THE INFECTED BLOOD INQUIRY: REPORT PUBLICATION

20 May 2024

SIR BRIAN LANGSTAFF: No. No, you've got it -- if that's for me, or for my remarkable team, thank you.

But you're actually applauding the wrong people. This is your report. I may have done the words, certainly the errors, the omissions they're all mine -- and one of them's already been pointed out to me this morning by one of you.

But the words come from you and your stories. I want you please, in a moment, to give me an applause at least as long, and probably longer, standing if you would, if you can, to those who are really responsible for what is in this report. Look to your right. Look to your left. Look in front. Those of you who can turn, look behind. Those are the people who have written this report all from your very different perspectives.

That's where the material comes from: you.

At 7.00 am this morning, my full report was handed to the Cabinet Office to be given to the minister, John Glen. At 8.00 am it was made available to most of you here. It is now my role to present it to you and to the wider public, who have watched this from home or on live stream, and the wider public who have had no

connection with the Inquiry before.

Well, here it is: seven volumes. There's quite a lot of detail in it. What it comes to is this.

In families across the UK, people -- adults and children -- were treated in hospital and at home with blood and blood products and that NHS treatment resulted in over 30,000 people being infected with viruses which were life-shattering. Over 3,000 have already died and that number is climbing week by week.

For everyone involved, the evidence given to this Inquiry has been difficult to listen to. No, that's the wrong word. It's hard for those centrally involved and it must have been hard for many observing. But it has been much harder still for those who were recounting their own experiences, or listening to stories which touched a nerve, which brought back memories they would rather have forgotten but which they brought themselves to tell the Inquiry because the truth was important to tell.

The harm that was done to people cannot adequately be put into words. I've tried. But patients -- parents watched their children suffer and, in many cases, die. Children witnessed the decline and the death of one, sometimes both, parents and their lives were irrevocably altered as a result. People had to care for their

grievously ill partners or other family members, often at the expense of their own health and careers. Early on, in particular, they had to do so whilst being shunned or, worse, abused by neighbours, workmates, by people they had once thought of as their friends -- sometimes even by health professionals.

The Inquiry is not just investigating something which happened years ago. It is still happening. People still have to care for the after-effects of what their loved ones still suffer. The grief, the trauma, which all of those lost loved ones experienced continues to this day.

The early treatments for HIV and hepatitis C were often worse than the illnesses themselves. The side effects linger, and for a number of those infected with hepatitis C the damage done over so many years to their liver has left them at risk of developing cancer and requiring liver transplants. Every aspect of their lives has been defined by their infections: childhood, education, career, leisure, relationships, marriages, home ownership, travel, finances. Dreams and ambitions have been lost, relationships broken. True though each of these consequences is, it really takes a person who has lived, and is living, with them to describe them in a way which brings home the full horror of what had

happened.

And that's why in this report I've tried to record peoples experiences in some detail and, where I can, using their own words. They're better than mine.

Those experiences have been central to this Inquiry's work and must be central to the response to this report. But I could not record every individual story in this report. I hope, therefore, that the thousands of statements which speak to people's suffering and endurance, which will remain accessible on the Inquiry's website, along with the transcripts and recordings of the oral evidence which the Inquiry heard, will ensure that their voices, and their pain, are never forgotten and will move future listeners and readers as they have moved so many during this Inquiry.

This disaster was not an accident.

People put their faith in doctors and in the government to keep them safe and their trust was betrayed.

There are generally two elements to any major public inquiry: one backward-looking, what happened and why; the other, forward-looking, what next? How do we stop it happening again? But this Inquiry's different. There is another third element to this Inquiry's terms of references: what was the response of government and

others in authority to what had happened?

Here, the NHS and successive governments compounded the agony by refusing to accept that wrong had been done. More than that, the government repeatedly maintained that people received the best available treatment and that testing of blood donations began as soon as the technology was available, and both claims were untrue.

That means that part of the "what next? How do we stop it happening again?" is not only taking steps to meet any threat of future infection carried by blood, blood products or tissue, but how to ensure, as far as we can, that the government responds to the citizens it serves -- how shall I put this? -- more appropriately in a way which reflects the true facts.

To turn back to what the report says then about why infections happened on such a scale over such a time to so many people, the picture is a complex one and the failings were multiple.

First, governments, blood services, doctors knew at least 80 years ago (since the mid-1940s) that blood could transmit hepatitis and that this was a significant disease which could lead to cirrhosis, liver failure, liver cancer, and death. This was not something kept to the dusty libraries of academic knowledge. The

consultant adviser on blood transfusion to the Chief Medical Officer wrote in 1946 that users or plasma "must be told that it is a potentially lethal fluid which should be used with discretion." A 1964 circular from the Scottish Home and Health Department said:

"No transfusion should be undertaken unless the benefits outweigh the risks of hepatitis."

One of the leading transfusion directors used to write on the boards for students "Blood can kill". The risk was not limited to hepatitis but it included the risks of future unknown viruses.

In the light of that knowledge, you might expect action to be taken to reduce the risks which were known of and a keen eye to be kept open in case new risks started to emerge.

What happened was not that. Tragically, the infections happened because those in authority -- doctors, the blood services and successive governments -- did not put patient safety first. They lost sight of what was known about the risks of viral infections from blood. "Doctor knows best" was such a strong belief that health departments did not issue guidance to curb the unsafe use of blood and blood products. Decision-making on measures that could make blood and blood products safer was put off, then dragged out

unnecessarily, and failed to reach clear and decisive conclusions. And patients were simply not given the information they needed to make fully informed decisions about their own treatments.

As long ago as 1952, the World Health Organization identified how to reduce the risks of transmitting hepatitis through blood and blood products. UK medical and government advisers took a central part in this. There were four key measures highlighted by the World Health Organization on which, despite its involvement in identifying them, the United Kingdom fell short: the first was the selection of donors; the second was restricting the size of the pools used to make plasmas products; the third was treating these products (for example, with heat) to reduce infection; and the fourth, maintaining good records and reporting infections. Each of these is addressed in detail in the report, and I shall say a little more about some aspects of each of them now.

But the key point is that if we had followed the World Health Organization's advice, there would have been fewer infections from blood and from blood products and fewer deaths.

As to the selection of donors, everyone who received blood, or products made from blood plasma,

depended on the quality of the donations which ended up in their veins. Now, that depended on donors. Knowing your donor and the risks that might come with their blood is fundamental to any system of collecting blood. The blood used for transfusions and to make blood products in the UK was from British donors who could, and should have been, better selected.

For instance, in 1975 the Chief Medical Officer for England said the practice of collecting blood in prisons could continue, even though prisoners were known to have higher numbers of hepatitis infections. This practice was not ended in the UK until 1984: for instance, no real efforts were made to prevent those who had used intravenous drugs (and who were therefore a higher risk of hepatitis) from donating blood; and, for instance, the steps taken to keep donors who were more likely to be incubating AIDS out of the donation chain were late in starting and, when they finally began, were inadequate.

As for pool sizes, the dangers of pooling plasma from many donors were established by the Medical Research Council in 1944: the greater the number of donors to a pool, the greater the risk from it, because one infected donation could contaminate the whole pool.

In 1951 the textbook that was then the bible of

blood transfusion said "the use of large pool plasma has, *of course*, been abandoned".

The use of only small pools lasted until after 1970. Then, however, something extraordinary happened. Just as the long-term seriousness of hepatitis became more and more apparent, the size of pools used to make UK blood products grew ever larger and larger and, with that, so too did the risk. Instead of reducing the risk, the UK was steadily increasing it.

Blood donors in the UK gave blood freely, purely for the good of other people unknown to them and they deserve praise for that. By contrast, the blood supplied in the United States was largely sold by people who needed the money. The hepatitis that gave rise to, and the number of deaths that followed, resulted in the UK authorities banning sales of whole blood for transfusion in 1973. But US authorities did not stop people selling their plasma to pharmaceutical companies to be made into blood products.

In 1973, the UK licensing authority gave the green light to the importation and distribution of an American blood product and an Austrian blood product, also made using paid donations, despite the manufacturers making no secrets of the risks of hepatitis they posed. The licensing authority knew of the risks from the sales of

blood plasma from people who, and I quote, "did not inspire confidence" and were motivated by money. The licensing authority knew too that these products were made from very large pools. The risks of hepatitis were freely admitted by the makers.

I have concluded that the UK was wrong to decide to license these products in 1973 and later decisions in the 1970s to grant further licences for similar US products were also wrong. Those products should simply not have been permitted to be distributed generally in this country.

Despite the World Health Organization's reminder in 1952 of the importance of record-keeping, poor record-keeping has been a problem across many of the issues examined by the Inquiry. This had an impact on safety. If you can't trace the source of the transfusion back to the donor who was infected, you cannot then tell and treat the donor and avoid any further donations from that source, nor can you trace previous donations to check if other people who have had transfusions from the same source have then become ill. And reporting of infections did not have the priority it should have done. For instance, at the height of the AIDS crisis, the North London Blood Transfusion Centre had to ask the government committee responsible for AIDS

three times to arrange for the Chief Medical Officer to ask doctors to find out if AIDS patients had previously donated blood.

As well as the more rigorous selection of donors, and until such time as direct tests specific to hepatitis C and HIV were available, a further way of reducing the chances that hepatitis C or HIV would get into the blood supply and be transfused was to test for certain markers in the blood which could help identify the donations that might be infected. This was known as surrogate testing.

The opportunity of this surrogate testing in the case of HIV was lost. In respect of hepatitis C, taking a decision about it was put off, put off, and then delayed until it was simply too late. One doctor involved, rightly, described the process as "going round in very small circles some distance away from the target". Nearly four years were lost during which the risks could have been very significantly reduced.

The government was to claim in the 1990s that the direct tests for these viruses were introduced as soon as the technology was available. That was wrong in the cases of each of the viruses. In the case of HIV, a test had been developed by August 1984. But it was not introduced for the screening of blood donations until

October 1985. It takes time to produce such a test in sufficient quantity to screen all blood donations and to check its reliability, but I have concluded that we lost months for no clear reason by delays and indecision with setting up a process to evaluate each available make of test. Yet a number were commercially available and being used elsewhere in the world.

Patients receiving transfusions in the UK were needlessly exposed to the risk of HIV as a result. In the case of hepatitis C, the delays were even worse. Screening of blood donations was not introduced until September 1991. Even when a screening test was available and approved, its use had to wait until all regions could introduce it on the same date; in other words, going at the pace of the slowest. When the government claimed that screening for hepatitis C had been introduced as soon as the technology became available, they ignored the long list of countries that introduced screening before the UK: Japan, Australia, France, Luxembourg, Finland, the US, Austria, the Netherlands, Canada, Germany, Belgium, Switzerland, Italy ... shall I go on? Spain, Norway, Sweden, Portugal, Cyprus, Greece, Hungary, Iceland, Malta and Denmark. 23.

Just because the Department of Health hoped what

they said was true didn't mean to say it was. You might have thought that as soon as a screening test for hepatitis C was introduced across the board in September 1991, donors who were infected and might not have realised it could be identified and told, and then anyone who had previously been given their suspect blood could be traced and checked. Well, you would have been wrong. It took around four years for there to be a general look-back like this.

One transfusion director, Dr Jack Gillon, Edinburgh and South East Scotland, thought this was so unethical that he arranged to conduct a look-back in his area. He had to call it a pilot study but he wanted to do it and did it. His work deserves praise. It was instrumental in a UK look-back being delayed no further than it was. But the delay which had already occurred made the look-back less successful then it would and should have been.

Hepatitis C tests concerned, obviously, hepatitis. Almost everyone who had a severe bleeding disorder -- severe bleeding disorder -- had hepatitis too as a result. But 1,250 people with bleeding disorders were also infected with HIV. Nearly one-third of those infected with HIV were children. Three-quarters of those who have HIV have died.

Now, these are figures. They're numbers, they're percentages, they're difficult to relate to. But look around you. The number of you who are filling this great hall today is roughly the same as the number of people who had bleeding disorders who were infected with HIV. Picture that. And now picture only a quarter of you being here.

A number of failures contributed to the infection of so many with bleeding disorders: failing to plan sufficiently to produce enough blood products to avoid the UK having to rely on imports; to a failure to achieve self-sufficiency, which, though it became government policy, was not delivered until the end of the 1980s; failing to suspend imports in mid-1983; continuing importations of products made from plasma collected before safety measures were adopted in the USA; and being slow to adopt and develop heat-treated blood products in which HIV had been inactivated and neutralised.

A real risk that blood products transmitted the cause of AIDS was known by government in July 1982. It was known by all haemophilia doctors by the end of 1982. There was already a growing epidemic in the United States likely to come to these shores, yet the response here was one of denial, disbelief,

dismissiveness, and delay. The government's response was unconscionably slow. So too was the response of haemophilia centre directors and of their organisation, the UKHCDO.

Professor Arthur Bloom was Chairman of the haemophilia directors and he died many years ago. He must bear some of the responsibility for the UK's slowness in responding to the risks of AIDS to people with haemophilia. In May 1993, the Mail on Sunday put "Hospitals using killer blood" on their front page. We in the Inquiry now believe that one of the sources for that story was Professor Bloom's respected senior colleague in Cardiff, who was reluctant at the time to be identified as a whistle-blower. Professor Bloom told the Haemophilia Society that "in spite of inaccurate statements in the press" he was unaware of any proven case in the UK and there was no need to change their treatment. The Haemophilia Society then relayed his advice to their members.

Yet he, Professor Bloom, himself was treating a patient he believed had AIDS. He reported as much to the UK Centre for Disease Surveillance. He was a member of the various committees involved in the response to AIDS and, disastrously, the Department of Health and Social Security was over-influenced by his advice, in

particular his advice to continue importing commercial factor concentrates when the leading epidemiologist and head of the Communicable Disease Surveillance Centre, Dr Spence Galbraith, had advised against it.

Inexplicably, no government minister was shown the epidemiological advice to suspend imports until the risk of AIDS was better understood. The decision taken in July 1983 not to suspend them was a bad one for a number of reasons.

One was the idea that the risk of AIDS was out-balanced by the benefits of using the products because, it was said, in the case of haemophilia it was life-saving. Well, that ignored both the fact that most treatments for people with haemophilia were not used in life-threatening situations and the fact that there were tried and trusted life-saving alternatives, in particular much less risky cryoprecipitate, each unit of which was produced from a single donation by a British voluntary donor.

Another reason it was a bad decision was the conclusion it was not feasible to replace concentrates with cryoprecipitate "on grounds of supply". Yet transfusion directors told the Inquiry that, if asked, they could have made more of the safer cryoprecipitate treatment for people with bleeding disorders. They

weren't asked.

Some clinicians explained how they would have adapted their treatment practices if fewer American products had been available, and this is not the benefit of the hindsight. On either side of the Peninnes, Alder Hey and Sheffield children's hospitals treated children with bleeding disorders at the height of the AIDS crisis.

Alder Hey treated its children almost exclusively with large pool commercial concentrates. Utterly inappropriate. Almost all the children were infected with AIDS.

By contrast, at Sheffield Professor John Lilleyman sought to minimise exposure to multiple donors by using cryoprecipitate. There was one infection with HIV at Sheffield Children's Hospital. It's still one too many but it's illustrative of the fact that the adoption of different treatment practices by haemophilia clinicians could have substantially reduced the number of infections. Treatment choices mattered.

Take the case of a haemophilia centre at Treloar's School. Of the 122 pupils with haemophilia who attended the school between 1970 and 1987, only 30 survive. The pupils were often regarded as objects for research, rather than first and foremost as children whose

treatment should be firmly focused on their individual best interests alone. There was a particularly heavy use of factor concentrates. Different concentrates were indiscriminately used, increasing risk. Pupils were given extra to see how prophylaxis might work. Research prejudiced the quality of treatment, and convenience of administration trumped safety.

Children were treated in this way without their parents having been provided with any, or anywhere near enough, information about the risks of treatment. It was unconscionable to treat children with concentrates capable of transmitting serious viruses without explaining those risks clearly to their parents. There were multiple research projects where informed consent for participation was neither sought nor given. That was unethical. It was wrong.

There are some echoes of what happened in Treloar's in the evidence relating to the haemophilia centres across the UK which is extensively examined in this report. All the evidence points to a single, inescapable conclusion: that children and adults were not treated in a way which prioritised their safety above other considerations.

Just as treatment choices by doctors mattered, so too did giving patients or their parents the information

to make an informed decision about their treatment with blood or blood products so they knew what to be alert for if they were infected. Very early on in the Inquiry, it became clear that most people were not told enough about the risks of treatment with blood or blood products to give informed consent, if indeed they were told anything, nor were they given information about alternative treatments. And yet respecting people's right to control what happens to their own body has always been an ethical cornerstone of medicine. Always.

A booklet produced by the Medical Defence Union in around 1953 explained that consent had to be "genuine consent ... a real expressed willingness by the patient to undergo the treatment after ... its nature, its risks and its objective" had been clearly explained.

In 1980, the British Medical Association's handbook on medical ethics said:

"Consent is freely given if the patient understands the nature and consequences of what is proposed."

The next year they added:

"Doctors offer advice but it is the patient who decides whether or not to accept the advice."

The failure of clinicians to tell people of the risks of infection from blood or blood products, the

failure to tell people of the availability of alternative treatments, the failure to tell them they were being tested for HIV or hepatitis C, and sometimes the failure even to tell them, or to tell them promptly, that they had been infected with HIV or hepatitis by their treatment, the failure to explain these devastating diagnoses privately in person and with sensitivity, these failures were widespread. They were wrong. They were unethical.

The failures in decision-making that led to the original infections were them compounded by institutional defensiveness and that's a pattern of institutional defensiveness that must stop.

When citizens have concerns that something has gone seriously wrong, fairness should be that they get answers. People infected with blood and blood products did not. Instead, their trauma has been compounded by the lack of recognition of what happened to them and by a lack of accountability. The report details how three lines were repeatedly deployed by successive governments: that people had the best available treatment, that the infections were inadvertent, and that screening for hepatitis C could not have been introduced earlier than September 1991. All of those claims were untrue.

That list I gave you earlier of the 23 countries that introduced screening before the UK did was compiled by a High Court judge in a landmark case in 2001. He found the screening should have been introduced earlier. Yet the government continued to assert that screening began as soon as the technology was available, even after campaigners pointed out that that was wrong and contrary to what the judge had found.

Much of the responsibility for this institutional defensiveness lies with the Civil Service. It was not until 2003 that a limited financial support was announced for people infected with hepatitis C through NHS treatment with blood and blood products. Prior to then, the line taken by successive governments was that no financial support whatsoever should be provided. On each occasion in the 1990s when a minister, having heard the pleas for help from people infected and affected, expressed an interest in changing that line, they were persuaded against it by civil servants.

One minute could have come from Yes, Minister:

"It is quite clear that he [that is the minister] is trying to change the line, little by little. He has had plenty of briefing (written and oral) on the subject but his sympathy for those concerned is clearly uppermost in his mind."

When, later in the early 2000s, a minister did seek an investigation to see if the advice given to her predecessors about the failure to achieve self-sufficiency was correct, because she doubted what was being told to her by her civil servants, the resulting report was not published for nearly four years. By then, it had been substantially changed from the initial draft which had, as the minister had asked, set out a factual account of what available documents had said. It had now become one which, without any input from the original author, expressed opinions favouring the lines the government had been taking and providing an incomplete and thus misleading picture.

The report as then published, the so-called Self-Sufficiency chronology, was an insult to campaigners who had, despite the challenges of ill-health and grief, determinedly pieced together a much fuller understanding of what had happened than the Department of Health. To cap it all, it was repeatedly asserted (as a reason for not paying affected people similar sums to those paid in Ireland) that in Ireland the sums paid were because the government there accepted there had been a fault, whereas in the UK the government had not. Yet again, it fell to a campaigner to challenge this and he succeeded. A High Court judge

decided that the government's position was an error. The Irish government did not set up a compensation scheme because it accepted there had been fault. Yet Civil Service briefings to ministers simply ignored this and repeated the original approach, and documents which might have been thought to assist those seeking compensation went missing.

Now, I've devoted a whole chapter in the report to that. In the case of some documents, it's simply not possible now to know how and why they went missing. For others, I have concluded that they were deliberately and wrongly destroyed in an attempt to make the truth more difficult to reveal.

Well, let me turn from what happened and how successive governments responded to the third element of the Inquiry's report: the future. At the start of the Inquiry, people told me they wanted to ensure that a disaster like this never happened again. The report begins to address that by setting out a number of lessons to be learned.

The first and most important lesson to be learned is that patient safety must be the guiding principle. Many, indeed most, infections would have been prevented if patient safety had been paramount throughout.

The second lesson to be learned concerns risk.

Risk was poorly understood and poorly communicated and the wrong questions were asked and answered. The line that there was no conclusive proof that AIDS had been transmitted by blood and blood products may have been strictly true at the time, but it was misleading and it misled. It gave false comfort to patients and clinicians that the risks were not as real as indeed they were. The public should be trusted with the truth with all its uncertainties.

Professor Arthur Bloom, to return to him in this context, was warned in a letter from the US Centres of Disease Control in March 1983 that AIDS was an epidemic evolving "with a frightening pace" and that blood products could transmit its cause. He failed to share that letter or the information within it. Instead, some clinicians advised that the small number of cases meant that it was not a big risk for the UK haemophilia population. Now, that confused incidence and risk. In a disease with an incubation period of some two years, the cases you diagnose on day 1 only tell you who was infected two years ago, not who is infected today but has not yet been diagnosed. The day cases showing today are just the tip of the iceberg.

In their slow and protracted decision-making, civil servants and ministers lost sight of the value of

taking steps to reduce risk even if full elimination was not yet possible. The infections could have been prevented and lives could have been saved even if just some of the measures examined in the report had been implemented. And if patient safety were the guiding principle, there should have been curiosity before 2017 about what led over 3,000 people to die and thousands more to live with infections.

Apart from lessons which should be learned, what else should happen next? Well, I fully expect the government to make an apology.

To be meaningful, though, that apology must explain what the apology is for.

It should recognise and acknowledge not just the suffering but the fact that the suffering was the result of errors, wrongs done, and delays incurred. It should provide vindication to those who have waited for that for so long.

And it should be accompanied by action.

Action, obviously, to recognise and remember what happened to so many people and to learn from the Inquiry, action to implement recommendations I made over a year ago to set up a proper compensation scheme.

A major task is the further work to be done in each of the four health services to put patient safety

at their heart. Now, ensuring a patient safety culture is not an easy task. Inquiry after inquiry has recommended it and it has not been achieved as yet. What I recommend is that where an individual is responsible for something going wrong that was or might have been harmful, they should not usually be blamed for owning up (owning up enables patient safety to be better achieved after all), but they should certainly be blamed if they keep silent.

They should be obliged to report near-misses as well as actual wrongs. Leaders in healthcare should be made subject to a statutory duty of candour where they are not already.

And to be made accountable both for ensuring that that duty is observed by those they lead and for recording and properly considering reports of concerns made to them. The regulatory landscape for patient safety should be decluttered so that patients, and for that matter healthcare professionals, know where to take any concern they may have and leaders know exactly what is expected of them.

Learning from other safety-critical enterprises and industries, the NHS should establish a safety management system and I highlight in my recommendations the work on patient safety being led in England by the

Health Services Safety Investigations Body. All of this should be informed by developments in the digitisation of patient records.

I've also recommended measures to end a defensive culture in the Civil Service and government. To do this, I have encouraged the government to reconsider whether, in the light of the facts revealed by this Inquiry, it is sufficient to continue to rely on the current non-statutory duties in the Civil Service Code and the Ministerial Codes to end the defensive culture in the Civil Service and government.

In particular, I recommend that there should be a statutory duty of accountability on senior civil servants for the candour and completeness of advice given to permanent secretaries and ministers and for the candour and completeness of their responses to concerns raised by members of the public and by their own staff.

I've recommended measures to ensure that people who have been infected with hepatitis C from blood transfusion or blood products have the monitoring for further liver damage which they need, and I have recommended that GPs should ask newly registered patients on registration if they have ever had a blood transfusion to try to find more of the people as yet undiagnosed.

That is, of course, in addition to the free postal testing now available in England and Wales. And if there is anyone who is listening online to this who feels that they need that test, that is where they can currently get it.

Amongst measures I recommend to improve the safety of transfusions is action to establish the outcome of every transfusion and to increase the use of alternatives to blood or blood products where possible, and there are measures I recommend to protect the safety of haemophilia care.

This Inquiry has aimed to listen and I hope it's succeeded in that. But listening is not just for inquiries or courts. I recommend measures to empower the patient voice so that it is heard and taken seriously in day-to-day healthcare. In particular, that clinical audit should, as a matter of routine, include measures of patient satisfaction or concern and that the results are reported to the board of the body concerned. I have recommended funding for patient advocacy and a particular consideration should be given to meeting the needs of people with sickle cell disorder or thalassaemia.

Another damaging failure to hold a public inquiry when one is clearly merited must be it avoided. Though

I recognise that the power to call an inquiry remains with the minister under the Inquiries Act, I believe there is a role here for the Public and Constitutional Affairs Committee (that's a Select Committee of the House of Commons) to consider whether to recommend to a minister that they should exercise their power and that if the minister disagrees with the committee, they must set out in detail and publish reasons for this disagreement sufficient to satisfy the committee that the matter has been carefully and properly considered.

My final recommendation considers the question of implementing the recommendations I have set out. I've written to the minister to tell him that I cannot as yet notify him that the Inquiry has fulfilled its terms of reference. Those terms include the nature, adequacy and timeliness of the response of government. As I've said repeatedly in public, delay not only causes frustration but it compounds the harm and suffering many of those infected and affected have endured. In the context of this Inquiry, perhaps beyond all other, it is unconscionable to allow a state of affairs to exist in which people's fears that the lessons and recommendations of this Inquiry will collect dust on a Cabinet Office shelf are realised.

I'm satisfied that I must do what I properly can

within my powers to try to ensure that that does not happen. Now, it's for the government to respond as it will but I intend to use my position, as far as I properly can, to prevent any unreasonable delay in its doing so.

I hope to be able to say soon that the Inquiry's work is completed.

FROM THE FLOOR: We'll see.

SIR BRIAN LANGSTAFF: After that, I recommend that the Public and Constitutional Affairs Committee should review both the progress the government has made towards responding to the recommendations of the Inquiry and, if those recommendations are accepted, towards implementing them.

Finally, I'd like to thank again all of you here and all of those of you who are watching remotely for your contribution to this Inquiry. Whatever your perspective has been, the sheer numbers here pay testament to the importance of the issues this Inquiry has been considering and it pays tribute to the interest and engagement which you have shown, which has never flagged, since the days when so many of you came to the preliminary hearing. An inquiry serves its purpose best when everyone involved from whatever perspective participates as you have done.

But I would like to thank too those who have contributed who would be here but can no longer be. Too many are too seriously ill as a result of their infections. Too many have died.

I will mention one person, but everyone here knows of others who have not survived to hear the outcome of this Inquiry. Perry Evans gave evidence on the very first day of the Inquiry's hearings in 2019. He had mild haemophilia and led an active life treated only with cryoprecipitate before factor products were introduced. He was diagnosed with HIV in 1985 and told he had two to three years to live. He survived. But he was diagnosed with an HIV-related cancer in 2002. He survived. He was in a coma for ten days in 2008 and wasn't expected to live. He survived, although with a range of health problems associated with HIV and hepatitis C and the treatments he had received.

But very sadly Perry died exactly five weeks ago. His wife Heather is here today.

You don't need me to tell you more people die each week. Imagine the difference it would have made if this Inquiry had been held 30 years ago.

FROM THE FLOOR: Justice now. Justice now!

SIR BRIAN LANGSTAFF: If people were given answers then and had recognition of their losses, they could have lived

the rest of their lives free from financial hardship and without having to fight for justice and recognition. It may be late but it's not too late. Now is the time, finally, for national recognition of this disaster, for proper compensation, and for vindication for all those who have been so terribly wronged.

That-- that -- is what my report amounts to. Thank you.
