Thursday, 25th March 2021

(10.00 am)

SIR BRIAN LANGSTAFF: Good morning. Can you see me?

THE WITNESS: Yes, I can.

SIR BRIAN LANGSTAFF: Well, I can see you and you can obviously hear me. I understand since you have retired from being a professor you prefer not to use the title "Professor". That's right, I think, isn't it?

THE WITNESS: I don't think I am entitled to call myself and I don't, so no.

SIR BRIAN LANGSTAFF: So you don't. So we will call you Mr Mildred if we have to use any name.

THE WITNESS: Yes, please do.

SIR BRIAN LANGSTAFF: Very well. Can I explain to you, Mr Mildred, where we are and who is listening. First you can tell us you are at home, are you?

THE WITNESS: I am, yes.

SIR BRIAN LANGSTAFF: I gather there is somebody else there who may come in with a cup of coffee as and when required?

THE WITNESS: I don't think so. There is somebody else here but I think doing something different in a different room.

SIR BRIAN LANGSTAFF: I have been misinformed but, in any

event, when we have a break, you can talk to that person about anything you like, but not about the evidence that you have given or may yet give. The familiar --

THE WITNESS: Yes, I understand.

SIR BRIAN LANGSTAFF: -- thing which judges say and it is the rule.

Now, you are talking, first of all, to this room here, Fleetbank House, where, although we have enough space in non-virus times to have a couple of hundred people, we have eight, all suitably masked up, except for Ms Scott, who will be asking you the questions. Mary will come and ask you to affirm in a moment or two. The other name you may hear is Soumik, whose job it is to show you any particular documents that Ms Scott wants to refer you to.

THE WITNESS: Yes.

SIR BRIAN LANGSTAFF: But the real audience is that beyond this room, watching remotely, for obvious reasons, there will be -- yesterday there were about 250 watching. It will vary from time to time during the day, but that's roughly the size of the audience who are interested to know what you have to say.

THE WITNESS: Yes.

SIR BRIAN LANGSTAFF: So those are the people you are

talking to. Now, Mary will ask you to take the oath.

MARK MILDRED (affirmed)

Questions by MS SCOTT

MS SCOTT: Mr Mildred, can you see and hear me?

A. I can. Thank you.

Q. You were the chair of the Skipton Appeal Panel from 2006 until its final meeting in July 2017; is that correct?

A. Yes.

Q. You have set out your background and experience and qualifications in your witness statement and you tell us you were admitted as a solicitor in 1975, and you worked in private practice, specialising in liability for defective products and in class actions and, during that time, you published a large volume of work on the subject and lectured; is that correct?

A. Yes.

Q. You also tell us in your statement that, during your career as a solicitor in private practice, you were a leading member of the team advising the Claimants in the HIV haemophilia litigation from 1988 and remained involved in that litigation through to settlement and the establishment of the Macfarlane Trust in 1991; is that also correct?

A. Yes.

Q. You also tell us that you gave some informal advice to the Claimants' legal teams in the hepatitis C litigation and in the vCJD litigation; is that correct?

A. Yes.

Q. Just to make it clear to you, Mr Mildred, and to those listening at home that I am not going to ask you any questions today about the work that you did in that litigation but that will be the focus of a further request to you for a further witness statement in due course?

A. Yes.

Q. You then tell us that you left full-time private practice in 1995 on your appointment as Professor of Litigation at Nottingham Law School, although you continued as a part-time consultant in complex litigation cases throughout your time as a professor; is that right?

A. Yes.

Q. You have also worked in part-time tribunal judicial roles, including for the Family Health Services Appeal Authority, and you have held non-executive directorships in the NHS, including at the time you were appointed to Skipton being the Department of Health Non-Executive Director of Wandsworth Primary

Care Trust; is that correct?
A. Yes. It is fair to say that, as time went on, the academic work and consultancy work diminished and the judicial work increased. So by the time I retired I was doing almost nothing but First Tier Tribunal work.
Q. You came across an advert for the Skipton Appeal Panel, you think, in the summer of 2006 in the Law Society Gazette. What drew you to apply for the post?
A. Well, it was a subject that I knew a little bit about, it was an area of law that I had some experience in and I was -- I think the expression is portfolio work, at that stage, I was doing different things. I had no full-time job, so this was something which I thought would be interesting to do and I might be able to do to a reasonable standard, so I applied.
Q. You presumably knew a little bit about -- as you say, knew a little about -- must have known rather more than that about the circumstances in which patients had become infected with HIV and hepatitis C as a result of your work in the litigation that we mentioned earlier?
A. I did, although hepatitis C played only a very small part in that. Most of what I knew was about HIV, but I did know a little bit about it. I had also acted

for the Claimants in the Gammagard case, which we might even come on to later. It was an immunoglobulin that caused hepatitis.
Q. You were interviewed for the post by the NHS Appointments Commission and appointed chair of the Appeal Panel in September 2006; is that right?
A. Yes.
Q. After the Skipton Appeal Panel came to an end, did you have anything to do with the new schemes, the English Infected Blood Support Schemes or equivalents in the devolved administrations?
A. No, in fact, before I knew that was happening I suggested -- by then I had been in post about ten years and I thought there was a public interest in roles being rotated and committees being renewed. So I thought it was time for me to go in any event.
Q. You also tell us in your statement that the other members of the Panel who were appointed at the same time as you were Annie Hitchman, who was the lay member?
A. Yes.
Q. The hepatologist Dr, then Professor, Mutimer?
A. Mutimer.
Q. Mutimer. Dr Patricia Hewitt, who was a consultant in transfusion microbiology and the GP, Dr Dracass; is

that correct?
A. Dracass.
Q. Dracass. Thank you. In 2009, Dr Dracass retired and was replaced by Dr Gourlay; is that right?
A. Yes.
Q. In 2012, Professor Mutimer retired and was replaced by Professor Peter Mills?
A. Yes.
Q. You tell us that on your appointment you met with Mr Fish of the Skipton Fund who provided the secretariat to the Appeal Panel; is that right?
A. Yes.
Q. At that initial meeting you were provided with a copy of the two different application forms, so that's the application form for stage 1 payment and the application form for the stage 2 payment, and you were also provided a document that you had, in fact, already seen, because it had been sent to you in the application pack for the appointment as chair, and we will look at that in a moment. You think you were also provided at that meeting with a copy of the Agency Agreement between the Department of Health and the Skipton Fund, although that document may have come to you later; is that right?
A. I certainly couldn't have been, because it hadn't been

signed at that stage. I got it some time later, because, as has been pointed out, it was not signed until a long time after the Fund was set up and a year or so, I think, after the Panel was set up.
Q. Can we look, first of all, at the Agency Agreement, although you didn't have it initially. Soumik, it is SKIP0000033_058. You see there it is an agreement between the Secretary of State for Health and the Skipton Fund Limited. This may sound an obvious question but it is right, isn't it, that neither you nor anyone else from the Appeal Panel were a party to this agreement?
A. No, no. So it is right, yes.
Q. Can we go to page 14 of the agreement, please, Soumik? We will see at paragraph 6.3, clause 6.3 there:
"DH [Department of Health] shall as soon as possible after the Commencement Date arrange for the provision of an independent appeals Panel to adjudicate on claims rejected by Skipton."
Then if we can turn on to page 31, please, part 4, "Appeals":
"4.1 An independent appeals panel having been provided in accordance with Clause 6.3, Skipton will provide the secretariat and organise all necessary meetings of the Panel, prepare cases to be considered,

record the Panel's decisions and communicate the decision to each appellant.

"Skipton will pay Panel members' fees and expenses."

Is this how it worked in practice?

A. Well, almost. I am sure you will come on to the writing of decisions but it says there that the Fund will record the decisions and communicate them. It was agreed with the Fund -- well, with Nick Fish -- that I would write the decision letter, send it to the Skipton Fund and he would send it out to each appellant, so it is almost right, but not quite right.

Q. Then we looked, when Mr Fish gave evidence, at the parts of this agreement that set out the definition of qualifying persons. I am not going to take you to those but was a copy of this agreement made available to other members of the Panel, other than yourself?

A. I don't know.

Q. So you didn't make that -- you didn't make this agreement available to them yourself --

A. No. No, I didn't.

Q. -- but the Skipton Fund may have done?

A. *(Inaudible)*

SIR BRIAN LANGSTAFF: Just one question on the process, which is set out at 4.1, and it really relates to

what's on the first page of the document. So if we can go back to 33_058, first page, please, Soumik. No, before that. It is the bit in brackets at the top:

"Incorporating amendments agreed between the parties on 30th April 2012."

The first question really to you, Ms Scott: is there anything on the face of this document which shows what those amendments were?

MS SCOTT: From memory, sir, no. I can't recall that. I am just having a look through to see if there's any text in underlining or brackets and I can't see that there is.

SIR BRIAN LANGSTAFF: One of the questions really is, as a matter of course, you had adopted the process of writing up your own decisions. Going back, if we can, please, to where we were at paragraph 4.1.

MS SCOTT: Page 31.

SIR BRIAN LANGSTAFF: Do you know why that itself was not amended in 2012?

A. Well, I have no idea. The only copy of this agreement that I ever saw was the one which must have been given to me shortly after it was first signed, which I think is 2007, from memory. I had no idea about the series of amendments that happened after that. I knew about

changes in eligibility, either because they were communicated by Nick Fish or else because they were in the public domain, but I didn't see the text of the document changing as it was amended.

SIR BRIAN LANGSTAFF: So you were sitting in appeal on decisions made under a scheme which, although you understood the basic idea, you had not seen the actual wording at that later stage?

A. I hadn't seen except -- well, I didn't see future copies of the agreement itself, but the things which mattered to us were the eligibility criteria, and if they were changed, those changes came to our attention.

SIR BRIAN LANGSTAFF: Thank you very much.

A. I don't think anything else in the agreement which relates to the appeal procedure was changed. I may be wrong. I stand to be corrected, but I don't recall anything about our process being changed.

SIR BRIAN LANGSTAFF: Thank you.

MS SCOTT: Can we turn, Soumik, then to SKIP0000031_229. Is this the document that you were provided as part of the appointment process and then provided with again by Mr Fish at that first meeting.

A. I remember having it to make my application, so I knew what the constraints on -- or what the scheme was for

the appeals. If Nick says that he gave me a copy when we met, then I am sure he is right. I don't remember that.

Q. In fact, that information came from your witness statement, so -- but you --

A. I know I met him after I was appointed. I must have had this document to make my application in the first place. If I said in my witness statement that he gave me another copy, that seems to me curious, but if I said it, I must have believed it when I wrote that.

Q. If we go to page 3 of this document, we can see it sets out the role, the Terms of Reference and the constitution of the Appeals Panel.

A. I am sorry, Ms Scott. I don't know if anything turns on this, but I am just having a very quick look at paragraph 9 of my witness statement and I can't see where I said I got another copy of the application form. I may be wrong, but ...

Q. Perhaps it is my misreading of your witness statement.

A. I saw that application form when I made my application.

Q. I understand, yes. I misread your witness statement. I don't think anything turns on it.

If we turn to page 3, we can see there it sets out what -- the role of the Skipton Appeals Panel, and

that's really set out at the end of the third paragraph. The role is, because there is a right to appeal to the independent appeal panel against the decision of the Skipton Fund, and then sets out the Terms of Reference:

"The role of the Appeals Panel is to reconsider the cases of any claimants who appeal against individual decisions made by the Skipton Fund. The Panel will look at how the decision was reached and examine all available evidence, or seek further written evidence where necessary ..."

Then it says:

"In considering the evidence the Appeal Panel will look solely at the written evidence and will not seek personal attendance."

Is this how you understood, that there was no power to hold oral hearings?

A. Yes. It suggests to me, and nobody on the Panel I think had any other view, in setting out: if you want to be on this Panel, you will deal with it by means of open hearings.

Q. Then it goes on to say:

"The Panel will not be able to consider appeals against the ex gratia payment scheme itself, but only to examine the process to determine the claims within

the terms of the scheme."

Again, is that where your understanding of, if I can put it this way, the jurisdiction of the Appeal Panel ended, ie if it was an appeal against the terms of the scheme, it had to be by way of judicial review rather than by way of appeal to the Panel?

A. Yes. I mean, it seemed to me plain that what this meant was there are qualifying criteria for payments and the Panel can't vary those. The Department has set out where it wants to make ex gratia payments and where it doesn't, and I didn't think we could just say "Well, we don't like that. We won't have a natural clearer rule", or "We won't have a" -- well, that's one example.

Q. Then it goes on to set out what the test is that the Appeal Panel will be applying:

"Appeals may be made against decisions concerning both stage 1 and stage 2 payments. For stage one appeals, the Panel will need to determine whether, on the balance of probabilities, chronic hepatitis C infection resulted from receipt of NHS blood or blood products, and for stage two appeals, the likelihood, on the information provided, that the claimant has developed cirrhosis or primary liver cancer."

SIR BRIAN LANGSTAFF: May I just ask a question here in respect of the first paragraph? The first sentence makes it clear that the job of the Appeals Panel is to reconsider cases, so that's reconsideration, but the second sentence begins:

"The Panel will look at how the decision was reached and examine all available evidence ... to either confirm or change the Skipton Fund's decision."

That sounds suspiciously like a review jurisdiction rather than a reconsideration, doesn't it?

A. Yes, it does. I noticed that.

SIR BRIAN LANGSTAFF: But you read it as a reconsideration?

A. Well, I think that may be a distinction without a difference, because the cases we were involved in, and I am sure we will come on to this, were nearly always -- well, two thirds at least, I think, were cases where the Skipton Fund appeared to have turned round the application for the payment simply, if not solely, very, very mainly, on the basis there was no documentation of transfusion. So one could say, really: We looked at it, we said yet again, "They have refused this applicant because there is no record of his or her transfusion". So I don't think --

I certainly agree, Sir Brian, that there are different appeal criteria, if you like, but in practice I don't think the second sentence really added very much to the first.

SIR BRIAN LANGSTAFF: It is certainly not the way you went about it, is it, from your witness statement? As you say, it probably doesn't matter, but it is a curious bit of drafting possibly.

A. Certainly, I think. I mean, we looked at the Skipton file, which was generally -- this is not meant at all critically -- a pretty modest file, wasn't very much in it, and we would see a letter which said, "Very sorry but there is no evidence you have had a transfusion. Rejected."

SIR BRIAN LANGSTAFF: Yes.

A. No doubt we will come on to our approach. We thought we had to do a bit more than that.

SIR BRIAN LANGSTAFF: Yes. Yes, thank you very much.

MS SCOTT: Turning to the second paragraph under "Terms of Reference", which sets out the test under stage 1 and stage 2, it is pretty clear the test for stage 1 is on the balance of probabilities, because it says so. How did you understand the test for stage 2, because it says that you must determine the "likelihood".

How did you understand and interpret that?

A. Stage 2 cases were many fewer than the stage 1 cases, and very sadly the preponderance of the stage 2 cases were sadly how far the disease had developed. So in many cases -- in the standard case, has somebody got cirrhosis or not, for example, with help from the hepatologist member of the Panel we can say, "Well, this person clearly has liver disease. In our view it hasn't yet got to the stage of cirrhosis but I am afraid to say it is likely that it will turn into cirrhosis". So what we did in those cases was to say, in effect: not yet, but please apply again when -- when -- the formulae which were -- I think were accepted by the hepatitis community -- showed that we had got to the stage where clinically a diagnosis of cirrhosis was appropriate. With the some sort of difficulties attached to that. They were much more diagnostic questions.

Q. I will come on to ask you some questions about what the criteria were in due course, but am I to understand that the balance of probabilities was the test applied to likelihood for stage 2 applications as well, so, on the balance of probabilities, whether or not the claimant has developed cirrhosis or primary liver cancer?

A. Sorry if I repeat myself but I don't think it worked

in quite the same way. On the stage 2 appeal there would be formulae on the application form, and I am afraid I can't remember the details but it would be measurement, and I know one of the enzymes was ALT and I can't remember the abbreviation of the other, but there was a set formula, which was, I think, accepted by all concerned, that once one passes a certain level there is cirrhosis and before that there may be fibrosis, but it hasn't yet got to the stage where clinicians would say this is cirrhosis, but in most cases, sadly, those who got that sort of liver disease progressed to cirrhosis, and at that stage the papers came back to us and we said "Yes, there is a diagnosis which we are happy to accept", and there will be a -- we allow the appeal. So it was a completely different process from stage 1.

Q. So it was effectively a "yes" or "no" to the diagnosis?

A. On the basis of, if you like, laboratory measurements, yes.

Q. Then the document goes on to the constitution of the Appeals Panel and sets out who would be on it. Are you able to assist us with the last paragraph there:

"Arrangements will be put in place for the Appeals Panel to take additional expert hepatological

advice to review the evidence in favour of cirrhosis where claims for the second payment have been turned down should this prove necessary."

Do you understand what that was referring to? Is that something that ever happened, that you got additional expert advice?

A. No, I have never seen before, but in the papers I was sent to prepare for this hearing, there was an earlier draft of arrangements for appeals, and that had a pool of five hepatologists who would do the research and then presumably serve up an opinion or a consensus to us. That never happened. There was never a pool of anybody else to help. There were simply the members of the Panel.

Q. Can we go then, Soumik, on to page 7 of this document? It sets out what the role of the Panel chairs and members are:

"... have a collective responsibility for the operation of the Appeals Panel. They will be required to:

"engage fully in collective consideration of each case, taking account of the information", et cetera, "including the substance and principles of the Scheme."

Were you given any information other than

what's in this document as to what the substance and the principles of the scheme were that you were supposed to be taking into account?

A. I can't remember when we got this document, but the only thing that could possibly have qualified I think would be the formality of the Agency Agreement, which, as I think we have agreed, we got in about -- well, some time after it was finally signed, which was the middle of 2007.

Q. And then to:

"reach" --

A. There was nothing else.

Q. And then:

"... reach fair and considered decisions in what can be difficult situations; engage fully in collective consideration of each case, taking account of the information available ..." et cetera. And:

"... act within the Appeal Panel's remit."

Then "Communications":

"Panel members will not communicate directly with claimants, their caring physicians or any physicians involved with their applications. Administrative tasks will be carried out by the Skipton Fund who will present appeals for consideration by the Appeals Panel. The Appeals Panel

will submit its decisions directly to the Skipton Fund, who will be obliged to accept those decisions. Should Panel members require any further information about the case when considering an appeal, it should be requested on behalf of the Panel by the Skipton Fund."

Was that procedure, that no direct communication between the Appeal Panel and the appellant, physicians, et cetera, was that something that happened in practice?

A. Strictly, yes. And I think, while we are at it, the sentence about the communication of decisions may be an answer to Sir Brian's question earlier. That's why we sent the decision which I wrote to the Fund for Nick Fish or one of his colleagues to send out to the appellant.

I suppose I should add one small qualification. There were several cases where Dr Mutimer was the clinician, but we dealt with that, of course, by excluding him from the discussions. We didn't ask him to make any comments about the case in advance of the meeting that members did circulate and he played no part in the decision-making.

In case I forget later, there is one case which we turned down where one of the reasons was that there

was a discrepancy between two places where the appellant said she had had the transfusion, and one of them was Roehampton. Well, that must have meant Queen Mary's, Roehampton, and by a historical quirk, that was owned by and under the jurisdiction of Wandsworth Primary Care Trust, of which I was the vice chair, so I absented myself.

This is all historic, a long, long time before I was involved with the Primary Care Trust, but from an abundance of caution I didn't play any part in that decision.

Q. Would it have been helpful to have had more information from the Department of Health about the terms of the scheme, the Appeal Panel and how they were expecting you to run it or was there -- did you have sufficient for your purposes?

A. In a sense we did. What was surprising to me was so little information, but by a year in we had the Agency Agreement, which formalised what we had been told fairly informally in the application form and the note on the Panel that we are looking at.

And what we took from it was that we didn't have paper hearings and we used the balance of probability test. It's fair to say that the involvement of the Department of Health with the Panel

was non-existent, except for the one meeting in 2011, I think, about the co-infected, changing the criteria for them. And I suppose that was because the Skipton Fund were their agents, I don't know, but we had no relationship at all with the Department of Health. So we were left to get on with it. That was the truth of it. There was a big backlog built up and we were expected to try to get on and decide the cases, the appeals.

Q. That was my next series of questions. What, if any, contact was there between the Appeal Panel and the Department of Health and you said there was none at all, apart from the one meeting you have mentioned in your witness statement, which I think you say in your witness statement took place in January 2013, which I will come on to ask you about --

A. Yes.

Q. -- but that was the only direct contact that the Appeal Panel had with the Department of Health?

A. That's right. The members were appointed for three years. I think, on occasions, I had to sort of send an e-mail to Nick Fish and say "Our terms are coming up, what are you going to do about it?" I think the truth was that the Department of Health was very busy. After a while, the Lansley reforms were going on and

huge amounts of their resources, as I understand it, were being transferred to NHS England. I think the last thing on their minds was our Appeal Panel. If I'm wrong, there was no evidence to show they were very interested in what we were doing. I think they thought "It is a problem we have, in some sense, resolved by appointing the Appeal Panel and they are getting on with it and nobody has raised any major objections".

You sent me sheaves of Skipton Fund directors' meetings and AGMs that, of course, had had nothing to do with us but, occasionally, I would see they would say "The fund is quite happy with the way the Panel is going on". Maybe that was the way the Department used its agents to satisfy itself what was going on, but all this is outside my direct knowledge.

Q. Was any information from the Department of Health ever fed back to you through the Skipton Fund?

A. Well, only, I suppose, when they changed the qualifying criteria. I can't think of anything else.

Q. So all the changes to the qualifying criteria came through the Skipton Fund?

A. I think so. I honestly can't remember -- I mean, there might have been Department of Health press releases or communications to the hepatology

community. I think the case is that we were informed by the fund that the agreement had been varied. I think that's right but I honestly can't remember the detail of it, I am afraid.

Q. Before I come on and ask you some questions about the relationship between the Appeal Panel and the Fund, I just turn to the meeting in January 2013. Your witness statement tells us that this arose as a result of changes made to the scheme criteria in 2011, allowing the estates of those who had died before 29th August 2003 to apply to the scheme, and the Panel was, therefore, being asked to consider some cases of people with haemophilia who were co-infected and had died prior to 29th August 2003 where the record of the main cause of death was HIV and there had been no biopsy or post mortem examination to establish cirrhosis; is that right?

A. It is right. The way I remember it is that David Mutimer -- and this is shortly before retired from the Panel -- he was very concerned indeed about this because he thought it almost certain, very highly probable, way more than one would need to convince a Panel to allow an appeal, that anybody who had HIV and who had a clotting disorder would almost certainly have had hepatitis C and cirrhosis, by reason of their

co-infection, and the question was how fast the co-infection increased the chances of cirrhosis. That was the basis of it.

So he thought that a logical application of the new rules was that almost everybody who was in the category you have just read out would, in fact -- although there was no evidence of it -- have had chronic hepatitis C and almost certainly cirrhosis. So David developed a model, and I can't remember the detail -- it was very highly technical and, although I understood in lay terms of what it was all about, I didn't understand the equations. He had an expert view about how quickly the fact of co-infection worked on chances of cirrhosis being -- it wasn't identified until the person was dead but the fact that they would, by the time of their death, have had cirrhosis.

The meeting with the Department of Health was simply to try to agree the formula of how fast the co-infection brought about the cirrhosis. It happens -- the only time I have met Howard Thomas, who the Inquiry heard from yesterday -- he appeared -- I think, but I'm not sure, it was before he was a director of the Skipton Fund but he was a world expert on hepatitis C and he was at that meeting.

By the time of the meeting David Mutimer had

retired and Professor Peter Mills had taken his place on the Appeals Panel. I think it is -- it is certain that Howard Thomas's view of the speed of co-infection causing cirrhosis was less -- I wouldn't say extreme, what is the right word -- was less dynamic than David Mutimer's; in other words, that Howard Thomas, and I think Peter Mills probably agreed with him, thought that the speed of development wasn't as fast as David Mutimer's formula suggested.

Anyway, that was the one contact we had with the Department of Health. I think the civil servant was Ben Cole. I know that the senior person was Ailsa Wight, who used to occasionally write and say "You have been reappointed, thank you for what you are doing". But that is the only contact I had with her.

We went to this meeting at the Department of Health. Dr Hewitt was with us and I can't remember who else -- oh, and Nick Fish was and maybe the chair of the Skipton Fund.

Q. Why, if Professor Mutimer had a view that this cohort would, in fact, have had cirrhosis, did the Appeal Panel feel it necessary to refer the question for agreement with the Department of Health?

A. Because this was all completely hypothetical and we were told -- I can't remember the detail of the change

of qualifying criteria, but David Mutimer said, in a sense, "Here's one way of looking at it". That's a very good question, come to think about it. I think we thought that, given this was an entirely controversial subject and that there were no measurements -- these people had died without any biopsies and without any test results, and David simply suggested a model.

One could say, I suppose, that we should have just said "All right, that's David Mutimer's model, we will use it". I am not sure I can do better than that. I think we thought the appropriate thing to do was to say "Was this the department's intention?" Yes, that's how we approached it. I think when David Mutimer first introduced the subject at one of our meetings or by an email beforehand, he said "I wonder if this is what they meant to happen because, on a literal application of this wording, those without measurements, without biopsies would appear, in some cases at least, to be entitled to a further payment; is that what they meant to happen?"

So I think we took the view that we ought to check that and once we had done that, of course, then there were questions of: what is the correct speed of infection? It was an exponential, I remember that.

There was no doubt there was an exponential increase in the likelihood of cirrhosis. We wanted to know, given we had no witnesses but only hypotheses, we wanted to know what was the right approach, if you like, in terms of a scientific enquiry.

Q. Do you recall what the outcome of that meeting was?

A. The outcome was that there was a reply, as I understand it, from the Department, again highly technical requirements. No doubt will have had -- I don't know whether it was Professor Thomas who was behind it or anybody else at all employed by the Department, but there was a formula that they suggested.

Now, I do remember, because I know that when we come on to the Ramsay report, there is a suggestion that I made a suggestion -- it isn't a suggestion, it is a fact that I made a suggestion to Nick Fish that they use, they rely upon the report. I can see the force of suggesting I shouldn't have done that, which I accept. But, on the other hand, I found in the documents that when the Department of Health gave their view on the matter, Skipton Fund, no doubt through Professor Thomas, developed its own formula for the speed of development of cirrhosis, and Nick sent me an e-mail saying "This is what we are going to

use; do you agree?" On this occasion I wrote back to him and said "It is not a question for me to agree, you develop your criteria, we will apply our criteria, otherwise the appeal would have very little effect".

Q. In effect, otherwise the Appeal wouldn't be independent from the Skipton Fund and Department of Health decision making?

A. If we had said "Yes, we will all sign up to the same agreement". What happened in practice, just to be clear about it, was that this whole thing arose as a big controversy, if you like, a big scientific controversy, but we had almost no appeals because, I think, nearly all the people who applied were satisfied with the Fund's decision. So the cases just didn't come to us. So, in one sense, it was academic because we had -- I am sorry to keep interrupting.

I think in the end we had slightly more generous, if you like, criteria in our formula than the Skipton Fund, but nobody appealed and therefore it must have been that the Fund's criterion was adequate for the appeals -- for the applications to be granted. This is all surmise.

Q. So is this right, that having gone to the Department of Health saying "Is this what you meant?" when they then in response after the meeting said "Well, this is

the criteria by which we say somebody should be awarded a stage 2 payment", the Appeal Panel effectively said "Well, we need to be independent, so you go your own way, we will do our own thing and we will see where we go"?

A. I think there was another stage. I think the outcome was the Department said "Yes, we can see that must be the logical consequence of the way we have shown the criteria", and then the Fund, no doubt highly influenced by Professor Thomas, used a formula, we used a formula, but we hardly ever used the formula because there were almost no appeals made -- zero appeals, because the applicants were satisfied by the Fund's decision, which must have been to accept the application.

Q. I am going to ask you now some questions about the relationship between the Skipton Fund and the Appeal Panel. We have touched on some of these issues already.

SIR BRIAN LANGSTAFF: Just before you do that, as I listened to you talking, the Appeals Panel was set up to look at the evidence, all the materials. It is entirely practical and sensible for one member of the Appeals Panel to say "This is my experience, this is my view", in essence, I suppose, providing evidence to

the Panel. Nobody ever thought of that as a conflict, I take it?

A. Do you mean because David Mutimer gave a view about it?

SIR BRIAN LANGSTAFF: Well, he would have a view but he was providing essentially evidence that "This is what happens, this is what my experience is, this is, if you like, the expert evidence I am giving to the Panel". That's one way of looking at it. This is a tribunal, of sorts.

A. Yes, I know, a very unusual one, in my experience, because it was picked, I imagine, because there were technical questions about these applications and these appeals which required expertise from a hepatologist and a haematologist. Now, we have seen that, or I have said, that in the documents is a draft for the working of the Appeals Panel, which suggests there should be a pool of consultant haematologists to give evidence, yet there wasn't.

SIR BRIAN LANGSTAFF: Yes. So, in essence, the scheme was set up to rely upon the evidence, if you like, of the expert view, the expert evidence, the opinion of the hepatologist on the Panel.

A. Yes, in a sense. The view, the technical view was clearly highly influential because, by definition,

that particular member had a greater knowledge of the subject than the rest of it and it could sometimes be the GP, I sometimes might have to give a legal opinion. But I think what we tried to do was, treating each other as much as we could as equals, we would ask "David, what does this mean, what are the likely consequences of this measurement?" and he would give his opinion, or Ms Hewitt would give her opinion about something to do with blood, and we would take that into account and then we would discuss it.

So there is no doubt that on matters of hepatology David Mutimer, followed by Peter Mills, had more than 20% of the input into the question, but we didn't automatically say "David says therefore we agree".

SIR BRIAN LANGSTAFF: Yes, I understand.

A. It is not perfect. I am certainly not suggesting for a second that this was an ideal way of going about things it but it seemed to be the set of rules that the Department had put in place.

SIR BRIAN LANGSTAFF: Yes, yes. Thank you very much.

MS SCOTT: So moving onto relationships with the Skipton Fund, you obviously had a relationship with Mr Fish, who was providing the secretariat to the Appeal Panel. Did you have any contact with anyone else from the

Skipton Fund, any of the other directors or members of staff?

A. Face-to-face, only in the early years when I used to go -- when it was time for a meeting, or a month or so before it was time I used to go to the Fund to read the files which were coming up for appeal, to identify to the extent I could what further material we would like to see to make our decision easier and, on occasion, I would meet Peter Stevens and we would have a sort of polite chat.

I had completely forgotten that he wrote to me asking me to intervene with the Department on the question of natural clearers until I was sent the papers for this exercise, and I didn't rebut that. I remember, to be honest, being slightly embarrassed because I could never remember which was Peter Stevens and which was Martin somebody else, who was the chief executive.

Q. Martin Harvey.

A. So I used to hope they would say "Hello, it is Martin, nice to meet you again". There was absolutely minimal contact. At Board level, no, we didn't get their minutes. The first time I have seen their minutes -- and I didn't read all of them because most of it had nothing to do with the evidence I could give to you --

was when I got the massive bundle of them for this exercise.

Q. Do you know whether any of the medical members of the Panel had discussions with medical directors of Skipton Fund?

A. Well, we know just from the papers I have been sent that Patricia Hewitt offered her opinion about the possible infectivity of UK anti-D product. I have seen somewhere in the bundle towards the end an e-mail exchange between David Mutimer and I think Nick Fish, certainly with somebody at the Fund. We didn't have joint meetings every year or anything like that. There was no institutional contact.

Q. You say in your statement that you attended meetings at the Skipton Fund when occasion demanded, certainly no more than once a year. Can you --

A. That's a quite sober estimate.

Q. Can you give us an idea what kind of meetings those would have been?

A. Looking back on it, I don't actually think I had any, except to the extent when I went there to read files, if Peter Stevens was there, he might say "Let's have a chat", and he used to say "How's it going," and I would say "We are doing our best", sort of thing. I know on one occasion he said "Nick, why don't we

invite Mark to the Christmas lunch". They never did and I wouldn't have gone but I didn't want to be rude.

Q. So you don't think, in fact, that there were any kind of formal meetings where the Skipton Appeals Panel and the Skipton Fund got together and discussed matters?

A. I'm certain there weren't.

Q. What information -- we know from your previous evidence, and indeed from looking at the files, that the Skipton Fund or Nick Fish, Mr Fish anyway, as the administrator, received the Skipton Appeal Panel decision letters. Was any other material or information provided by the Skipton Appeal Panel to the Skipton Fund about the decisions that it had reached?

A. I can't think of anything. Do you have something particular in mind?

Q. No. It is an open question.

A. No. As far as I remember, I would write, if necessary, to him saying -- well, at the end of each meeting, almost without exception, there would be cases where we felt we just didn't have enough evidence to make a decision. So I would ask him, aside from the decision letters, to look at these cases. "We need the following information", but apart from that I can't think of anything.

Q. The Inquiry has seen minutes -- indeed they were sent to you and I don't know whether you read them, it doesn't matter for the purposes of this question -- seen minutes of the Skipton Fund meeting minutes, in which Peter Stevens has asked Mr Fish to seek further clarification from the Skipton Appeal Panel as to how they reached a certain decision. Do you recall such requests being made of you for further clarification from the Skipton Fund?

A. Now you say it, Nick Fish was very scrupulous and I am sure if he was asked to do that, he would have written. I don't remember the occasion or the occasions. I don't remember what sort of questions they were. General speaking, we didn't feel we ought to account to the Fund. That is also to say that it went the other way round, that, if we had accepted or refused all the appeals, we would not have thought that they had any business or jurisdiction to say "Well, that's not right". Equally, we had no targets, we had no budgets. We dealt with every case as it were.

If I had been asked -- suppose I was asked "Why did you decide that", I don't think I would have chosen to add to the decision on the basis we were told in the initial paperwork that you looked at this

morning that the decision of the Appeals Panel was final.

Q. Can we look at an e-mail thread? It is at NHBT0091224_007? This is an e-mail thread between -- it starts off with an e-mail from yourself to Mr Fish and then -- so this is the end of the e-mail thread on 18th August 2011. So if we can start on the last page, page 4, please. So about halfway down the page is the first e-mail on 9th August. It says:

"Nick

"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 it says:

"In cases involving haemophilia it would be very useful to know whether the haemophilia was ... mild or severe and ... whether the treatment was restricted to cryoprecipitate. If it was not, as much evidence as possible should be provided to show whether the clotting factors included commercial concentrate or were restricted to NHS product.

"I look forward to hearing from you in due course."

So that's the beginning of the e-mail trail. We will look at where it goes in a moment, but why was it that you were asking the Skipton Fund, or inviting the Skipton Fund, to collaborate on the approach to the scheme?

A. I had forgotten all about this and I can't, I am afraid, give you a very good answer. I think what prompted it was when we came on to -- it was a very long time, as I remember it, before we got any cases where the appellant had a clotting disorder, and maybe this is me with a throw-back to the HIV/haemophilia litigation and I suddenly think "Am I being silly here, does NHS blood or blood product mean manufactured by or provided by?" That's where it all started.

In other words, is the criterion that you are paid if anything you get is provided through the NHS or, in the case of haemophilia, do you only get paid if Factor VIII is NHS Factor VIII and not commercial concentrate? That's where it all started.

The, I suppose, more direct answer to your question is that, as they were the agents of the Department of Health, my wording is sloppy and what I am doing is asking the Fund, as agents, to provide a view from the Department. I accept that that e-mail

says -- that would have been why we sent it to them.

Q. Why then would it be appropriate for the Appeal Panel to seek clarification or guidance from the Department of Health on an issue of the interpretation of the scheme?

A. Because their intention would have at least have been informative, if not binding on us. I can't remember now, and I am sure we are not going to look at the Agency Agreement, but I can't remember whether NHS blood or blood products was defined in the Agency Agreement as anything that was given to a patient in an NHS setting or anything that was made by the NHS. The whole thing in retrospect -- and, as I say, I have no recollection of this at all until I saw it in the bundle -- was a complete red herring.

Q. Do you think taking this kind of approach asking for clarification, going to the Department of Health, asking for their view or their guidance on how matters should be interpreted, do you think that that impugned the independence of the Appeal Panel?

A. Well, if so, to an extremely small extent. The Agency Agreement is the only formal document that we have that governs our business and I think it would have been important, that it turned out to be a complete red herring, to check that people were entitled if

their infection came from treatment in an NHS facility rather than treatment from a product the NHS had made. I don't think I can say any different to that.

I perfectly accept that we could have taken an independent view without asking the Fund on behalf of the Department or the Department direct, but that's what we did. I can't change that.

Q. Having said I am going to look at other -- the rest of those e-mails, in fact, I don't think it is necessary for the purpose of that question. So, Soumik, you can take that document down.

You have already mentioned the e-mail that you sent to Mr Fish, suggesting that the Skipton Fund should use a particular report when dealing with applications about intravenous drug use and you said in your witness statement that you think, with the benefit of hindsight, that that was an error. Can you just explain to us why you think that that was an error to have made that request of the Skipton Fund?

A. It was a suggestion, not a request. Because, as with the criteria for co-infection, it was for them to develop their formula and for us to develop our formula. We had got something -- I think I said in my witness statement that it seemed to us that where

there was a paper by, we were told, the leading authority in the UK about infection from intravenous drug use and infection from blood transfusions, we thought they were objective, quantitative, peer reviewed -- well, derived from peer review journal evidence that was, in one sense, objective and we thought it would be a shame if somebody had been turned down on non-quantitative grounds, if you like, and appealed to us and we would say "Well, there is a piece of paper that proves that it is wrong".

I accept I shouldn't have done it and I learned the folly of my ways by the time I told Nick Fish that they should use their formula for co-infection and we would use ours.

Q. I am going to ask you some questions now about the procedure and we have touched on some of this already and you have explained to us that you -- well, is this right: you were provided with the appeal papers by Mr Fish?

A. Yes.

Q. Were those all the papers that the Skipton Fund had; in other words, there wasn't a cohort of papers that the Skipton Fund saw that the Appeal Panel never saw?

A. Well, I couldn't possibly answer that, could I?

Q. But as far as you were aware?

A. I understood we were provided with complete files. What else was in Skipton's office, I wouldn't know. I can't see any reason why we wouldn't have done. I assumed that we did have complete files.

Q. You have explained how in the early days you would attend the office to decide whether any further information was required prior to the hearing of the appeal. What happened latterly? There's an inference that you stopped attending the office to stop carrying out that task, so how was that task performed latterly?

A. We would get the papers in advance of the meeting. Of course, when I went to look at the files, I could only -- if there was something which would have been very helpful, some laboratory test results that I just wouldn't, as a lawyer, have known existed or should exist or what they might mean or whether they were complete, et cetera. So I was really saying, in cases where there was minimal information, "Could you please at least ask them to provide such and such?"

But there would also be cases where one of the technical members of the Appeal Panel would say, either before or at the meeting, "The records end here but they should go on to there, we can't really make a fair decision without seeing the rest of it", in

which case the case would be adjourned or deferred and we would ask for more.

Q. We know from what you have already told us that all requests for information would have gone via Mr Fish. Would he make requests for further information off his own back or would they always have to be directed by the Appeal Panel?

A. Again, I mean, I can't really answer that question. I heard at the end of Professor Thomas's evidence yesterday, the very end of it, he talked about seeking out information, but I think -- again, I don't want to trespass on the Skipton Fund's territory -- but it looked as if they started off with Nick Fish, and Mrs Boyd -- or Dr Boyd, I can't remember her status -- making a decision, and then toward the end, because we were making different decisions so often on the basis of getting more information and making inferences, I think they enlisted -- I know they enlisted Professor Thomas and Professor Dusheiko to make similar sorts of inferential decisions that the Appeal Panel made.

That's a long way off saying -- Professor Thomas himself said yesterday "We would ask for information, like photographs of a scar". So I suspect the Skipton Fund's process and procedures

changed when they got medically qualified directors employed to look at files on board, but that really is a question for the fund.

Q. I don't think I made my question specific enough: I meant in relation to the appeal process. So would Mr Fish, in performing the role as secretariat to the Appeal Panel, make requests for further information himself or would those requests always have to come through somebody on the Appeal Panel?

A. Well, in the papers these are guidance notes -- are our guidance notes for appellants and that would set out what would help us make a more informed decision, and it seems from the files that we have seen that this was routinely sent out by the Fund to people when they say they wanted to appeal.

Q. I will look at that in a moment. Just sticking with the procedure, is this right from your witness statement: you tell us there were no time limits for appeals --

A. Yes.

Q. -- there were no fees payable for appeals --

A. No.

Q. -- and there was no application form that had to be completed for an appeal?

A. No, that's right, and also -- I am sorry to interrupt

you -- it was also the case that we didn't say "Right, you have appealed, that's it". You could come -- "If there is more information, come back to us and we will look again".

Q. Shall we look then at the guidance provided to appellants? It is NHBT0090738. Was this a document that you wrote, can you recall?

A. There are different versions of this document in the papers and I know it was expanded and I got this wrong. I think I misremembered in my witness statement. After or around the time of the judicial review, and I think, if I remember rightly, and in my bundles, if we need it, we have got the different versions. I don't know yet, because I can't see the end of it, whether this is the final version, but as I describe in the witness statement, because all of the difficult cases in our initial few meetings were cases where there wasn't any documentation of a transfusion, it wasn't an argument about whether or not the case was outside the parameters of the scheme, if you like.

There were cases where the appellant said "I had one", and there was no indication in the notes, medical records or in the file that they did. So we thought we are never going to resolve this for

certain, but helping to allow us to make better decisions would be a list of things that would help us in our decisions and as some sort of explanation of the way we went about it.

Q. So you have there, under "Missing Records", set out some steps that appellants can take in order to find their records --

A. Yes.

Q. -- including going to the GP and obtaining -- if records aren't available, obtaining a letter to that effect from the relevant NHS body?

Did the Skipton Appeal Panel provide any direct assistance to appellants in tracking medical records down; in other words, would they --

A. No.

Q. No. Did you ever come across an appellant who could not afford the cost of copying or producing medical records?

A. We were never told that was the case and I suppose, perhaps naively, I assumed that wouldn't be a cost to the appellant. I vaguely remember from my days of practice, and perhaps one of the tribunals that I sat on, that there was a small fixed fee, which I think to be in the order of £10, but the honest answer is we never had that experience of somebody saying "I can't

do this because I can't afford it". To be honest, we didn't think about it.

Q. Then you set out at paragraphs 5 to 7 the direct first-hand evidence that the appellant can provide: a personal statement, paragraph 5; paragraph 6, any statements from witnesses; and then paragraph 7, written evidence about treatment that they believe led to the infection.

Were you aware that the Skipton Fund had not been able to consider any of this kind of evidence? All they had considered, at the first stage, was the form as it had been filled out by the clinician?

A. I don't think -- I wasn't specifically aware of that. What I was aware from looking at the files was that most of the cases we got to deal with were cases where no documentation of transfusion equals no ex gratia payment, which may be an answer to your question meaning, yes, that's what happened. But, I mean, we didn't intervene in the Skipton Fund's decision-making.

Q. Then paragraph 8:

"In the absence of complete records the Panel will make a judgment on the likelihood of your exposure to hepatitis C given the type of treatment, the circumstances and the outcome that you describe."

Is that what you refer to in your witness statement as "clinical plausibility"?

A. Yes, in effect.

Q. I will come back and ask some questions about that.

Then, over the page, there are some paragraphs on IVDU:

"Applicants who have had a history of exposure to recreational intravenous drug use (such as heroin) are unlikely to succeed in their appeal."

Then there is a reference to the expert report, or the expert advice:

"However, because the Panel considers each case individually, you should document all your intravenous drug use in as much detail as you can.

"2. The Panel will make a judgment on the relative likelihood of your having obtained hepatitis C from [IVDU] or from NHS treatment."

Again, I will come back to ask you some questions in relation to that, but certainly this suggests that IVDU isn't the end of the application; there is an assessment that is carried out. Is that right?

A. Yes, yes. We have to be the right approach.

Q. Then, at the bottom of the page -- it then sets out what other risk factors are, other reasons for

refusal. And then at paragraph 3, at the bottom, it says:

"Fluid replacement ... artificial plasma expanders and intramuscular anti-D immunisation, (in pregnancy and miscarriage/abortion) are not associated with hepatitis C infection and will not be considered by the Panel as probable causes of your infection."

So is it right to understand that if the history was infection via anti-D, that was a "no", that was a strike, there was no balancing and consideration of the evidence?

A. Well, that's slightly too simple, if I may say so, because if somebody had had anti-D, which was manufactured in Germany or the Republic of Ireland, then there was a distinct probability that product would be infected. But that being said, NHS produced anti-D immunisation. And I know there's a -- I have heard questions to Mr Fish and I've heard counsel's presentation about anti-D, and no doubt you will ask me about it and no doubt you will ask Dr Hewitt about it.

Q. I will come back to that.

You have said that there were different iterations of this guidance?

A. Yes.

Q. We are not entirely sure which iteration this was, but -- sorry.

A. Well, if that's (inaudible), it is an early one.

Q. Well, there's another page. If we go over to the next page, it says:

"Obtain a copy of your original application form ... make sure you agree with your consultant."

And then the last paragraph is on natural clearers and explaining the position in relation to them.

A. I think that is a later version, that long paragraph on natural clearers. The last one was longer than the first one, I know that, so you could compare possibly the two documents in the bundle.

Q. Whichever iteration was in place at the time, this was the information and guidance and assistance that the appellant would have received from the Appeal Panel?

A. Yes.

Q. One of the features of the scheme was that there was no -- the clinicians filling out the application form couldn't charge a fee, or at least if they did charge a fee, Skipton Fund or the Appeal Panel wouldn't pay for it.

Given that the clinicians were required to search -- or could be required, in some cases, to

search back through many years of old records to find relevant entries, do you think that the quality of the evidence provided by clinicians may have been improved if payment had been made?

A. Well, with respect, I don't think that's a question for the Panel. That's surely a question for the Fund, isn't it? We had no relation with the doctors. We simply had a file of papers delivered, read them carefully and discussed them and made a decision.

The problem -- I think the problem, as I understand it, was the long lapse of time leading to the destruction of records under NHS policies. So I don't know -- I mean, I know from other tribunals that there's an evidence gathering stage, normally done by the office, where the relevant NHS body is asked or ordered to produce somebody's records. So I don't think it is a question of the consultant trawling through records to try and find a clue. I think that's something that the Fund would have done or we would have done. I think, as I understand it, the clinician had to give an opinion about whether or not somebody had been given a blood transfusion which had infected the appellant with HCV, not that the consultant was being asked to do a very onerous search of large files. The problem was the lack of

documents, not the burden of going through them.
Q. The same, as I understand it from your witness statement, was to have all five members of the Panel present at every meeting. Is that right?
A. Yes.
Q. And we know from your previous evidence that all hearings were conducted on the papers. There were no oral hearings at all?
A. Yes.
Q. Is that something that you ever considered to be an impediment in your decision-making?
A. Well, I deal with this in my witness statement. If there are questions of credibility or memory or quality of evidence or even looking for scars that weren't -- operation scars in photographs, I have no doubt that with -- and with representations, submissions, cross-examination, I have no doubt we could have given more informed decisions, but the Department of Health set up a system we applied to be appointed -- we were appointed. We worked by the system. Like rules of court, in effect.

Of course, I am not saying that this was the best system of justice available. I am saying that this was -- within the rules set by the Department we did the best we could.

perhaps.
SIR BRIAN LANGSTAFF: Okay. Well, let's proceed.
MS SCOTT: You describe in your witness statement that you would discuss each case on the agenda in turn and come to a determination with your fellow Panel members and you would seek for unanimity, and if you couldn't get that, there would be a majority vote. Is that right?
A. It's right. It was extremely rare that it came to that. Very rare indeed.
Q. Your options were, effectively: uphold the Skipton Fund's decision, overturn the Skipton Fund's decision or send the matter back because you needed more information and you weren't in a position to make a determination?
A. Well, yes. I would express the third as "ask for more information".
Q. Then you have explained to us that you drafted the reasons following the decisions made by the Panel. Was it necessary for the Panel to agree on the reasons or was that left to you, your discretion?
A. I don't know how far you want to get into the decision writing process now, because the answer varies on what the decision was.
Q. It is the process rather than -- that I am interested in.

Q. You have explained in your witness statement the Panel would meet approximately quarterly?
A. Yes.
Q. Is that right? Did the Panel keep any records of their decisions or any minutes of meetings or anything of that sort?
A. I kept notes of the discussion, and at the end of 2017 -- because, remember, this was all being done from my home, I have hidden in my home some extraordinarily sensitive documents about 443 individuals. I said to Nick Fish "I really don't want to keep these. I shouldn't keep these", and they were sent back to the Fund.

We didn't publish notes of our discussions. We didn't publish minutes of the decision-making process.

I fully accept, as I am sure you will come on to, that there was a question about the form of the decision letters. But I mean, no, we didn't keep full minutes.
Q. Sir, I note the time. I still have a few more questions on the procedure itself. I don't know whether it would be sensible to finish those before we break or whether we should break now?
SIR BRIAN LANGSTAFF: How long will they take?
MS SCOTT: They shouldn't take very long. Ten minutes

A. As I said in my witness statement, if it were clear what the decision was and the reasons for it, then I would write -- at the end of the discussion I would say, "Right. This is what I am going to say. Is that right?" and people would say "yes" or "no", and then I would send it.

In some cases where there were technical matters I would -- this is probably one in 30 decisions -- I would send the -- if it were a hepatology query, to the hepatologist, if blood, to Dr Hewitt. I would say, "Here's a draft of my letter. Have I got this bit right?"
Q. Where there was a split in the vote, if I can put it that way, was that something that was ever relayed to the appellant?
A. No, because it was very rare indeed. Whether it was because, in a sense, I think we trusted each other and we deferred to each other on matters technical, I think if there were a real weight of opinion one way, it would be very, very unusual for one person, as it were, to register a minority opinion requiring a vote.
Q. The Inquiry has seen a range of decision letters. Is this fair, that when the decision was to overturn the appeal, that the reasons were generally rather

shorter; when the decision was to effectively reject the appeal, they went into somewhat more detail? Would that be fair?

A. Well, it was more than that. I don't know whether you want me to get into the whole subject of decision-writing now, but in effect when I first met Nick Fish at the Fund, I said to the effect of, "What is the Fund looking for in terms of the decision? Do you want a judgment? Do you want a letter?" And he said -- and you may say I shouldn't have accepted this -- "A letter, keeping it as brief and simple as you can". I don't know whether at that stage or subsequently I said, "What if we are allowing the appeal? Do you want us to go into reasons? Does the Fund want reasons or shall we just say, 'We are satisfied that you qualify'?" And to the best of my recollection, and you might want to ask Nick Fish whether he remembers the same, I think it was the agreed that a simple decision saying "You have been successful" would be enough. There is, of course, a question about whether we should have produced more formal judgments, and no doubt we will come on to that, but that was what happened. So, yes, if you succeeded, you were just told in effect, "Good news. You have succeeded."

Q. Just finally then on the procedure, you have told us a little bit about the role that the medical members of the Panel took in advising been the Panel as to medical matters within their own expertise. What was the position, or did this ever arise, where you were faced with a medical question that was outwith the expertise of all those on the Panel? Were you able to or did you ever seek further input from clinicians?

A. I didn't and, as I said a moment ago, I'm sure that most of the members would have looked at old medical textbooks if they needed to, might have consulted older colleagues if it was a question of what happened in the 1950s, that sort of thing, but people came armed with whatever corpus of expertise they had or information they had to contribute to the decision.

Q. Do you recall instances where secondhand information, if I can put it like that, secondhand advice was being relayed to the Panel from another clinician who was perhaps practising in the '50s or perhaps practised in a different discipline, to tell you about the likelihood of blood transfusion being used for different procedures?

A. Not specifically. The other thing is -- I was thinking about this before we started -- Dr Dracass, I think the appointment letter or the press release

said he was 62 in 2006. He was an immensely experienced GP and I thought had an extremely wide medical knowledge. If he was 62 in 2006, by 1965 -- which was, I think, the -- generally -- well, certainly for the purposes of co-infection, it was the date that hepatitis C was thought to be circulating in the UK, he would at least have been a medical student, if not a doctor.

That's a roundabout answer. I can't be certain, but -- put it this way, we never based our decision -- or what swung us to "yes" rather than "no" or "no" rather than "yes" was never a relayed secondhand decision by a different clinician.

MS SCOTT: Sir, those are the questions I wanted to ask on process. So perhaps now would be a good time to break?

SIR BRIAN LANGSTAFF: Yes. We will take a break. We normally take half an hour. So if you can be back here, please, at 11.55. So 11.55.

(11.27 am)

(Short break)

(11.55 am)

MS SCOTT: I am going to ask you some general questions now about how the Panel approached appeals and then I am going to come on to ask you questions about

particular cohorts of appeals.

Firstly, what was your understanding of the risk of being infected with hepatitis C via a factor blood product?

A. I know that Dr Ramsay in her report -- I think it is on page 3 -- said that in -- I think it was 1980 to 1990, one unit in 200 of blood was infected with HCV.

Sorry, 1 in 200. I said 1 in 100, I think but it was 1 in 200.

Q. So your understanding of the risk of being infected with hepatitis C from blood transfusion came from Dr Ramsay's report, did it?

A. Dr Hewitt would have talked in general terms about the history of infectivity of blood with hepatitis C but, as I said, before when we tried to get some cogitative data from Dr Ramsay she quoted 1 in 200 units of blood being infected with hepatitis C in quite a late decade for the lifetime of this Panel -- sorry, not the Panel. But the cut-off date was 1991. So for the ten years before that, when presumably hepatitis C was no lower than it was in earlier years, it was said to be 1 in 200.

Q. We have heard evidence from various witnesses in relation to the risk of being infected with hepatitis C via a blood product such as Factor VIII or

Factor IX being 100%; is that the view that the Panel took?

A. I am sure it was but, in a sense, it didn't matter what view we took because there were no cases coming to us, because all of the people infected -- sorry, all the people who had had clotting factors were automatically allowed -- their applications were granted. So we didn't have any "I had Factor VIII but I have been refused" appeals because there weren't any.

Q. Did you have any appeals were people had said that they had had cryoprecipitate?

A. Not that I can remember. Again, this wasn't something I looked into closely because it didn't affect us but I have a recollection, which may or may not be right, that cryo was counted as a clotting factor and, therefore, the stage 1 applications were being granted. I may be wrong about that, I don't know.

Q. How did you assess the balance of probabilities as a matter of generality when you were determining appeals?

A. It is an extremely difficult issue, isn't it, because it is clear that that's the standard the Department set: it must be probable that the infection came from blood or blood products, but for our purposes really

blood. Was it more likely than not? Now, what we did do, we made a major presumption in favour of appellants, which was that if they had a transfusion, we made the assumption against the arithmetic that it was infected. If Dr Ramsay is right, and I have no way of knowing whether she is or not, only 1 in 200 units of blood transfused to appellants would have been infected with hepatitis C.

We ignored that. We thought we don't want to make it too difficult, we will assume that anybody who has had a blood transfusion, unless there is a countervailing factor, such as intravenous drug use, we would assume that that blood unit was infected.

We could see when we started work that the Skipton Fund took a rather literal approach: if there was no record of a transfusion,then that was it, application refused. We thought it couldn't be right for us to do that, because it would make the whole appeal process pointless if we simply followed the Skipton approach, and I thought it was legitimate, and we discussed this and we agreed, that one could look at inferences. One could say "There is no proof as such that appellant X had a transfusion but looking at the overall context of medical history, availability of records, outcomes, strength of recollected

evidence, we think in some cases that one can say, hand on heart, it is probable that there was a transfusion". Then at that stage our presumption in favour of the appellant kicks in and we would not say "But we still have to find out whether that was an infected unit or not; we will assume it was and we will allow the appeal".

I don't know what the right time to -- just a matter of context because of the very helpful note that counsel produced on the Skipton Fund on this area. I think, from memory, there were 6,700-odd applications to the fund and there were 433 appeals, which is, I think, about 6.5%. 300 of those were cases variously described as "medical records" or "lack of information" and, of those, by common consent they are the most difficult cases. We allowed 60% of those, round numbers. There were 300, we approved 180 and refused 120.

I noted at the end of -- in his witness statement and at the end of his evidence Professor Thomas, who Professor Mills said was the foremost authority on hepatitis C, certainly in the UK, possibly in the world, he describes them as "difficult decisions" and if we can later, because I looked up the transcript last night, there are two passages

where he deals with the inferential process and I think what he says is very interesting indeed. But I will leave it to you when you want to do that.

So what we got was as much information as we could and then we said "Now, on the basis of all this taken together, do we think it is probable, not possible, but probable", which is our criterion, "that there was a transfusion, in which case we will assume it was the cause of the infection".

Q. The application form already included a statement from the clinician to say that they thought the blood transfusion or a blood transfusion was the probably cause and that there were no other risk factors. Why was that not enough, given the fact that they had assessed the patient and the Appeal Panel was not in a position to do that?

A. We thought our obligation was to take a fresh view because, in the same way as we didn't want to just say "Skipton Fund said no evidence, therefore we refuse the appeal", if the Department of Health had wanted a scheme where the certification of the clinicians was conclusive, it would have said so.

May I add, as well, that of the 300 cases that came to us, and particularly of the 120 that we refused on those grounds, the information of the

clinician was often much more equivocal than "Yes, I confirm it is the only cause". I can't give you examples off the top of my head, but if one trawled through those 120 cases, I would be very surprised indeed if all 120 had certificates from the clinician "Yes, there was a transfusion". Quite often we would see things like "Patient says transfusion such and such".

Q. So clearly if the certificate is equivocal, then that's something that the Panel would have taken into account; is that correct?

A. Yes.

Q. If the certificate is "Yes, it is my view that the probable cause of the hepatitis C was the identified blood transfusion", what weight did the Panel give to that?

A. It gave it considerable weight, but it didn't, of itself, push us over the balance of probabilities, really for the reasons I have just said, that if that's what the Department had wanted, a certificate from a clinician equals a payment, that's what it could have had but it didn't choose that.

Q. Did the qualifications and experience of the clinician filling out the form make any difference to the amount of weight given to it by the Panel?

A. I honestly can't remember. It certainly wasn't a system where "He is a professor or she is a professor, we will accept that" or "He or she is a junior doctor in the back of beyond, we won't accept that". There was nothing like that.

Q. Would not a straightforward application of the burden of proof on the balance of probabilities mean that, unless you had a reason to think that the clinician was wrong, you could approve the application?

A. I don't think so.

Q. I am going to ask you some questions then about natural clearers.

A. Before you go onto that, I was sent a decision from an HIV Panel by Benet Hytner QC, and I was told that was because the approach there was the least unlikely and did we think about using that. Do you want to deal with that?

Q. I will come on to deal with that a little bit later on this morning.

I am going to ask you some questions about natural clearers. Was the test for determining whether someone had cleared hepatitis C within six months determined on the balance of probabilities?

A. Yes, it was, but it was really determined on PCR tests, the results of PCR tests, as I remember it. In

other words, if there is evidence that there is a positive PCR test after six months, we would just allow it, straight up.

Q. What did the Panel do where there was evidence that the person had cleared hepatitis C but no evidence as to when this had been cleared; in other words, the PRC test was after -- was not taken until several years after the infection was identified?

A. You mean a positive test or a negative test? Negative?

Q. Negative test, yes.

A. I think, at that stage, we fell back on the general epidemiological data, which suggested -- I can't remember the proportion -- but a very, very high proportion of people who cleared it, cleared it in the first six months, which was presumably why the Department put that criterion in the scheme. Therefore, if the burden is to show it is more likely than not and, say, 95% -- I am picking a number out of the air, but of that order -- if they clear it, clear it within six months, there is a 1 in 20 chance that is this person didn't.

Q. Did the Panel ever consider an alternative approach, namely that on the evidence before it, it was only possible to conclude that the applicant had cleared

the virus at the point the PCR test was negative, why it was only safe to conclude that the person had cleared the virus on that date?

A. I don't think so, for the reason I have just articulated. These were relatively unusual cases for us. They weren't the sort of main diet of the Panel and, in general, we reserved ambiguities like that on terms of -- according to the advice -- or on the accepted view was 95% likely that it had cleared, if at all, within six months.

Q. I am going to ask some questions now about anti-D immunoglobulin. You say in your witness statement that the Panel had a settled view on the chances of being infected with anti-D, as a result of the advice from Dr Hewitt. Can we look at SKIP0000031_071? This is a letter dated 24th February 2005 to Mr Keith Foster, the scheme administrator. Can we go over to the second page, please? We see there it is signed by Dr Patricia Hewitt. Can we go back to the first page?

Is this a document that the Appeal Panel had, do you recall?

A. I honestly don't remember. I know there were two letters. I know that Patricia Hewitt wrote another one with a co-signatory and I think, but I will be corrected, that was in response to a request for

a sort of template from Nick Fish, but the views were pretty much the same, as I recall it. I mean, I have read both of these letters recently preparing for today. I can't remember whether I saw this letter. Of course, it was written long before the Panel was convened.

Q. So when you say in your witness statement that the Panel had a settled view on advice from Dr Hewitt, was that advice given during Appeal Panel meetings rather than written advice that the Panel were aware of and understood to be her view?

A. In essence, yes. There was no doubt I think, from her experience, her position and, indeed, her reputation, she was the person who knew most about this in the UK. She made it perfectly clear there were no recorded cases of hepatitis C infection caused by UK anti-D. And if that's the case, given the yellow card systems and the close community of haematology, and particularly -- I can't think of the right word -- the transmission of blood products and blood to patients, I think she was best placed to know. And Dr Mutimer and all the other medical members never raised any possible objection to her view.

Now, having seen somebody with -- sometimes there were batch numbers which were confirmably UK

product, sometimes not, but she says in either this letter of the other one that anybody who got Irish or German anti-D was only given on a named product basis. Which would mean that the records would be very likely to reflect the fact this was a specially authorised treatment. We never saw one.

Q. Was this the Panel's understanding from Dr Hewitt, that intramuscular anti-D that had been manufactured in the UK had an unparalleled safety record?

A. Well, that's a normative judgment, isn't it? What we accepted was there were no records of intramuscular NHS or UK-derived anti-D had ever been recorded to cause hepatitis in a patient.

Q. Did the Panel also accept that there were cases of infections from anti-D where they were manufactured outside the UK and imported and provided on an IV basis?

A. Well, I'm not sure what you mean. We knew that certainly the Irish product was imported. I see now, at the bottom of this page, Dr Hewitt says:

"I am not aware that the product used in Germany was ever imported into the UK."

I am in no position to agree or disagree with that, I simply don't know, but the position on the ground was there was never any evidence that anti-D

treatment was with anything but UK product and there was no evidence that UK product had ever infected a patient with hepatitis.

I am sorry, there are lots of negatives in there, but the short answer is we did not believe anti-D carried a risk, let alone a balance of probability risk.

Q. Soumik, you can take that document down.

Was it possible to know, when you saw an appellant's records, what kind of anti-D had been given?

A. I think you would be far safer asking Dr Hewitt that question. I never remembered seeing something saying "Irish product. Named patient basis", anything like that.

Q. Do you --

A. Sorry, just to finish the answer. In some, but not all, of the cases, the batch number of the anti-D was written in the notes and Dr Hewitt said, and I was no position to contradict her, "That is UK product."

Q. So, is this fair: in some of the appeals it was possible to identify conclusively from the records that the anti-D was a British product?

A. Yes.

Q. But for some of the appeals that information wasn't

available?

A. In some of the appeals it was not -- well, I was not in a position to identify the batch number or the source of the product, and at that point Dr Hewitt, uncontroverted by other medical members of the Panel, asserted that this was anti-D and there was no risk of hepatitis. That's the best I can do, I am afraid.

Q. I have shown you the 24th February 2005 letter from Dr Hewitt, and you mention that there's another later letter, from July 2010. Were those letters ever provided to applicants as part of the decision process to help them understand the basis for the decision?

A. No, we didn't send out "Attached to this decision is a copy of Dr Hewitt's letter".

Q. Do you think it would have been a good idea to do so, in the interests of transparency and fairness to the applicant, so they could understand the basis on which their application had not succeeded?

A. Potentially, but we were this a position where, as I mentioned before the break, we had agreed, rightly or wrongly, with the Fund that we would send out short, concise letters, and we were -- I mean, I could have written judgments, but I wasn't encouraged to or asked to, in which case one would set out, as in a normal court or tribunal judgment, evidence relied

upon.
Q. Did you have any concerns that --
A. May I add to that?
Q. Yes.
A. We also put the basis of the decision in the guidance notes for the applicant.
Q. Did you have any concerns that, as Dr Hewitt was the only member of the Appeal Panel who had expertise in this area, she was effectively assessing the value of her own expert opinion?
A. Well, theoretically yes, but we have heard that the Department was very hard pushed to get a haematologist onto the Panel. I am not suggesting this makes this all perfectly okay, but Dr Hewitt was, and is, a well-recognised expert on the subject. She was, in my view, entirely neutral, and very fact rather than value-based in her judgments and appeals, and I didn't think we had a better source of opinion. I can see in one sense it is not transparent, but it seemed to me that it was -- what we had was most likely to lead to both a truthful and a fair outcome.
Q. Do you recall having any appeals about gamma globulin?
A. No. I mean, I knew all about that because in 1995, just as I was leaving private practice, there was a gamma globulin -- I think two batches were imported,

it was made by Baxter Healthcare in the United States, and two of the batches had hepatitis C in them. And I negotiated settlements on behalf of those who were infected with Baxter, and their lawyers. So I knew about it. It was intravenous, as far as I remember, and there was no doubt whatsoever that these batches were infected with hepatitis.

I even, oddly, remember why. It was infected through the manufacturing process and that they had no defence under the Consumer Protection Act, because the FDA in America had used them to use a particular manufacturing process as the price of getting a product licence and it was -- so the company wasn't protected by a national or EU requirement, which would have been a defence under the Act, but they couldn't avail themselves of that. I remember the case very well. But there weren't any -- we didn't have any gamma globulin cases.
Q. I am going to move on now to intravenous drug use.

Can we look at the Dr Ramsay report. It is SKIP0000031_217.

So you have explained in your witness state how this came about, that the members of the Appeal Panel had a hunch -- I think you put it slightly stronger than that -- that the risk of being infected by

hepatitis C was higher for an intravenous drug user than it was for somebody who had received a blood transfusion?
A. May I interrupt you? I use the word "hunch" but it was more than that. The received wisdom, if you like, not by me, because I wasn't a doctor, but the Fund, whoever trained Nick Fish, trained him that IVDU was, in principle, far more likely than a blood transfusion to affect someone with hepatitis C.

The three doctors on our Panel were clearly of the same view. So it wasn't a hunch in the sense of a guess, it was a received wisdom. But I thought, rather than say it is a received wisdom, it would be fairer to appellants if we tried to quantify their relative risks.
Q. The purpose of this report was to do precisely that?
A. Yes.
Q. Can we go over to page 2 of the report? Third paragraph down she set out what their model is. She says:

"Using this model, it was not possible to estimate the risk of infecting" -- I think she must mean infection -- "for periods less than one year but this does suggest that, over recent years, about 16% of injectors in England and Wales acquire HCV

infection in the first year of injecting."

Then she goes on to say:

"Data suggests that most injectors are initiated or assisted by friends, and that amongst those who initiate others into injecting, sharing of needles and syringes and of paraphernalia is more common than amongst those that have not initiated others."

Did you take from this that the history of how the person started to take intravenous drugs was important?
A. I thought it was a factor to be considered, yes.
Q. Then in the next paragraph, about halfway down that paragraph, she says:

"The risk of transmission from a single episode of syringe-sharing with an individual with chronic HCV infection was estimated to be between 1 .6 and 4.3%."

Then skipping the next sentence:

"Assuming that susceptible individuals share randomly with [injecting drug users] in this population, this would generate a risk of transmission of between 0.4% and 1.5% per single sharing episode for intravenous drug users in London in 2002-3."

Then she goes on at the bottom of that page to say, in that last paragraph there, talking about

additional factors that may influence the risk, she says the prevalence in London and north West of England are particularly high and associated with high risks of transmission.

Then over the page at the bottom of the first paragraph, she talks about the temporal connection:

"... injecting drug use prior to 1990 is likely to be associated with even higher levels of risk of HCV acquisition."

At the bottom of that page, in the last paragraph in the middle of that paragraph, is the part that you have already referred to:

"Assuming that infection would follow receipt of all donations from HCV RNA positive donors, this would equate" -- she is talking about risk of transmission by blood transfusion -- "this would equate to an approximate risk per transfused donation of around 0.0 5% in that period."

Soumik, you can take that down now.

Did understand this report to exclude transfusion as a cause of hepatitis C where there was a history of intravenous drug use?

A. We can't exclude it absolutely, but we looked -- I mean, on page 2, about one in six injectors acquire HCV infection in the first year of injecting. Now,

amongst syringe-sharing deniers you halve that risk. So one in 12 people who deny sharing needles are infected. So about 8% in round numbers, whereas about half a per cent-- have I got that right -- yes, about half a per cent-- no, 0.05, so 1 in 2,000 get hepatitis from transfusions. It seemed, not just to me, because I wouldn't have thought I had the best view on this, but the medical members on the Panel said "This is clear confirmation that if there are two competing causes, the probably cause is injecting even once, even denying sharing, with an intravenous drug". But the plain numbers -- I must admit that was immediately my -- I don't claim expertise on the subject but I have dealt with a fair amount of epidemiological studies over my career in litigation, and it said the same to me. You are far more likely to get it from even one sharing-denying use of intravenous drugs than you are from a unit of blood.

Of course, that doesn't mean the risk is nil, but it means it is not over 50%.

Q. Did the Panel consider the history of drug use versus the history of blood transfusion and amend the percentages accordingly? In other words, if there is one account of one intravenous drug event and there is an account of multiple transfusions, would the Panel

have adjusted the percentages accordingly?

A. There was no such case. There was one case, certainly, where -- in fact, I think probably the only appeal we had where there was a confirmed transfusion but there was also IVDU, and we thought in that case, taking into account the account from the person herself and, if I remember rightly, members of the family, we thought if we applied the Ramsay figures to that, the analysis to that, it was still comfortably more likely that the hepatitis C infection was from drug use.

Now we may have been right; we may have been wrong. What it appeared to us, if we had to say was it probable that the infection came from hepatitis C (sic), we had to say no, it wasn't. It was possible, but it certainly wasn't probable. That was our view of it.

Q. In some -- I wouldn't say many -- of the cases -- I wouldn't say many because I don't know if that is right -- but some of the cases that the Inquiry has looked at, there is a history given by the appellant that there was no sharing of equipment.

A. Yes.

Q. Is it right to understand that in those cases where they were rejected by the Panel, it was because the

Panel did not accept that account given by the appellant?

A. The last thing we wanted to do with any appellant who had the misfortune to be infected with hepatitis C was to make judgements about truth. We weren't equipped to make judgements about truth. We weighed in the balance somebody saying "I used drugs but I never shared needles" against the figures in the Ramsay report.

The Ramsay report says half the people who -- sorry, half as many people are infected with hepatitis C from drug use who deny sharing needles as those who admit sharing needles, and the overall incidence is more than ten times higher than the risk attached to hepatitis C.

I think I go back to an earlier point. If we had had a system where there were complete records, there was first-hand evidence, the Skipton Fund, if it wanted to, was able to cross-examine the appellants and we could make a decision based on what we heard, that would have been one thing, but we didn't. We had a paper-based appeal. We had, if you like, the population statistics. We took into account what the appellant said. We didn't -- as far as I remember in 433 appeals, we didn't suspect anyone was lying to us.

Q. Where there is no opportunity to test the evidence, for precisely the reasons you give, wouldn't the fairest approach have been to have accepted that evidence about the sharing of needles, and so on, at face value, unless of course there was objective evidence in the material before the Panel to suggest that that wasn't the case? Wouldn't that have been the fairest approach?

A. You have to go back to the way the scheme was set up. There was a burden of probability. So I can't see, in the face of those figures, how one can -- the Department of Health could have said "And on appeal any appellant who asserts that she didn't share needles shall have the benefit of the doubt". It could have said any of those things. It could have said "Where there's a possibility that infection came from blood, the appellant is entitled to an award" but it didn't. I know that this is caused a great deal of unhappiness but we perceived that we were applying the burden that the scheme was set up to administer.

Q. Did the Panel look at other evidence to try to work out whether the dates of the transfusion were consistent with the infection, compared with the dates of the intravenous drug use, so, for example, progression to liver disease or matters of that

nature, evidence of that kind?

A. I can't remember in particular. The truth was that after the Ramsay report was used and appeals were unsuccessful, the appeals -- they didn't completely dry up but they were very, very rare after, say, 2007/2008. You might say that's unfair too but, based on the evidence we had -- and the case you put in the bundle is one of the most marginal cases because we know for sure there is a transfusion and we know for sure that there was a small amount of drug use. If I remember -- and I may well be wrong, in which case I'll be corrected -- that particular appellant said she bought the drugs from a friend. Well, Dr Ramsay says buying it from friends -- doesn't say those exact words -- increases the risk of infection with hepatitis.

Q. Isn't the risk of relying on the conclusions in Dr Ramsay's report, which are of necessity at the general level, isn't the risk of that that one ignores or overlooks or doesn't give appropriate weight to the actual evidence from the appellant that's in front of the Panel?

A. Well, I think I am going to repeat myself. We looked at the evidence from the appellant and any other witnesses. We gave it what weight the five of us

together thought it should have and we then contrasted it with the risks set out in the Ramsay report. It is the classic case where, in our view, it failed on the balance of probabilities. I am entirely open to the fact that in some cases we got it wrong. It would be a miracle if we had 433 cases and they were all decided correctly, but we did our best in what were very limited circumstances and with limited resources. I don't think I can say more than that, I am afraid.

Q. You have seen the report that the Inquiry has provided about its analysis of the Skipton Fund and the Appeal Panel's decision-making?

A. Yes.

Q. Is this right, that there were 48 appeals before the -- I can take you to the pages if that would help -- 48 appeals where intravenous drug use was a factor. 44 of those were refused and the four that were allowed were allowed on the basis that the appellant had been wrongly accused of being an intravenous drug user, ie they succeeded because the appellant was not an intravenous drug user?

A. Well, I have not reviewed these files. I am very happy to accept that that note is completely correct.

Q. Does that not suggest that, in fact, the Panel were treating the Ramsay report as meaning that it excluded

transfusion as a risk -- as the probable cause of hepatitis C when an appellant has a history of intravenous drug use?

A. In most cases we thought the risks documented in Dr Ramsay's report far outweighed the risk of a hepatitis C transfusion. I think I said before, but I will repeat, there is only one case that I can remember, and I have not reviewed these cases for today, where there was actual evidence of a transfusion, let alone was it a 1 in 200 or 1 in 2000 risk, if there was a transfusion of the unit being infected, there wasn't even a record of a transfusion.

One can envisage a case where somebody, for medical reasons or for experiment or academic study or something, somebody is given a single injection with intravenous drugs in a clinic or experimental surrounding and it is clear that all the kit is completely virus free, sterilised, and the drug is pure and has been obtained from a government laboratory or something, where one can see that there is no risk of transmission of hepatitis. Those were not the cases we were dealing with.

Q. What was the approach in relation to intranasal drug use? Did you have any appeals in relation to that?

A. No. I think Ms Richards in her presentation said "What's that got to do with it", in effect. I think the answer -- I wondered myself -- I think the answer is that it was to do with sharing straws for snorting cocaine but we never had any of those cases.
Q. Was a copy of Dr Ramsay's report provided to appellants --
A. No, for the same reason.
Q. Do you think it would have been a good idea to do in the interests of transparency and fairness, so they could understand why their appeal had been turned down?
A. In a different regime, yes. If I had been writing a judgment, such as I wrote for different tribunals, I would refer to the passages from Dr Ramsay's report relied upon or accepted by the Panel, but that wasn't the situation. It is a highly technical report. This is going to sound really weak, there was nothing to stop an appellant or an applicant turned down by the Fund asking for it. I would have had absolutely no objection to anybody seeing it but we didn't routinely send it out. Maybe we should have done, but we didn't.
Q. Do you also think it would have been fairer to the appellant if the decision letters in these cohorts of

cases had explained what conclusions the Panel had come to about the appellant's own account of their drug use?
A. I mean, yes, in the sense that had we not assumed, rightly or wrongly, what was intended and what I provided was a short form summary decision, yes, one could go into it. I was used to writing 20 pages of A4 judgments about medical cases in a different tribunal. It could have been done. Our belief -- I should take responsibility myself. My belief was that wasn't what was required or intended. Again, I may be wrong but that's the view we took.
Q. I am going to ask you some questions now about the largest cohort of appeals that you have identified, the lack of medical records cohort.
A. Yes.
Q. We have touched on the clinical plausibility and you have explained to us how that works. Was that something that the Panel considered, both in cases where medical records were missing entirely and cases where there were medical records but they didn't show a record of a transfusion?
A. Yes.
Q. Were they used in most cases where there was a lack of medical records or a lack of a record of transfusion,

or were they only used -- was clinical plausibility a fallback position used where there was no evidence either way to suggest a transfusion, ie if there was a first-hand account from the appellant that there had been a transfusion, and supporting evidence from family members that there had been a transfusion, would the Panel still rely on clinical plausibility?
A. Yes, because, for example, somebody might say "I was in a road traffic accident and I broke my ankle and I got hepatitis some time afterwards and I have been told there are no records". Yes, we would have said "Is it probable somebody on this limited information with a broken ankle would have had a transfusion?"
You see, from our point of view, the alternative really, if you are applying a balance of probabilities test, is just to say "Well, hard luck, there is no evidence". We were trying to be helpful when we did this. We were trying to say "The Fund has turned you down on the basis there is no proof, literal proof, no record of transfusion, we must be here to do something a bit more than that, and that's how we will approach it".
Obviously, the more records that existed, the more confident we could be that our leaning towards transfusion or not was in the right direction.

Q. How confident could the Panel be about its conclusions on clinical plausibility where, for example, the history is of a procedure that's outwith anyone on the Panel's expertise, so for example, an orthopaedic procedure or a gynaecological procedure or something of that nature. How confident could the Panel be about the likelihood of requiring blood transfusion for that procedure.
A. Well, there were three doctors who had had medical training. I think you can ask Dr Hewitt to confirm she has had some experience of gynaecological work. I'm not sure, but I seem to remember so, but I may be wrong. Doctors would no doubt look at the standard, the leading textbooks, Panel member doctors would, I am sure, as I've said in my statement inform themselves. I wouldn't and Annie Hitchman wouldn't. We wouldn't go on the Internet and say "such and such gynaecological procedure, what's the chance of a blood transfusion", that would not be within our competence, but the doctors would express an opinion.
Q. We heard --
A. May I just add that I think all these questions are going to end up in the same place. If you had been able to award a payment to somebody who had possibly had a transfusion, of the 120 refusals we actually

made, certainly not all of them would have been awarded because somewhere there were good records and there was clearly no transfusion, but I would have thought a majority of the 120, if the criteria -- I am sure the majority of the 120, if the criterion was a possibility, or a reasonable possibility, or you get an award unless the Fund can prove that you didn't have one, all these different counterfactual standards, many more of those 120 -- those 300 overall -- it wouldn't be 120 winning the appeal. It would be -- I don't know -- maybe 250. We considered that the phrase "balance of probabilities" was there for a purpose.

Q. We heard evidence yesterday from Professor Thomas that the approach that they took at the Skipton Fund to this was to look for evidence as to the likelihood of the blood transfusion being carried out for that particular procedure in the same way we have heard the Appeal Panel did, and that if there was a less than 50% likelihood of the procedure requiring a blood transfusion, then the fund would consider it unlikely to have occurred. Is that the same approach that was taken by the Appeal Panel?

A. If we thought it was less than 50% likely that there had been a transfusion, we felt constrained by the

obligation to deal with the case on the balance of probabilities, we would have felt constrained to turn down the appeal. What Professor Thomas said -- I looked up the transcript last night -- is in fact very interesting. Perhaps you will take us to the passages, which are on page 161 and 170 of the transcript respectively.

But effectively he says "If it was 20% likely, we would have refused it and sent it to the Panel". He then justifies this on the basis that the Fund uses an objective standard and we use a subjective standard. With the greatest respect to Professor Thomas, I don't find that anywhere in the Agency Agreement. We are surely operating on the same standard, which is the balance of probabilities.

Q. So on --

A. While we are on the subject, I can't remember which page -- that's 161. At 170, he says "These were terribly difficult cases". Well, I completely agree.

Q. So would you accept that, on the basis of the approach that Professor Thomas outlined and which I think you have said was also the approach of the Appeal Panel on clinical plausibility, ie there had to be more than 51% -- out of every 100 people that had a procedure, that particular procedure, if only 49 of them would

have required a blood transfusion, ie there was a 49% chance of having a blood transfusion, then you don't make the burden of proof on clinical plausibility. Is that -- you are looking like you don't agree with that?

A. Well, not that I don't agree with it, but we didn't -- I can see why you are putting it that way. We didn't say, "Let's have 100 cases like this", because there would have been no factual basis for that. We said, "Now, here we have somebody who says, no doubt honestly, that he/she recalls a blood transfusion in certain circumstances, we can't find any evidence of it in the papers, we can find peripheral evidence that suggests that he/she did/didn't have a transfusion, given that we have to think it is more likely that he/she did than didn't, we allow or reject the appeal".

We didn't do it on a sample of 100 basis. I accept that that's what 51% means, but we didn't do it on a cohort basis. We did because otherwise partly we're -- not under attack but it has been put to us we didn't take enough account of the individual circumstances. If we had said of 100 people, what would have happened? That would be diminishing the importance of the individual's testimony even further,

which would have been highly undesirable and highly unfair on the appellant.

Q. So is this right: clinical plausibility was not assessed on a percentage basis, ie the discussions the Panel were having were not "Well, this particular procedure has about a 20% or a 25% or a 40% chance of requiring a blood transfusion"?

A. What we did was we looked at all the evidence supplied by the appellant. We looked at all the medical records. We looked at anything like the Ramsay report or Dr Hewitt's report and we said "Well, here we have two conflicting versions, for this appellant to be given an award we have to show that the positive to her version is more likely than the negative to her version". I don't think I can put it any other way than that.

Q. How did the Panel factor in accounts from the appellant about, for example, a history of significant blood loss or having to stay in hospital for a long period of time after what should have been a routine operation or the operation going on for longer than it should have been, matters of that nature? How were those factual matters weighed in the balance as against a conclusion that the Panel had reached that it was clinically implausible that the particular

procedure required a blood transfusion?
A. I will have to resort to anecdotes here. I remember vividly one case where somebody said, "I was gushing with blood, I bled for a long time, severe loss of blood". Then there is a record of blood loss in the notes and it is less than one unit of transfused blood.

Now, Dr Hewitt again, she may be right, she may be wrong but, in my view, she was likely to be right, she said you would never, ever give a transfusion to someone who had lost less than a unit of blood. You know, every time one has a nosebleed or cuts yourself in the garden or something you think "Oh, my God! Look at all that blood", but that is a perception which is real to the perceiver but it is certainly not determinative of the need for a transfusion.

Again, when somebody stays in hospital, we just didn't have that much information in most cases. So what was very helpful was a discharge note to the GP from the hospital, where you say, "Arrived on such and such a day; prepared for surgery; routine procedure; no complications; discharged on the Nth day, which was expected", there is no basis in that to suppose that things went in such a way that they required a confusion -- I keep saying that -- a transfusion.

We may be right, we may be wrong, but we were trying to use the evidence as it existed.
Q. In the example you gave, that's an example, isn't it, where there is objective evidence within the material before the Panel that suggests that the first-hand account being given by the appellant is not all that it seems?
A. No, no, sorry, I am not saying that at all. I am saying that the appellant's perception that she lost loads and loads of blood is not borne out by the measurement taken by the hospital.
Q. Yes.
A. Now, you know, maybe the hospital measured it wrong, I don't know, but we are doing the best we can with what we've got. On the evidence as we have it, it seems very unlikely, in this example, that somebody who had lost less than a unit of blood would have been given a blood transfusion. Maybe, actually it did, but we are dealing with the balance of probabilities.
Q. How could the Panel consider and come to conclusions on the credibility of first-hand evidence where there is no objective evidence to tell the Panel one way or another, as there was in the example you gave, without having heard from an applicant or the witnesses?
A. We had to do the best we could. We'd say "Here is an

account by somebody we presumed to be honest, telling his or her recollection to the best of their ability, but it seems to us unlikely, going to pretty much impossible, that this could have happened in the way described". I'm sorry. You asked me about cases where there is no countervailing evidence. Right. I don't think I can do any better than that. Don't forget, we approved 60% of these cases. We were not turning them down left, right and centre.
Q. Can I put this example to you? If the Appeal Panel knew the particular person a particular operation in respect of which 10 or 20% of patients would have required a transfusion and the appellant said that he or she had had a blood transfusion, and there was no evidence of other causes of contracting hepatitis C, but equally there was no record of the blood transfusion, what would the Panel's view of that have been?
A. Probably the same as Professor Thomas's: if it's a 20% chance, it is not probable.
Q. But on what basis --
A. Don't forget -- (overspeaking) -- evidence.
Q. On what basis, though, could it be said that the blood transfusion was not the most likely cause, because there was no other cause, no other probable cause had

been identified?
A. There was no evidence that a transfusion had taken place, let alone, if there was, there was a 1 in 200 chance it was infected.
SIR BRIAN LANGSTAFF: I thought you were actually being asked to look at the situation where the evidence is not just a 20% chance of this particular procedure having a transfusion, but where the applicant him or herself says that they had a transfusion.

That was the scenario you were putting, wasn't it, Ms Scott?
MS SCOTT: Yes.
SIR BRIAN LANGSTAFF: So it is not just a question of the 10 or 20%, he or she could very well be one of the 1 in 10 or 1 in 5, and what might make the difference, it is being put to you, is that he or she says "I did" and there is no evidence that there is any other source of hepatitis C, because that, of course, is the starting point. Someone has hepatitis. Question: have they satisfied you on the balance of probabilities that they got it from a qualifying cause?
A. It is not a direct answer to the question, but Dr Hewitt, I remember -- I am sure you will ask her about this -- to the best of my recollection she said

that lots of people who haven't had blood transfusions have hepatitis C and nobody ever really knows where it comes from. Now, that's obviously a paraphrase of what she said. I can only repeat -- well, I suppose it also depends on the reasoning process, because I think it's -- maybe it's going to be put to me that we should look for the least unlikely, well -- and I will have something to say about that in due course. If the -- we didn't go out of our way to say "She is not telling the truth", because generally speaking we didn't think it, but I mean, may I say, *post hoc ergo propter hoc*, unless there is some reasonably convincing evidence that a transfusion took place in the first place, the fact that somebody remembers it we put in the balance, but in our view it couldn't be conclusive. I mean, it couldn't be determinative even on a balance of probabilities basis.

And I can see that that -- I can see a view which says if somebody said they have had a transfusion and they have got hepatitis, then it's for us, the Fund and everybody else, to disprove it, but I don't think that's what the scheme asked us to do.

MS SCOTT: You asked me if I was going to ask you a question about an approach in the document from the

HIV blood and tissue transfer scheme case.

A. Yes.

Q. I can take you to the document if that assists, but this is the moment when I am going to ask you that question.

Where there are a range of possible causes of hepatitis C infection, none of which are likely, either because they haven't been identified as risk factors for the particular appellant, or because of clinical plausibility, or for any of the reasons that we have been discussing this morning, did the Panel ever consider taking a different approach and considering, "Which one of these four possibilities is the least -- which one of these is the least unlikely"?

A. We never articulated in that way, and I have obviously thought quite a lot about this since seeing that decision by Benet Hytner, an immensely distinguished lawyer, and obviously one takes those reports very seriously.

First of all, there are a number of very significant differences between that case and one of the cases we would have had. There was a massive amount of information. There were purported recollections by the consultant in charge about the

use of fresh/frozen plasma. It was a Dr Rejman from the Department of Health who went down to Swansea to look at all the data. There was quite intimate history about the quality of the marriage concerned and there was enough for Mr Hytner to make a deduction about the prospects of the wife of the marriage being unfaithful, having sex with other people who might have infected her. That is just miles away from the paradigm case that we dealt with, where there was -- the only thing that was certain was hepatitis C infection.

More than that, because I was curious, and I hadn't looked at this area of the law for ages, but preparing for today, I looked up to the extent I could without a law library the proper approach in cases of competing causes. The most alternative decision I could find was Nulty v Milton Keynes Borough Council, a decision of the Court of Appeal in 2013, which said precisely that one should not do what Mr Hytner did.

I could read -- it is only two little paragraphs. It says:

"The Court of Appeal reiterated the principle in cases where there are competing explanations for a loss" -- in this case hepatitis C -- "that causation cannot be established only by a process of elimination

such that the least unlikely cause of a loss is identified.

"The claimant" -- in this case an appellant -- "must demonstrate that the particular version of events that they rely upon is more likely to have happened than not in order for the civil standard or burden of proof to be satisfied."

I am not pretending for a second that I took the Law Reports into every Panel meeting and referred to this or any similar iteration of the principle that Nulty says is being reiterated, but that's in a sense a sophistic answer. The fact was we didn't have such rich pickings of evidence as there was in the HIV case. I don't know anything about the way that that Panel was set up. I don't know if there was oral evidence. I don't know if there was advocacy. I just don't know anything about it, but the level of detail of evidence in that case was light years away from what we had in the cases that we turned down.

Q. Sir, I am going to move on to another topic. I note it is almost 1 o'clock. I think I have got about another fifteen minutes or so of questions. So I don't know whether now is an appropriate time for a lunch break?

SIR BRIAN LANGSTAFF: Yes. In that case we will have to

have you back after 2.00, if that's all right.
2 o'clock. So time for lunch now and we will start again at 2 o'clock.

MS SCOTT: Thank you.

(12.58 pm)

(Lunch break)

(2.00 pm)

SIR BRIAN LANGSTAFF: Before we continue with this afternoon's evidence, I would like to say something to those watching online. I expect that many of you will have heard about this morning's statement by the Paymaster General, the Right Honourable Penny Mordaunt, MP. You will recall that I first called for action to rectify the lack of parity and financial support for people infected and affected after the Inquiry's preliminary hearings. When we started the hearing of oral evidence I felt it was essential to hear from people infected and affected in each nation of the UK, because the impact of treatment with infected blood and blood products was felt in all corners of the UK.

Today, I really welcome the commitment to bring the four national schemes into broader parity, to help to alleviate what I have described as the grinding hardship to which far too many people have been

condemned through no fault of their own.

The statement also sets out the Government's intention to appoint an independent reviewer to carry out a study looking at options for a framework for compensation to inform the Government's preparations for what the Inquiry may recommend.

I want to reassure you that this is completely separate from the Inquiry, that it does not affect the Inquiry's Terms of Reference and that we will continue in our investigative work to get to the truth of what happened and, where recommendations are appropriate, to make them.

I look forward to the announcement of who the independent reviewer is to be and expect that many of you will take great interest in their work.
I anticipate that the Inquiry will want to hear from the reviewer once the proposals are published and that all Core Participants will have the opportunity to express their views to me on those proposals.

In the meantime, as I have said, our work continues.

So, that said, we turn back to hear this afternoon's evidence.

Ms Scott?

MS SCOTT: Thank you.

What role, if any, did the genotype of the person's hepatitis C infection have in the Appeal Panel's assessment of applications at stage 1?

A. Very little that I can remember. I know there were questions of whether there had been infection within the family. I think it was a relevant consideration whether the partners had the same genotype to exclude or make more likely infection through sexual intercourse. I'm afraid I really can't remember much more than that but I am sure hepatologists will be able to -- I'm sorry, in the Panel, maybe Professor Mills or Professor Mutimer could add more to that, but it wasn't a major consideration.

Q. Can you recall what score the appeal Panel required on a Fibroscan result in order to be satisfied that somebody had a diagnosis of cirrhosis?

A. I am afraid I can't.

Q. Can you recall if it was the same score as that used by the Skipton Fund?

A. No.

Q. You can't recall?

A. I can't recall.

Q. Do you know whether or not the score that this Appeal Panel required was ever published or notified to appellants?

A. I can't. As I say, I can't remember. I don't know.

Q. Do you recall whether or not the Appeal Panel ever required appellants making applications for stage 2 payments to undertake further tests?

A. Well, I know that it was -- on an ethical basis a biopsy was never required, no invasive test was required. I think the way we went about it was to say, "On the present readings of the various laboratory tests, our view is that you have not yet reached the stage of cirrhosis, please -- when you have more information, please come back to us". As I said, I think earlier this morning, in effect, claims for cirrhosis were never rejected because, regrettably -- I don't know whether it was in all cases or in a preponderance of cases -- the disease was progressive and if you didn't have a diagnosis of cirrhosis today, you might very well have one by later this year or next year. I am afraid, I am just not expert in these matters.

Q. How much weight did the Panel give to the treating clinician's diagnosis for stage 2 applications? Was that determinative?

A. No, it wasn't determinative because, as I say, we relied on objective markers, but in a sense these weren't very concerning matters, because we thought it

was, I am afraid, inevitable that progressive liver disease would end up with cirrhosis. So we were never saying "No". We were saying "Come back when the disease seems to have progressed in order to surpass the scores that were accepted -- conventionally accepted as evidence of fibrosis".

I seem to remember there were four or five stages. I am afraid my recollection of these things is very dim. It was scarcely an issue for the Panel, for the reason I said. We were never rejecting people at stage 2, unless there were some very odd cases where somebody said it was liver cancer and the preponderance of opinion was that it wasn't. In terms of cirrhosis, it was a question of "not yet" rather than "no".

Q. Going back to stage 1 applications, did the Panel ever consider whether and, if so, how transfusion practices might vary locally?

A. Well, yes, to the extent that we realised there was no uniform criterion for transfusion and, of course, practice changed over the years. So there were two variables but, unquantifiably, we didn't ask for evidence of the rate of transfusion incidents in North Shields. I mean, I don't think we could possibly have gone to that level of detail.

Q. Would you accept that evidence of local transfusion practice is likely to be a more accurate way of determining whether someone had had a blood transfusion rather than the clinical plausibility test that the Panel applied?

A. In theory, clearly, yes, but you would need somebody who had surveyed all the data and, of course, there is the problem of definition of a locality or a region. You would need a comprehensive survey in exactly what cases transfusions were probably given and probably not given. But, even that, one fractured ankle or -- I can't think of another example -- one category of disease, the severity depends on the individual. So it isn't that you can say East Anglia broken leg equals transfusion.

Q. How did the Panel get evidence of historic blood transfusion practice?

A. Well, all I can remember is it being the consensus once the medical members of the Panel, all five of them over the lifetime of the Panel, that people had been much more liberal with transfusions and that, whether it was caused by recognition that viruses travel in the blood or what, I honestly don't know, but that practice became more restrictive as time went on. I can't give you proportions or dates, but it was

a general consideration -- well, certainly there is a principle, I would say, that the fact it wouldn't be given today was nowhere near proof that it wasn't given in 1970. Absolutely not.

Q. Was the problem of over-transfusion, in particular historically, discussed at Panel meetings?

A. I think that's the other side of the same coin, isn't it, that people -- I can't tell you which medical members and on which meetings, but the consensus was that practice was more -- less cautious, if you like, and no doubt within that there might have been some people who thought in almost any surgical procedure "We had better give him some blood to be sure", versus there must presumably have been some outliers on the other side who with principle and foresight said "Be very careful indeed putting other people's blood into a patient". It was a sort of sense of the passing of time and the development of good practice. It wasn't more than that.

Q. Were you aware during your time on the Panel how much money had been paid out by the Skipton Fund --

A. No.

Q. -- during its existence? Did the money of amount which had been paid out by the Skipton Fund have an impact on the Panel's decision-making?

A. I said before, no. We didn't have any targets. We didn't have any budgets. We didn't have any quotas. We looked at each case on its merits and did our best. I have never seen the Skipton minutes before I was sent them for this hearing. I can see there that every -- I can't remember if it was quarter or what -- the Fund told the department how much had been paid out and how much they expected to pay out in the next quarter. We knew absolutely nothing of that; it was none of our business.

Q. I am going to ask you some questions about the procedure now. Did the Skipton Appeal Panel try to reduce the amount of decisions coming through from the Skipton fund by talking to the Skipton Fund about what they could learn from the Appeal Panel's decision-making?

A. There's no meeting between the Fund and the Panel saying "Let's look at some cases. This is why we said yes or no", nothing of that sort. Presumably the Appeal Panel -- sorry -- the Fund -- and I don't know at what level -- would have read the letters and said "Oh, that's the way they are looking at it". It's clear from what -- as I say, I've never seen them before, but from the Board minutes that they were saying "Well, the Appeal Panel can take into account

things we can't, that's why they are allowing lots of appeals and that's okay". I paraphrase.

Q. You have given evidence about -- well, let me put it this way. Did you ever make representations to the Department of Health to make the procedure of the Skipton Fund more flexible?

A. The Fund?

Q. Sorry. The Appeal Panel, sorry. Let me ask you that question again.

Did you ever make recommendations to the Department of Health to make the Appeal Panel procedure more flexible?

A. No.

Q. Why not?

A. I think we all thought that the Government, as a matter of Government policy, decided that it was prepared to give ex gratia payments to people who had been probably infected by NHS blood or blood products according to certain criteria, and I don't think we thought it was our place to say "Change the criteria". After all, apart from cases where there was a -- I won't use the word "fixed" but a pretty clear view, such as anti-D, IVDU to a lesser extent, people who were outside the dates of the scheme, people who got treatment abroad, and -- the minor categories in your

note about the Skipton Fund, the problem cases, as I keep saying, are the 300 cases where there wasn't evidence of a transfusion. Not that it was too late or it wasn't -- it was abroad or anything like that. We dealt with those as best we could and, as I keep saying, we approved 60% of them.

I suppose one could say we didn't think it was our place. I don't know that we thought "This is a discussion we should be having". We were asked to adjudicate on the basis of what's in the agreement. We adjudicate. If the Department or the Fund, as the agent for the Department, think too many are succeeding or too few are succeeding or the burden of proving a transfusion without notes is too heavy, they could certainly have said so. I didn't think it was our place.

I keep repeating, the burden of proof could have been unless the Skipton Fund can disprove a transfusion, there will be money. There will be an award if there is a reasonable possibility that the claimant was exposed to infected blood or blood products. Any of those are possible, but it wasn't what was set out.

Q. We looked at the guidance this morning that was sent out to the applicants, suggesting how they might go

about finding their medical records.

A. Yes.

Q. One of the suggestions was that they get a letter confirming that there were no medical records. How did the production or the non-production of such a letter influence the decision-making process in cases where there was no supportive medical record?

A. There were a lot of -- I mean, the bundles we got -- the appeal files we got from the Skipton Fund contained generally very little information. Quite a frequent member of those notes or of that appeal file was a statement from one or more NHS body saying, "I am very sorry. In accordance with our policies we destroyed your notes in 19 X."

Q. So in terms of how the production of such a letter influenced the decision-making process, are you able to assist us with that?

A. Well, I said in my witness statement, one reason we went about applying a more liberal standard than the Fund was we realised the unfairness on the appellant if the fact of a transfusion which had, in fact, taken place wasn't there for us to see because the notes had been destroyed. That would have been very unfair, wouldn't it? But we couldn't change the fact of destruction. We proceeded on the basis there was no

records. That doesn't mean there was or wasn't a transfusion but there was nothing for us to work with there.

Q. Why were your decision letters not more informative? In your answers this morning you were suggesting that there was a choice between the decision letters as you drafted them and a full judgment. Was there not room for something in between, a more informative decision letter?

A. Yes, there was and, looking back on it, I think that's potentially a major criticism. We could and possibly should have written fuller letters. We didn't, for reasons I've -- sorry, I shall accept personal responsibility for this. I didn't, for the reason I have described this morning.

Q. When decisions were made on the basis of clinical plausibility, ie advice from medical members, either from their own experience or from investigations that they had undertaken, was the nature of that advice or those investigations ever spelt out in a decision letter?

A. Sometimes, but shortly. There's also -- there's one which you sent me in the papers. There is a case, I can't remember the document number, where the reporting doctor said that the haemoglobin was 6 or

something and therefore it was highly likely that a transfusion was needed, it was perfectly clear looking at the records that the doctor had misread the column in the records, everybody could see it was, in fact, 12.4. At that point the consensus of the Panel, guided of course by the medical members, was that a person with 12.4% haemoglobin-- I don't know I am expressing this right, it is technical medical term -- wouldn't in the majority of cases, or commonly, need a transfusion. You can see that's mentioned in the decision letter.

Q. In those --

A. -- (overspeaking) -- sorry. Carry on.

Q. No, sorry, I interrupted you.

A. Well, there were other cases where it was plain from the records that units of blood had been prepared for the operating theatre but equally plain that they weren't used and were put back into the blood bank or whatever it was called.

Q. In those cases where reasons were not spelt out in the decision letter would you accept the reasons that were given were incomplete and therefore inadequate?

A. I would accept they were incomplete in that they didn't detail the whole of the reasoning in most cases, and I suppose that that was a catch-all,

explaining that the criterion of clinical plausibility -- I am not saying I used those words -- was borne out. So I accept they were short letters and could have been fuller. Of course I do.

Q. I am going to ask you a couple of questions now about natural clearers.

What sort of evidence could an appellant who was antibody positive but PCR negative provide to persuade the Panel that they were in the rare category of those who cleared at the chronic phase?

A. I am afraid I am not qualified to answer that question. I haven't looked at any of these cases since 2017 and I wouldn't have been able to answer that question probably without prompting in 2017. I certainly can't now. Dr Hewitt, if you are calling her, might be absolutely the authority on what the answer to that question is, but I am not.

Q. The last question so far that I have from both myself and from Core Participants is: would the appellant -- this is in relation to an intravenous drug user case.

Would an appellant reporting that they had used a needle exchange be sufficient to satisfy the Appeal Panel that intravenous drug use was unlikely to be the route of transmission?

A. I think you would have to answer the question --

I don't know from memory what exactly a needle exchange provided, because a point that was frequently made in the Panel was needles are one thing but what has been described by others as paraphernalia is another. The condition of the drug itself, the bowl in which it was heated or whatever. So the answer is it would have helped the appellant towards satisfying the burden, but it wouldn't have been conclusive.

Something I have remembered I meant to say in relation to the letters, this is not a beginning of an excuse but never once, to my recollection, did anybody come back and say "We don't understand the basis for the decision" or "Please tell us some more". Of course, I would have answered not only out of courtesy but out of fairness, if somebody had said "What is such and such". There were one or two communications I had via Nick Fish which either expressed disappointment or said "Why, again", or something. We obviously couldn't get into long and certainly not direct discussions but had there been -- the Fund never said that these letters -- they wouldn't have had to say they are too short. If the Fund had said "Look, 23 people have come back to us and said they don't really understand the basis of the decision", we would clearly, or I would have clearly have been

a bit -- I would have reviewed my practice and, again for the record, I accept that these letters were very far from ideal, but I thought they were what was needed -- no, that's the wrong word -- I thought they were what was expected and were satisfactory on a very limited basis. They could have been expanded greatly.

MS SCOTT: Sir, I am going to suggest, if I may, that we take a very short break, a five-minute break, to see whether there are any further questions.

SIR BRIAN LANGSTAFF: Yes. We will do that and see if there are any more questions the Core Participants want to ask. So five minutes. Let's say 2.30. 2.30.

(2.23 pm)

(Short break)

(2.30 pm)

MS SCOTT: Sir, thank you. I have no more questions that I am going to ask from Core Participants.

Questions by SIR BRIAN LANGSTAFF

SIR BRIAN LANGSTAFF: I have just one question, really. It is about where this particular tribunal, because that's what it was in essence, fitted into the whole general scheme of things. It wasn't, I think until 2007 that the tribunal system, as it now is, came into force. You have been a fee-paid tribunal judge in a number of tribunals since.

A. And before, if I may say so. Under, I think, the Health and Social Care Act 2001 a tribunal, which was called the Family Health Services Appeal Authority, was set up and I was member of -- one of the original judges of that before, as you say, the Courts and Tribunal -- before the Tribunal Service, as such, was established, and certainly before the amalgamation of the Court Service and Tribunal Service.

SIR BRIAN LANGSTAFF: Tribunals obviously vary tremendously in what they can do and how they should do it, although the tribunal procedure rules bring a measure of uniformity to a number of different chambers these days.

A. Yes.

SIR BRIAN LANGSTAFF: How did you see this tribunal operating, compared with those others that you had been concerned with?

A. Well, in practice, we had very, very much less information and rule structure. When I was asked what I was doing, I would say -- this may be an unfortunate word in the context -- I said "It is an internal tribunal of the Department of Health", ie it was completely outside the Ministry of Justice System and remained so until 2017, as far as I know, and then the functions were transferred to -- I can't remember what

it was called. The Infected -- whatever it was. So, as far as I was aware, we were wholly outside the tribunal -- the general tribunal rules and structures and, in some ways, one might say that we suffered by that.

SIR BRIAN LANGSTAFF: How would you say you suffered by that?

A. Because we didn't have a fixed set of rules. We didn't have the resources that we would have done in a tribunal, the secretarial resources, we didn't have the same discovery compulsory powers that tribunals have.

SIR BRIAN LANGSTAFF: Although you would have described yourself as an internal tribunal of the Department of Health, you were, I think -- and you made the point yourself, earlier -- independent of it and of Skipton?

A. Yes. I should perhaps use the word "sponsored" rather than "internal".

SIR BRIAN LANGSTAFF: The whole sponsoring Department, I think, probably is the best description?

A. Yes.

SIR BRIAN LANGSTAFF: In terms of the way it worked, how did that, in your experience, compare to the other tribunals you have been concerned with?

A. Much less guidance, much less fair -- not fair to

everybody -- much less open-to-everybody procedures. One could look at the tribunal rules on the Internet but if you had looked for Skipton Fund Appeals Panel rules, you would have found a sentence, wouldn't you? I certainly -- I make absolutely no secret of the fact I wouldn't have written the decision letters the way I did if I had been sitting in a Courts and Tribunal Service tribunal.

SIR BRIAN LANGSTAFF: That would have been much more of a judgment, would it?

A. Yes, and the answer to the question from Ms Scott, if we were turning down somebody on the basis of Dr Ramsay's epidemiology, we would have set out the relevant bits to justify our 1 in 200 versus 1 in 6 or 12, depending on whether you denied sharing needles or not comparison.

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

MS SCOTT: Mr Mildred, is there anything you would like to add to your evidence?

A. Not really more than that. The sort of potential criticism or dissatisfaction, I suspect, is the people who had only clinical plausibility to rely upon, and the 40% of those who we found, as we saw it, on a proper interpretation of the test, had fallen the

wrong side of it. We were all aware what a terrible affliction hepatitis C is. We took no pleasure in saying "We can't satisfy the standard the Department has set us". As you mentioned, I came from a background of doing exactly this sort of work on behalf of claimants. There was no appetite on our part for turning people away, but we felt we couldn't just do what we felt like.

SIR BRIAN LANGSTAFF: Can I then just thank you for giving us a very clear picture of how, because of the way that the tribunal was set up, and because of the way that you were told you were expected to operate it, that really limited a number of the options you might otherwise have had. You have been very frank about that and about the way in which you operated the discretions as you saw them and applied the standards and made the decisions that you did.

So can I thank you for that and for giving us your time. I think this may have gone a little bit longer than you had anticipated, but thank you anyway for being here and for helping this Inquiry.

A. Thank you.

SIR BRIAN LANGSTAFF: Now we will take a break, Ms Scott, before our next witness, who is Mr Lister?

MS SCOTT: Yes. We will need to establish the link with

him.
SIR BRIAN LANGSTAFF: Do we need ten minutes just to make sure he is ...
MS SCOTT: Yes, that's probably safest.
SIR BRIAN LANGSTAFF: So let us say 2.45.
(2.36 pm)
(Short break)
(2.45 pm)
SIR BRIAN LANGSTAFF: Right. You can see me, Mr Lister?
THE WITNESS: Yes, I can. Hurray. I was wondering what was happening so I am glad to see we are connected.
SIR BRIAN LANGSTAFF: I am sorry we have left you on your own until now during the day. You might have expected to be heard a little bit earlier. I am glad to say we are now in a position to start.
Let me first set the scene for you after you have set the scene for us. You are at home --
THE WITNESS: Yes, indeed.
SIR BRIAN LANGSTAFF: -- and are there other people there with you somewhere?
THE WITNESS: Yes. My partner and two dogs.
SIR BRIAN LANGSTAFF: Right.
THE WITNESS: I mention the dogs just in case of barking.
SIR BRIAN LANGSTAFF: Whenever there's a break, as there will be, because we will probably have to continue

this tomorrow morning, what you must not do is discuss the evidence you have given or may yet be asked to give with anyone, whoever they are, whether it is canine or partner, but you can talk about anybody else you like?
THE WITNESS: Thank you, understood.
SIR BRIAN LANGSTAFF: Let me tell you who you are talking to. You may have heard me say this before, I don't know. It is very similar to what I have said to others, because it is indeed very similar. There are eight people here in the room, one of whom is Mary, who will ask you to affirm in a moment or two. Another name you will recognise but you will probably not see him, is Soumik, whose job it is to make sure that you get the right document on your screen when it is referred to by counsel. Then there's Ms Scott, who is the only person, apart from myself at the moment, who is not wearing a mask, and she will be asking you the questions.
But the real audience is beyond this room. There will be about 200, 250 of them, thereabouts, who want to hear what you have to say. It is to them that you are talking. This is a public Inquiry. They are our public.
So without more ado, Mary, would you ask

Mr Lister to affirm.
CHARLES EDWARD LISTER (affirmed)
Questions BY MS SCOTT
MS SCOTT: Mr Lister, can you see and hear me?
A. I can. Thank you.
Q. You were a trustee and then, later, a director and vice chair of the Caxton Foundation between August 2011 and April 2015. Is that right?
A. That's correct.
Q. And you, during that time, served on the NWC, first of all as a member and then as a chair, between September 2011 and March 2014?
A. That's correct. I took over as chair I think in March 2012.
Q. You also served throughout your time at the Caxton Foundation on the Audit Committee?
A. Yes.
Q. And on the Caxton Foundation and Macfarlane Trust Liaison Committee?
A. That's correct.
Q. And you also regularly attended the Partnership Group meetings?
A. I attended all the Partnership Group meetings and chaired one of them.
Q. Now, you were employed by the Department of Health

between 1971 and 2011, save for a period between 2003 and 2009. Is that correct?
A. That's correct.
Q. I am just going to put up the part of your witness statement where you set out your roles in the Department of Health.
It is WITN4505001.
We can see that's your witness statement, and it is page 2 of your witness statement, paragraph 3. You tell us there that from 1991-1995 you were responsible for various aspects of microbiological food safety policy.
'95 to '98, you were a team leader on HIV/AIDS and sexual health promotion.
1998-2003, Head of Blood Policy.
2003-2008, you were at the Human Fertilisation and Embryology Authority.
Then various senior roles: project management for HFEA and then senior business manager for the Director General NHS Workforce and head of NHS Leadership 2009-2011.
Soumik, you can take that down.
Just so it is clear to those who are listening, and indeed to you, Mr Lister, your role at the Department of Health, and in particular as Head of

Blood Policy, is not going to be the focus of my questions for you today, but you will be receiving a further request for a statement to cover that area of your employment in due course, and, if necessary, further oral evidence in that regard as well.

How did you become to be appointed a trustee at Caxton?

A. Well, as you have mentioned, I went back to the Department of Health in 2009 after a period of absence. I think at that point I wasn't sure where my career was going to go and, fortunately, it was one of those periods when the Department decided to downsize and I had the opportunity to leave on an early retirement package, which I applied for and was successful. So by the middle of 2011 I knew that I would be leaving the Department in six months' time, and I was looking around for other things to do.

And one of the things I had thought about quite early on was trying to find a suitable role as a charity trustee, because I felt that would suit a number of skills. I can say more about that if that's helpful.

It just so happened that around that time the advert appeared in The Guardian for trustees for the Caxton Foundation, and given the fact that I had

a good deal of understanding, certainly around HIV and hepatitis C, through previous roles in the Department -- I had been the departmental sponsor for the Macfarlane and Eileen Trusts, and I had met a number of the campaigners at that time -- this was a role I was drawn to. I felt that, given those skills and experiences, it would be something that I could make a positive contribution to.

Q. Did you have any experience at that stage of serving as a trustee on a charity board?

A. I did not.

Q. You have described in your witness statement how the first few meetings at Caxton Foundation were concerned with obtaining a clear understanding of the duties of the charity and the experience of living with hepatitis C, and you received an induction pack from the legal adviser which included a copy of the Trust Deed and you heard a presentation from a member of the Tainted Blood campaign and also from Professor Thomas on hepatitis C. Is that correct?

A. That's correct. From memory, all that took place in the first two meetings of the board, in August and September 2011.

Q. We heard evidence from Mrs Ann Lloyd on Monday and she told us that two years later, when she became the

chair of the Caxton Foundation, she had no such induction and, in fact, had not even seen a copy of the Trust deemed. Can you assist us with how the induction process seemed so different for her?

A. I can't, to be honest. I mean, the only thing I can add is that I was responsible for, you know, drawing up the job description both for trustee roles that we interviewed for in 2012, and indeed for the role of chair, and one of the criteria for the role was familiarity with the legal requirements, including the Government's document for the charity, the Trust Deed. So I was surprised that Ann had said she hadn't seen it.

Q. Did you anticipate that there would be concerns about your appointment from the beneficiary community, given your previous role at the Department of Health and Blood Policy Unit?

A. Perhaps naively, I didn't. It didn't occur to me, initially, that there would be a conflict of interest, in that the Department of Health had set up the Caxton Foundation to meet the charitable objects of providing discretionary financial support and what would I be doing as a trustee was furthering those charitable objects.

So it didn't honestly seem to me there was,

therefore, a conflict with having previously worked for the Department of Health, but I do understand that because I had also worked as, sort of, Head of Blood Policy, that might be perceived as such, and certainly, as I have said in my witness statement, when I was asked if I wanted to be on the liaison committee with the Department of Health, I recused myself from that, because I felt it would be, sort of, inappropriate for me to be in a negotiating position with the Department, given my past history, and given, as well, that I would know some of the people involved at the Department of Health end.

Q. When did you become aware that there were concerns about your appointment as a trustee?

A. I can't remember exactly when. I mean, it was certainly made very explicit at the Partnership Group meetings and I know one campaigner described my role as Chair of the National Welfare Committee as "The fox in charge of the chicken coop". So yes, I was aware of that and I understood why people might think that but, in all honesty, my motivations throughout were always to achieve the best for our beneficiaries.

Q. So if you were appointed in August 2011 and the first Partnership Group, as I understand it, was in June 2013, do you think you had become aware of

concerns before then?
A. I can't recall. It is quite possible because, although there wasn't routine contact unfortunately with the beneficiary communities until then, it may well be that I had been aware through other contact. I just don't know exactly when I became aware of that.
Q. What do you think the advantages to Caxton were of you being a trustee, given your previous role?
A. Well, the advantages, as I saw them, were, firstly, that I had got a long career in developing policy, so looking at, you know, legal requirements and thinking about how those could be implemented effectively. I had a lot of experience around good governance, setting up organisations to meet legal requirements. So that felt relevant. I obviously knew how the Department worked, I knew how ministers operated and how government in general operated, and I came with a sort of understanding of the whole infected blood tragedy.
Q. What do you think were the disadvantages?
A. To be honest, apart from the perception of a conflict, I still, to this day, can't think that there were particular disadvantages.
Q. Did you consider that that there may be a suspicion that your appointment may mean that the Caxton

Foundation was not independent of the Department of Health or the Government?
A. I think, firstly, I was one member of a Board, drawn from a huge range of backgrounds. So, you know, it is not as if all decisions were down to me, not at all. I had also been aware, of course, that the Macfarlane Trust had a history of appointing people with a Department of Health and an NHS background and, indeed, without stepping into my time at the Department of Health, certainly at that point were actively looking for people from the Department to provide the kind of experience that I have just talked about.
Q. So when you arrived at the Caxton Foundation, were you involved at all in the decision made that the Caxton Foundation should share a Chief Executive with the Macfarlane Trust?
A. No. That had been decided already.
Q. Can you recall being told anything about why that decision was made?
A. I don't recall. I assume it was in order to have some read across between the two charities. I think in practice -- well, this is perhaps going on to a further question, so I will stop there, but, no, I don't think -- it seemed sensible to me at the time.

Q. At the time, was there any consideration given to whether or not there may be a conflict of interest in one Chief Executive having two charities to manage?
A. Well, we had -- for that reason, we had the service level agreement between Caxton and the Macfarlane Trust and the liaison committee to address issues. So if there were concerns that one organisation was getting more of the Chief Executive's time than another, then those could be dealt with there.
I think the alternative of having two Chief Executives -- presumably, they would have to have been two part-time Chief Executives, who would have had to have liaised sufficiently with each other to ensure read across -- they would be managing the same group of staff together and, again, without thinking about that in detail, I can imagine two Chief Executive might cause more problems than a single one.
At least with a single one it would be possible to talk through any issues of concern around conflict. With two Chief Executives, I think the scope for miscommunication and issues around staff leadership might have been much greater.
Q. Were you involved at all in any discussions about the terms of the Trust Deed?
A. No, not the initial Trust Deed. There were clearly

later amendments to the Trust Deed after Caxton was established, but I had no involvement with anything to do with the first Trust Deed.
Q. Excluding issues around the user trustee, which I am going to come on to ask you about in a moment, did you have any concerns about the balance of skills and experience on the Caxton Board during your time there?
A. That was something that we reviewed. We had -- during 2012, we had some of the initial trustees leave the Board, either as planned or, in one case, because of other commitments, and that certainly gave us the opportunity to take a look then at the skills we needed on the Board. So we looked, for example, at the need for somebody with communication skills. So we certainly took the time to think "Okay, what skills do we have on the Board? What skills are needed?" When we advertised for trustees we were specifically looking for those additional skills.
Q. Were you concerned that it had too strong a representation of people with NHS and Department of Health background on the board? A point picked up by the APPG in their report. They reported in January 2015 that there were four out of the nine directors at that time who had that kind of a background. Was that something that concerned you

or was it a focus of discussion on the board?
A. No, it wasn't. I was the only one, I think, who had a direct Department of Health background. Ann obviously had an NHS background as chair at that stage. Margaret Kennedy had worked for the NHS but as a podiatrist, from recollection. So I didn't see that as an issue. I think it was really about the balance of skills and experience on the board, which I think was quite right.

I was not entirely clear particularly why people might think that there was an issue with people who had had past experience in the NHS. I can see the Department of Health, because there was an ongoing issue about the campaign to have a public inquiry and compensation, and I can see that the NHS was seen as responsible, you know, for the way people were treated in the early days, but the fact that somebody worked for the NHS in a particular role I didn't see created a conflict. The NHS is, after all, a vast organisation.
Q. Can we turn then to a document that you authored with Peter Stevens on the recruitment of user trustees in January 2013.

It is CAXT0000109_122.

We can see here:

"The possible recruitment of a director with experience of living ..."
SIR BRIAN LANGSTAFF: It should be on your screen, Mr Lister.
A. It is. It is, yes. I was just looking at my own copy with scribbled notes on as well.
MS SCOTT: So it starts by saying:

"The possible recruitment of a director with experience of living with Hepatitis C."

It says:

"The campaigners have been urging for a long time that we should have beneficiaries on the Board. The Department of Health ... are sympathetic to the idea. We have reservations, which is why we have prepared this paper recommending a solution."

Is it right to read this as this is the first time that the board has been giving consideration to recruitment of a director with experience of living with hepatitis C?
A. Yes, I think so. In the early days Charles Gore was a trustee and did have experience of dealing with hepatitis C. After his departure, we didn't have anyone who could give us any insights into that experience.
Q. Why had it taken until January 2013 to consider this

issue?
A. I'm not sure, to be honest. This is one of those issues that I have indicated in my witness statement that I think we didn't get right, and I really don't know why it took that long.
Q. Was any consideration given or was concern raised about the fact that there wasn't anybody from the beneficiary community on the board at that initial crucial period where the Caxton Foundation were drawing up their policies, their strategies, nailing down their principles and so on?
A. Certainly there wasn't concern expressed by one on the board that that hadn't happened.

Just to add, and we may well come on to it, very early on I had pushed to have a discussion about communication and engagement with beneficiaries, that was at the second meeting of the Trust, and I wrote a brief paper to try and get discussion going, because it hadn't otherwise been on the agenda. That didn't pick up on the issue of recruitment of a user trustee, but it did try to address the issue of the need for active communication with beneficiaries. So perhaps we can come on to that as well.
Q. Yes, certainly. I think that was in September 2011 --
A. That's correct.

Q. -- and I will certainly take you to that paper. In fact, after dealing with this topic.

Again, going back to that first paragraph of the document there, is it right that the genesis for this coming before the board is not the board itself, but because the Department of Health seemed to be pushing for the idea? Is that the correct way to read that paragraph?
A. I don't think that's the correct way to read it. I don't think the Department of Health, to my knowledge -- I mean -- were pushing for it -- I, obviously, was not part of any direct discussions with the Department of Health through the Liaison Committee. I am assuming that Peter Stevens had discussed it with them, which is why he knew they were sympathetic to the idea, but I am not sure the initiative had come from them.
Q. Then if we go down to the --
A. The Department of Health after all -- sorry -- did pretty much leave -- well, did leave Caxton to decide its own policies, and there was really very, very little interference with that, if any.
Q. Then we go down to the bottom of the page and you set out there the concerns that you have about having a user trustee. The last paragraph:

"A problem with appointing beneficiary trustees to Caxton is the absence of a 'neutral' outside body with rights of appointment, which means that beneficiary volunteers for the Board would most likely come from activist groups. Such people are likely to have difficulty with the requirement that they should not represent anybody or any cause outside the charity, but should at all times and only act in the best interests of the charity itself, not of its beneficiaries nor of any outside interest such as a campaign group ..."

It is a little bit difficult to understand what's meant there when it says the user trustees shouldn't be acting in the best interests of the charity or its beneficiaries. Can you assist us with what was meant there?

A. I was trying to think about that myself. I mean, certainly it is true that, you know, Boards are there to govern the organisation, not to represent particular groups, and that's sort of clear in Charity Commission guidance, in the essential trustee, for example. So although you are not there as a trustee to represent individuals, clearly, as far as beneficiaries are concerned, their only purpose for being there was to provide a service to those

beneficiaries.

So I think somehow there's a distinction there between -- I am not quite sure. I think this is very badly worded, to be honest. I will admit to that. So there is a distinction between governance of the charity, which is for the benefit of its beneficiaries, and representing particular groups, which is not the role of trustees as a group, and I think maybe that's what it's trying to get at.

Q. Then there is a concern raised about the difficulty that such a director or trustee would have in keeping information obtained in that role confidential. If we go down to the bottom half of the page, the solution is that you have, rather than a user trustee, somebody who has hepatitis C but is not a beneficiary of the charity. That's the proposal that both you and Mr Stevens were putting to the Board, was it?

A. That is correct. I mean, this paper misses off one other issue that should have been covered in there, I think, on this issue of conflict of interest. Certainly, looking at Charity Commission guidance and the terms of the Trust Deed, I think it might have been difficult to have had someone as a trustee who was also a beneficiary of the charity, in that they were actively receiving funds, at least in the terms

that the Trust Deed was written at the time. That's not to say it couldn't have been amended, but I think that might have been an issue.

The other thing that occurred to me, reading this -- are you happy for me to reflect on things from my position now, as well as talk about how it felt at the time?

SIR BRIAN LANGSTAFF: Yes, indeed.

A. I thought there was a certain arrogance about this paper, to be honest. I was thinking to myself, well, here am I saying "Yes, of course I can perfectly well manage conflicts of interest but, you know, beneficiaries couldn't". I really think, and I did say this in my witness statement, that we could have found a way of having a beneficiary trustee. It might have meant they had to abstain from certain discussions which were about -- they couldn't have been a member of the welfare committee, I would have thought, and there may be other things, as well, that we would have needed to have looked at where it would have been perhaps inappropriate for them to have participated from a conflict of interests point of view, but with an effort, I think it should have been achievable.

MS SCOTT: Just as a matter of fact, we understand from

Mrs Lloyd that interviews were, in fact, open to user trustees?

A. Yes, they were. I should have gone on to say the policy developed from this and we did -- when I wrote the job description and we had some negotiation as well with the Haemophilia Society and the Hepatitis C Trust, having agreed with the Board, as you say, this would be open to anybody, regardless of whether they were a beneficiary or not.

Q. Just as a question of fact, can you recall whether the only people to apply were, in fact, from campaign groups?

A. No. Well, as a result of that, we appointed Margaret Kennedy. So that was not the case. Indeed, my recollection is that I don't think anybody from campaign groups applied.

Q. So, in fact --

A. I may be wrong about that.

Q. So the fear that the only people that would apply to become a beneficiary trustee would be those from campaign groups turned out, in fact, to be misplaced?

A. I think so, yes. I think there is another issue here about Caxton's relationship with campaign groups that I think is sort of -- I think we can perhaps talk about later.

Q. Can I just pick up then on another point from this document? Can we go back up the page, please, Soumik:

"A minor point is that the [Department of Health] did not wish the Secretary of State to be asked to approve the appointment as trustee of somebody whose main activity is campaigning against Government policy. It would also appear that we were supporting, or at least sympathising with, the campaigners."

What was the concern about such a trustee being put forward to the Secretary of State? Was it that the Secretary of State would not approve the appointment?

A. Yes. I mean, again, just to say in my witness statement I sort of questioned that that was more of a supposition about how DH would react than based on any particular understanding because, although all appointments had to be approved by ministers, certainly, in practice, they were pretty much nodded through.

There was always the understanding that Caxton had not been set up as a campaigning group. That was something that I think was said to me pretty early on. I can't remember whether it was at the interview for the trustee role or whether it was on one of those

early Board meetings, but there was a sort of very clear message from the founder trustees to those of us who were new that Caxton was not there as a campaigning group, and that, you can argue, is borne out by the Trust Deed.

So to have somebody who was -- I think one of the -- the main issue, really, for me would be that, had we appointed somebody who was actively campaigning against government policy, the issue would have been for them that, as a trustee, they would have been expected to have been, sort of, fully supportive of the aims and objectives of the Caxton Foundation, and I would imagine that a campaigner would have found that rather difficult because part of the campaign was what shouldn't be happening is that people were expected to come cap in hand asking for charitable support from Caxton, that they should have compensation as an entitlement. So with that point of view, being a trustee of Caxton and campaigning for a settlement might have put somebody in a difficult position.

Q. This here, though, is talking about the position that the Caxton Foundation would find themselves in in these circumstances. What was the concern about appearing to the Department -- it reads as if there is

a concern about the Caxton Foundation appearing to the Department of Health as though they are supporting or at least sympathising with the campaigners. What was the concern in that regard?

A. I don't think it should have been a concern. So I'm sorry, as one of the joint authors of this, I should be able to give you a better explanation of that than I have, but I think it was -- I don't think it should have been in there, to be honest.

Q. Was there a concern that if the Department of Health considered that that was the attitude of the Caxton Foundation, that they would be somehow displeased and that it might impact on the relationship or even the funding? Was that ever a concern?

A. I don't think -- there is -- the Department had made a commitment to fund Caxton. I'm sure we'll talk about the fact that, you know, we only had commitments to funding annually and that was an issue. But it was a public commitment. They'd, you know, set up Caxton to do a particular role. I don't think there's any way that they would show their displeasure by withdrawing funding. The worst that would have happened is that ministers would have decided that they didn't wish to approve a particular trustee. I don't think there would have been any comeback on

Caxton had that been the case.

Q. It could be said, in making comments like this in papers for the board, it shows a lack of independence from the Department of Health. What would you say in response to that?

A. I think it shows -- you could argue it shows an awareness of the politics around this, potentially. I mean, after all when we are looking an independence from the Department of Health, trustee appointments in the Trust Deed are for the decision of the founder, for the Secretary of State. So to that extent we were obligated to the Department for appointment of trustees, but the Department did not interfere in the development of policy or anything else. And, in practice, they never interfered in the appointment of trustees either.

Q. Can I just pick you up on the point about the Trust Deed not allowing campaigning? Can we just have a look at that before we take a break to see precisely what you mean by that.

Can we have, please, Soumik, CAXT0000095_006?

Here we have 28th March 2011 Trust Deed, and if we go to page 12, we have "Schedule 3, Powers of the trustees".

Now, I am going to take you to the

paragraphs I think are relevant but do tell me if you think there are other relevant paragraphs.

A. Sure.

Q. Can we go it page 13? So, first of all, not strictly relevant, but potentially so, paragraph 18, the power of the trustees includes:

"To raise funds for the Charity in such manner as may be expedient ..."

A. Uh-huh.

Q. Paragraph 21:

"To procure, publish and distribute material in any form that may be deemed desirable for the promotion of the Objects and for informing the public about the work of the Charity."

Then paragraph 24:

"To cooperate with other chart tears, Persons or statutory authorities and to exchange information and advice with them."

Just bearing those clauses in mind, why is it you say the Trust Deed doesn't allow for campaigning?

A. I think you have to relate all of that to the charitable objects. So I can't remember which paragraphs they are in now. It is further up.

Q. Can we go back to page 3, please. Sorry, page 4 of the document.

A. So my arguments would be the charitable objects are to provide financial assistance and other benefits to meet the charitable need of individuals who have received blood products, et cetera, their partners, parents, carers, et cetera.

So it's -- there is the single object to provide financial assistance and other benefits, and then the rest of that sets out who should be eligible for those benefits. There is no reference in the charitable objects to anything else. So there is an argument to say that if Caxton had taken on a campaigning role, and I would argue as well we just didn't have the resources to do that anyway, that would have been outside of our charitable objects.

Now I think there is provision in here for the trustees to amend charitable objects, but that would need to be with agreement of the founder. So we could have said "We would like to add a campaigning element to our objects", but we would have needed the agreement of the Secretary of State to that, and we would also have needed to demonstrate to the Charity Commission that that was -- there was a public benefit there. That's my take on it anyway.

Q. Is this right, that the Trust Deed allows for what one might call campaigning or lobbying activities, but

they must be in accordance with the charitable objects? So if it were a campaign to, for example, bring to an end the Caxton Foundation, that wouldn't be in accordance with the charitable objects --

A. Correct.

Q. -- but if it was a campaign to promote the idea of meeting the charitable need of the beneficiary population, then there would be nothing -- that would be within the terms of the Trust Deed?

A. Yes, I think, arguably. So, for example, we could have -- in the very early days, we could have put out a number of press statements to draw attention to Caxton. There was a big argument that I felt at the time that this was a major human-interest story. There would be plenty of -- the national media who would be interested in this, you know, perfect for The One Show, or whatever, and that would be the best way to make people aware of our existence. That is something I am sure we certainly could have done within our objects.

MS SCOTT: Sir, I note the time. Is now Anna appropriate time to have a break. I am going to change topics?

SIR BRIAN LANGSTAFF: Yes, it is. We normally have a break for about half an hour in the afternoon, but it will be shorter this time, because we have already

had a late start and a small break before we began your evidence. So 20 minutes this time, and we will come back, therefore, at 3.55. So 3.55. Time for a cup of tea, Mr Lister.

A. Thank you.

(3.34 pm)

(Short break)

(3.55 pm)

SIR BRIAN LANGSTAFF: Yes.

MS SCOTT: Mr Lister, I am going to take you to your beneficiaries communication and engagement paper from September 2011. It is --

A. Could I interrupt, briefly? Would it be all right if I just reflected back on one of your earlier questions --

Q. Of course.

A. -- before we move on? Apologies for interrupting.

Q. Of course.

A. I didn't want to forget myself. You asked why it had taken until February 2013 to have a discussion with the Board about having a beneficiary trustee.

Q. Yes.

A. I have been thinking about that in the break. I think part of the reason involves an explanation of what had been going on in Caxton in the previous year. You may

want to come on to that anyway, but the fact that, as well as trying to get the National Welfare Committee operating in a good way, dealing with issues around throughput of applications and speed of response to beneficiaries, which was pretty poor in some places to begin with, the fact that our Chief Executive, Martin Harvey, was becoming increasingly ill and decided to leave partway through the year, so we had a need then to recruit an interim and then a full-time Chief Executive. We also needed to find a new chair.

There was, I recall, a decision that we would recruit to those new posts and we would recruit additional trustees and then the last thing, rightly or wrongly, that we would do is look at a beneficiary trustee, someone who could at least provide some of the experience for the Board that we lost when Charles Gore left.

So that's, I think, a big part of the explanation about why it happened at this point and not sooner, if that helps at all.

Q. If we look now at your paper on "Beneficiaries -- Communication & Engagement", CAXT0000108_045, so this is a paper -- we can see at the top it is "30.11", but if we go to the second page, at the bottom your name with September 2011. So if we go back to the first

page --

A. Just before then -- this is -- I think I refer to the fact on 16th August I had had e-mail exchange with Martin Harvey, because he had circulated the agenda for that Board meeting, and I said the -- the communication with beneficiaries wasn't on it, so I said, "I think we do need early decisions on how the Board will engage with the beneficiary community", and suggested that we have this on the agenda and then I wrote this sort of brief paper to try to get a discussion going.

Q. The purpose is to:

"... seek members' views on the most appropriate vehicle for the Board to use to engage with beneficiaries."

Then the recommendation, paragraph 3, is:

"... the board take a view on how it wishes to communicate with beneficiaries."

Then you set out in the background why it is important that there is this communication.

Then if we go over the page, you set out the different options as you see them and you suggest -- one of the options is a forum and you set out the pros and cons. Open sessions in Board meetings is another of the options, and again you set out the pros and

cons. Then the third option you identify is a newsletter/content on website. Again, you set out the pros and cons. Can you just help us with what "content on website" means?

A. I am assuming what I was meaning -- it could have meant either just the provision of information, which I think is what I was talking about. I guess it could have referred to something more like having a forum but I am not sure I had thought that far at this stage.

I mean, looking at this again, this is a very tentative paper of mine. I was very new on the Board, second meeting, and I think, in future, my papers, they tend to have more of a recommendation. I was leaving this rather open. There was certainly no appetite at the Board for having open sessions at the Board meeting. I think the feeling was that that would be difficult to organise, given a lot of the content would be about specific cases, et cetera. I think that was the argument, although I did suggest that there would be perhaps a way of managing that.

I think I had seen other examples where Boards of organisations would have a public part of the meeting and then a closed part of the meeting and managed their business that way, but there was no

appetite at all for that. So the only things of interest, I think, were the idea of having a forum, which, of course, we didn't have. We didn't set up the Partnership Group until the first meeting of June 2013, so a long, long time after this, and the first newsletter was not until even later, in 2014.

Q. So you are there suggesting -- your conclusion at the bottom of that page says:

"A newsletter/website is the minimum needed."

Presumably you take that view because the cons of that is it doesn't allow for any direct interaction with the board. Is that right?

A. Yes. I think I was being concerned. I think I used the expression which was sort of picked up on my written evidence, about the board not wanting to be a kind of ivory tower kind of body, that it needed to be accessible and willing to listen.

Q. Then you say:

"Views are sought on other options or alternatives that enable two-way communication."

A. Uh-huh.

Q. This paper gives the impression that your view is: well, the starting position is a newsletter/website, and then what else are we going to do that allows two-way communication? Would that

be a fair reading of that?
A. Yes, yes, indeed. I think that's a good way of reading it, yes.
Q. As you have identified, you have got no user trustee on the board until -- for some time. You have got no partnership --
A. Well, we don't ever exactly have a user trustee.
Q. Yes, you are quite right. No trustee with lived experience of hepatitis C for some time?
A. We had at this stage Charles Gore on the board, of course, but we had a period after Charles left and before Margaret arrived when -- it must have been about a year -- we didn't have anyone.
Q. No Partnership Group meeting until 2013.
A. Indeed.
Q. No newsletter, I understand, until December 2014. Is that right?
A. Uh-huh. That's correct.
Q. No forum on the website at all during your time at Caxton. Is that also correct?
A. That's correct as well. I think there was a concern about having the staff resource to moderate that, from recollection.
Q. Why was that? Given that you in September 2011 are saying -- assuming this is going to happen in some

form or another, that really very little happens for quite some time. Why is that?
A. It is a very good question. I mean, you will find, going through the board papers, that this issue of communication with beneficiaries comes back constantly.

So, for example, in March of 2012 the minutes of the National Welfare Committee on 15th March -- you'll recall this was the first one I chaired -- I sort of brought up the issue of having an event for beneficiaries, and there was an agreement that a notice would be put on the website asking for input from beneficiaries, but it does not seem to have happened.

So it was something that trustees pushed for, to have better communication, but it kept going down the priority list, to be honest.
Q. So are you identifying there a problem with the staff for whatever reason actioning --
A. I wouldn't want to just put this on the staff, because I think this was something -- you know, if things weren't happening, then it is the job of the trustee board to ask why not and to continue pushing. So I think it is a factor of a lot going on with a very, very new organisation and maybe the focus not always

on the right priorities. And managing -- I mean, I think there is an issue -- for example, we were very, very poor in our turnaround time on grant applications in the first few months. So we had difficulty getting even the basics right to begin with. Doing extra things on top of that seemed to be too much of an ask in many ways.

Can I mention as well there was a -- I mean, I kept bringing this back. I mean, it wasn't until some time later, that in -- in February '13, the same board meeting where we discussed that paper on beneficiary trustee, I took a paper on issues raised by beneficiaries and again tried to sort of address some of the criticisms and some of the ways in which would he could reach out better. It is not actually authored -- the authorship isn't on the paper, but I recognise it as one that I wrote. It is CAXT0000109_115.
Q. If you just give me a moment. I'll just -- CAXT0000 -- sorry?
SIR BRIAN LANGSTAFF: 109_115.
A. So I think this was at the stage where, after the Contaminated Blood Campaign and others had met Anna Soubry and made their criticisms of Caxton, which we were aware of -- we had not had the opportunity to

meet the Minister ourselves, but I took the opportunity to try to set out what I thought were the criticisms that were being levelled at Caxton and what we should do about them. At paragraph 7, further down, you know, I say:

"These criticisms will all be familiar to longer serving members of the Board."

I mean, this was taking the opportunity to get a number of the trustees, the new trustees, and the new chair, up to speed with this:

"There is always a risk that this familiarity leads us to not taking complaints sufficiently seriously."

I think this was a concern I had that -- I don't know, sometimes organisations just sort of think "Oh, well, yes, they will complain, won't they?" and don't necessarily take a serious enough approach. On the next two pages I just go through the key criticisms and some suggestions about what we should do.
Q. So if we go over to the second page, please, Soumik, so you are talking here about the table that's provided?
A. The table, yes.
Q. And down the left-hand side you have got "Issues

Raised with the Minister", and on the right-hand you have got "Comment". Do we understand that the issues raised with the Minister are the criticisms that had been raised about Caxton with Anna Soubry?

A. Yes, indeed.

So this was around staffing levels and how long it takes to process grants, the length of Caxton's forms and their complexity, the burden of justifying charitable need, which was one thing we couldn't do much about and, you know, the application of the sort of poverty, and managing read-across and, yes, not having a beneficiary on the board. So, again, these were all things that ideally we should are been having -- you know, I raised with the board that ideally we should by then have been having an active dialogue with beneficiaries about this I think.

Q. Was one of the consequences of this failure to have formal communication with the beneficiary population or community -- Soumik, you can take that down -- that all the policies and principles and indeed strategies of the Caxton Foundation were set without any consultation from the beneficiary community?

A. Yes, that's correct. I mean, there is always a question in these circumstances about how much consultation it's reasonable to do, because the board

of Caxton was responsible for setting its policies and working out how to best meet the needs of beneficiaries, and sometimes those are -- you know, those are certainly decisions we took very much on a case by case basis. It wasn't as if we had a policy review about one point and a series of recommendations. There were changes and new principles adopted as we learned more about the needs of beneficiaries. But there was a point I think, by this stage -- so, for example, there was a paper I wrote for the board in May 2012 about addressing beneficiary debt --

Q. Yes.

A. -- which looks at the various different types of debt and our approaches to those. Arguably that is the kind of paper that, if we had got our act together, we might well have discussed with beneficiaries. Because there is nothing in there that gives anything away about individuals. It just sort of focuses on what is a reasonable approach to take.

Q. I am going to ask you some questions about debt in due course and I can certainly take to you that paper then if you like me to.

A. Yes, that would be helpful. Thank you.

So yes, in conclusion, I think we could have

been having or should have been having much more active dialogue. I mean, for my own part I have to confess, you know, throughout that sort of period of 2012 I was very much absorbed with making the whole grant application process more effective and then in dealing with the consequences of the Chief Executive leaving, finding a replacement and finding a replacement chair as well, and also beginning to look at the beginning of a regular payment scheme. I am arguing, I suppose, that I was really busy during that period, which I was. That's not necessarily an excuse for not really picking up on the fact that we should have been doing more in reaching out to our beneficiaries.

Q. Can you help us with this: when Mrs Lloyd was giving evidence, she thought, but she wasn't sure, I think was the position she ended up in, that there had been an event, a beneficiary event, during the time she was at Caxton?

A. There hadn't. There wasn't.

Q. Again, do you understand why that was?

A. We had talked about having events and you will see the sort of references to things that might be planned. In the end -- I can't remember when exactly, I will have to refer to my notes, I think it might have been

as late as 2014 -- we did a survey of our beneficiaries finally to ask what they wanted and one of the things we asked them about was whether they wanted regional meetings, for example, and there wasn't much enthusiasm for them.

So, unlike the Macfarlane Trust, where they had lots of, sort of, get-togethers of one kind or another with beneficiaries, sometimes over weekends, sometimes on certain stances, we didn't do that, partly because we just didn't. With the new arrangement with one Chief Executive and a very small staff servicing all five AHO bodies there was just not the resource to do that and, as I say, I think my priority immediately was, you know, we need to speed up on our grant application process. That was the thing that I really was focusing on in 2012 because that was entirely unfair to the beneficiaries who had applied, that some of them had to wait far too long to get a response.

Q. Can I ask you now about the reserves policy?

A. Uh-huh.

Q. Can we go to a minute of the meeting of the Audit Committee on 19th July 2012, which is CAXT0000065_062. We can see you are in attendance -- sorry, you are present at the meeting. If we turn over to the page 2, right at the bottom, the last line there:

"The Chief Executive reported the DH's view on whether or not [then over the page] the Caxton Foundation should maintain a retained reserve fund. He went on to say that the DH were advocating that each charitable entity in Alliance House should not maintain a reserves fund but should maintain an operational balance in the event there was an interruption to the funding applicable to each body. The Committee noted that the Charity Commission require a charity to have a reserves policy even if there are no retained reserves. The Committee noted that funding to the Foundation and other Alliance House entities is a commitment; negating the need to maintain retained reserves.

"Mr Lister agreed to prepare a form of words in respect of the Reserves Policy in time for the next meeting of the Board of Directors scheduled for 2nd August ..."

I can't find reference to that in the Board meeting of 2nd August. I confess I haven't chased that through, but is it right to understand that this is -- this was the forum at which recommendations on reserves policy would have been made to the Board? It would have been the Audit Committee that was doing that?

A. That should have been the Audit Committee, absolutely.

Q. As a matter of fact that was the reserves policy that the Caxton Foundation settled on?

A. Essentially that we did not have a reserve.

Q. Yes. Is it right -- it looks from reading this minute -- and I appreciate it is only a minute -- that there really wasn't very much discussion about it. It was simply: this is what the Department of Health want, this is what the Charity Commission require, we will go along with what the Department of Health want. Is that a fair reading of that minute? Is that what happened?

A. It's a bit long ago for me to remember this particular discussion, I have to confess. This is in the context, I am sure, of -- and forgive a little speculation on my part -- the fact that the Department of Health was unhappy at the level of reserves held by the Macfarlane Trust and did not want Caxton building up reserves in the same way, and there was a lot of discussion about how Macfarlane were going to use those reserves, if I remember rightly.

As the Department of Health was the sole funder, we would have had to have reached agreement with them on any reserves policy, because that would have meant drawing down enough money for a reserve.

So if the Department of Health said "We don't want you to have a reserve", I think we would have probably pretty much accepted that.

Q. Can I suggest two consequences to you of the reserves policy that was adopted by the Caxton Foundation and see whether you agree with them or whether you have any comment to make?

A. Uh-huh.

Q. It meant, first of all, that any underspend was lost to the Caxton Foundation, because it was simply retained by the Department of Health?

A. Yes. I mean, we were working on that public sector notion of annuality that, if we don't spend the money in year, it goes back to the Department or it never gets drawn down, effectively. We don't get to use it. I think that might have been the case, even if we hadn't had a reserve policy. A reserve policy would normally mean you would have enough money -- for a normal charity would mean you have enough money in the bank to ensure if you have to close the charity, for example, you can pay your staff or you can see to your liabilities, et cetera, and a lot of charities will have, say, four months' running costs or maybe even six months' running costs put into reserves.

In our case, you could argue that because we

were going to be wholly funded by the Department with a sum of money every year, there was no need to have a reserves policy, because any plan to run down Caxton would have to be managed alongside the Department of Health and the right level of funding provided.

So, on top of that, we have got this business that happens a lot with government funding that government provides funding for something to an external organisation and if it is not spent, there is no facility, generally, on public spending rules to hang on to that money for the following year and we were caught by that.

So I think I would say that that's a slightly separate thing from reserves, and sort of tied up with the way, generally, that public spending rules operate.

Q. So we have heard evidence from witnesses that were concern with the Macfarlane Trust. I think it is the Inquiry's current understanding that the Department of Health treated their pot of money slightly differently. They were given, it seems, their money and they were able to invest it, hence they were able to build up such significant reserves. Was that, do you recall, ever a conversation that the Caxton Foundation had with the Department of Health?

A. I think, to start with, the Macfarlane Trust was given a sum -- I mean, right at the start, was given a sum of money of something like 10 million and it was some years later then before there were additional sums of money added to that. By that stage, they had built up some reserves in investment and then the Department provided top-up funding and allowed them to keep those reserves that they had built up in the early days.

So I think it was quite different in that sense, because where we started off with potentially one year's funding, Macfarlane started off with a much larger sum intended to last for a longer period.

Q. Is there anything that Caxton could have done about that? Could it have made representations to the Department of Health to say, "We want to be treated as the Macfarlane are so we control over our allocation to spend as we want, if we don't spend it all in year 1, we want to roll it over and be able to spend it in year 2?"

A. I guess we could have done. I mean, I wasn't party to any of the discussions that the founding trustees had with the Department during the set-up of Caxton. So I don't know whether that was discussed at all.

Q. But it certainly wasn't discussed your time on the audit committee?

A. No, not at all. At the point where I became a trustee, you know, we had a funding arrangement that had been agreed and was not challenged after that.

Q. Then the second consequence -- I wonder what you would say to this -- in your witness statement you say on several occasions that one of the difficulties the Caxton Foundation faced was the uncertainty over the annual allocation?

A. Yes.

Q. And that one of the consequences of that was that this became difficult to make long-term plans for Caxton, because there was a concern that if one set up disbursement policies to give, for example, regular payments and then the following year that money was halved or it wasn't there, then the beneficiaries would be in a very sticky situation, having been reliant on that money coming in. Is it right to understand your evidence in that way?

A. That's certainly true. So in 2014/15, when we finally were able to roll out the regular payments scheme, in that same year the Department was giving us messages about how the allocation for 2015/16 could possibly be reduced, and yes, certainly we were forced to say to recipients -- well, it wasn't a regular payment at that stage -- the first one was a one-off payment, but

we were obliged to say, "Please don't rely on this every year".

I mean, that was always one of the concerns. I am sure you will get on to this issue of dependency, that was always one of the concerns about a regular payment scheme, I think, in the first place. That understandably, if people have got an income coming in, they will adjust to it. They will adjust their spending in the light of that. And if there is uncertainty about future funding, that's a problem.

Q. I said I was going to ask you about the second consequence of not having a reserve policy. Is it this, that that difficulty, that uncertainty is compounded by the fact that you don't have any researches to guard against that cut in funds?

A. Yes. I suppose it depends, really, what you want a reserves policy for. I mean, the Charity Commission's expectation, as I say, is that charities have a reserve policy to ensure that should the worst come to the worst and they have to cease operating, that they are able to meet all their liabilities.

In this case we are talking about something different. We are talking about building up a reserve that enables us to guarantee a level of income for beneficiaries year on year. So that would have

required more than just the usual four or six months' running costs. It would have required something much more substantial.

I think one of, you know, the Department's issues, particularly in that sort of period of public spending austerity, was that it didn't like the idea of public money sitting around in a bank account somewhere not being spent when, you know, it could be spent on front line NHS services or whatever.

MS SCOTT: Sir, I am going to move on to a new topic. I am conscious that it is nearly 4.30. So I wonder if now is a good time to break?

SIR BRIAN LANGSTAFF: Well, how long is this new topic going to detain us roughly?

MS SCOTT: I would have thought twenty minutes to half an hour.

SIR BRIAN LANGSTAFF: Yes. Very well. In that case, what we will do is we will take a break now and come back tomorrow morning at 10 o'clock, and I think we can probably guarantee you a 10 o'clock start. So we look forward to seeing you then, and 10 o'clock for everyone else. 10 o'clock.

A. Okay. Thank you.

(4.27 pm)

(Adjourned until 10.00 am on the following day)

INDEX

F:

F:

F:

F:

F:

F:

F:

F:

F:

F:

F:

F:

F:

F:

F: