interest. So thank you very much.

A. Thank you. It is a pleasure. Happy to help.

MS RICHARDS: Sir, tomorrow we have the evidence of Professor Howard Thomas.

SIR BRIAN LANGSTAFF: Yes. 10 o'clock. So 10 o'clock tomorrow. Thank you very much.

(4.10 pm)

(Adjourned until 10.00 am the following day)

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