HAEMOPHILIA
SCOTLAND

Submission to Sir Robert Francis, Interim Chair of the Infected Blood Compensation Authority, on behalf of Haemophilia Scotland on the Proposed Infected Blood Compensation Scheme

1. Introduction

Haemophilia Scotland write to provide a written response following attendance at the engagement meeting with Sir Robert Francis on 18th June 2024. This document stands alongside the submission made by Thompsons Solicitors. That submission has our full endorsement.

Our position is that the compensation scheme as currently proposed does not follow the recommendations of Sir Robert Francis' Compensation Study and the Inquiry's second interim report in a number of material ways. Both the Compensation Study and the Inquiry involved the infected and affected in their process and consequently those processes had the trust and confidence of the community. The Inquiry in particular had a large body of evidence regarding the impacts of HCV, HBV and HIV on those infected via contaminated blood and blood products in making its recommendations on compensation in its second interim report. For the compensation scheme to have the confidence of the infected and affected, it is absolutely vital that it operates as envisaged by both the compensation study and the Inquiry's second interim report.

2. Support Schemes

It is impossible to convey adequately in words the distress and anxiety that has been caused in the infected and affected community by the information contained within the proposed compensation scheme about the payments under the support schemes stopping once compensation payments have been made. The anger and frustration that this has caused was expressed at the meeting we attended on Tuesday 18th June.

The information on the proposed compensation scheme states as follows:

"The IBCA will not be able to assess all cases at the same time. Therefore, to ensure a fair and consistent approach over the transition from the IBSS to the new scheme, any IBSS payments received from 1 April 2025 will be deducted from a person's total compensation award. In the event that the IBCA assesses that a person is entitled to less compensation through the compensation scheme than may have otherwise been paid to them through continued IBSS support payments, an additional top-up payment will be provided to bring the compensation they receive up to the level of the support payments. This will ensure that no one will receive less compensation through the compensation scheme than they may have otherwise expected to receive through payments under existing support schemes. Any top-up payment awarded will take into account other compensation payments that a person has received through the compensation scheme, either in their own right or as an estate beneficiary."

The Inquiry's recommendation in relation to support payments was contained in Inquiry Recommendation 13 of the Inquiry's Second Interim report as follows:

Inquiry Recommendation 13: "I recommend that, with regard to the relationship between compensation, support payments and benefits:

a) In assessing compensation under the scheme, no account should be taken of any past payments made under the support schemes or their predecessors;

b) the current annual payments under the support schemes should be continued (or merged into the compensation scheme) and guaranteed for life, by legislation or secure government undertaking;

c) such continued payments should be taken into account in assessing awards for future financial loss or care provision..."

The government may argue that the ability for applicants to elect to receive their award by periodic payment sufficiently meets the recommendation, but such a position would be disingenuous. Both the spirit and letter of the Inquiry recommendation recognises the significant importance of support payments continuing albeit with the future support payments being offset against the future care and future loss of earnings.

The offset recommended clearly shows that Sir Brian Langstaff considered the support payments relate to care and earnings and do not relate to any other awards (injury, autonomy or social stigma).

The principle of only 'like for like' off-sets reflected in Recommendation 13 (c) has not been followed in the proposed compensation scheme.

This approach does not sit comfortably with the standard approach to off-sets applied by the courts whether it is benefits, insurance premiums or sick pay. It is our view that the compensation scheme does not implement Recommendation 8 of the Second Interim Report:

Inquiry Recommendation 8: "I recommend that the government should approve a scheme setting out a framework of tariff-based compensation for eligible infected and affected persons, **at rates which broadly take account of but are not limited by <u>current practice in courts</u> and tribunals across the UK** and sums payable in other UK compensation schemes, and allowing an assessed basis for defined financial losses. The rates of compensation should be based on the advice of the independent clinical and legal panels and set by the compensation scheme."

The importance of the compensation scheme following Inquiry Recommendation 13 cannot be overstated.

One suggested approach would be for individuals to be given an option to waive assessment of future financial losses in exchange for continued receipt of the support payments (as envisaged at paragraph 2.54 of Sir Robert's Compensation Study). This would be one aspect among many where an applicant to the compensation requires legal advice (see further detail below).

We note that the information as published by the government states that the Infected Blood Support Schemes (IBSS) are delivered separately in England, Wales, Scotland and

Northern Ireland and decisions on individual schemes will be for the devolved administrations.

We consider that there should be an uplift to support scheme payments as per the recommendations of Sir Robert Francis. This was an integral part of the link between support scheme and compensation. The relevant paragraphs of Sir Robert's report are as follows:

9.88 In my view, unless they already exceed this figure - and some do - the regular, guaranteed annual payments under the support schemes should be brought to a level where it equates to a total of the following:

- 5 % above national median earnings - net, as these payments are and should remain, exempt from tax. Median national full time earnings in April 2021 were £31,772 per year (£611 per week). If that were taken as the base figure the 5% enhancement would make a total of £33,361.11'
- A tax -free sum in recognition of additional financial issues caused by the diagnosis of HIV or HCV, for example, increased or hard to get insurance cover, convenient medical treatment, additional transport costs, etc. of, say, £10,000.

9.89 Payment categories in the support schemes which already exceed this level should be increased by the same proportion to preserve the differential.

We read the £10K to be per annum and not a one off payment of £10,000 which we consider to be an insult.

These changes are, it is submitted, entirely sound in principle, consistent with the evidence heard in the Inquiry, consistent with the principle of providing proper support via the support schemes and sensibly aligned with and complimentary of the principles which underpin the compensation tribunal.

These provisions should apply equally to those infected with HBV. Sir Brian in his Second Interim Report says (page 31) "Hepatitis B cannot be eradicated and the natural course of the disease is slow deterioration of the liver towards cirrhosis and then liver cancer. It follows that people infected with chronic Hepatitis B in consequence of transfusion, blood products or tissue transfer should be compensated. **They should be eligible for interim payments and support payments.** The deaths of those who died from Hepatitis B during the acute period of infection, should also be recognised."

3. Severity bands

Another matter which has caused the utmost concern to our clients is that the classification of the severity in Hepatitis has been linked solely to the condition of a person's liver.

They do not take any account of psychological factors, socio-psychological factors or the side effects of treatment. The three stages of progression and therefore severity of Hepatitis B and C that the government's expert group have identified are:

- chronic
- Cirrhosis and
- Decompensated cirrhosis or liver cancer

This has been described by our clients as “regressive” and taking “a step back in time to the criteria of the Skipton Fund”. They fail to take into account the development of medical knowledge about the impacts of infection. The impacts of Hepatitis C infection are extensive and devastating.

The progression of these conditions is NOT linear - people get really ill, improve a bit and get really ill again. The same is true therefore of the impact on the ability to work and the need for care. Tariffs require some assumptions, but the limited and simplistic views of the expert group reflected in the proposed compensation scheme have stolen the justice that Sir Robert and Sir Brian said that victims should receive and the government promised. A promise that they have broken.

As stated at page 29 of Volume 3 of the Inquiry’s final report:

“Where the infection becomes chronic many patients suffer from neurocognitive symptoms including fatigue, anxiety, depression, “brain fog”, attention deficit and impairment of memory. These symptoms are associated with a low-level inflammation in the brain, and with functional changes which are identifiable. They may last even beyond successful treatment. There can be a skin rash and peripheral nerve damage, and a loss of sensation in the fingers. Again, any nerve damage may not improve after treatment”

Page 60 of the Inquiry’s Expert Group on Hepatitis report sets out the large array of extra-hepatic manifestations of the condition. This list should be considered in full.

Many of the symptoms to which Hepatitis C infection led in individuals are described in the chapter on People’s Experiences (Volume 2 of the Inquiry final report). The chapter states at page 64 that

“The myriad of non-specific symptoms resulting from Hepatitis C were described in numerous written statements”. These symptoms, especially the life-changing impact of debilitating fatigue, have had significant effects on people’s lives.”

Regarding the mental health impacts of hepatitis C, the chapter at page 73 states that “The impact of Hepatitis C on people’s mental health has been profound, particularly in combination with the physical effects of the infection, and the impact of treatment”.

Regarding social isolation, page 73 of the chapter states that “Many people describe disengaging from the world because of the mental health impacts of the diagnosis.”

On the Impact of treatment, at page 79, it is stated that “Early treatment with interferon came with significant side effects.”

As acknowledged in the Inquiry final report, the vast majority of people suffered severe side effects both physically and psychologically.

There are two particularly powerful examples in the final report, at page 82 of chapter two, including highlighting the ongoing psychological effects as follows:

"Mr AC [1] described how the treatment made him want to "end it all". "It was just horrific. I 'couldnae' sit down. I was wandering about the house. I was smashing things up". There was no support to help him through the treatment and it was his father who talked him down from throwing himself out of a window. Although a third and final course of treatment was successful in clearing the virus, he has been left with significant bladder problems and with ongoing psychological problems: "I still have flashbacks. I can wake up screaming". Mr X said that treatment with interferon and ribavirin was "like being napalmed from the inside out." He was aggressive, angry, experienced suicidal thoughts and his body came out "in suppurating pustules and blisters which got infected"

Very many people continue to suffer from physical and psychological symptoms after treatment.

Page 90 of Chapter two of the final report provides a further example:

Graeme Malloch fears he will "forever live with a sense of trauma about what has happened to me and fear and trepidation about what lies ahead. I may have cleared the virus six years ago, but having ultimately lived with hepatitis C for 30 years with slightly elevated liver function tests, I am not reassured that some damage has not been done. I am also not reassured that three courses of interferon treatment in different guises have not damaged me or added to the burden."

Similar considerations apply in relation to HIV, where both early and later treatment options had significant side effects.

The problems with the Skipton Fund Stage 1/Stage 2 criteria and the point at which it was recognised that someone had moved into the more advanced "stage 2" payment are highlighted as follows in the Inquiry's final report in volume 6, page 223:

"As a consequence of these improvements in understanding the nature of the progression of the disease, what had seemed like a logical bright line rule was no longer so justifiable. It could now be seen as ruling out claims from those who were symptomatic, but who did not yet have cirrhosis. In not distinguishing between the symptomatic and the asymptomatic it seemed to have become unfair. Moreover, those whose infection had been diagnosed but who were pre-cirrhotic often underwent treatment. Until the 2010s, this usually involved interferon, often pegylated, and more often than not this was coupled with ribavirin. There is no doubt that this treatment gave rise to serious, often close to horrific, side-effects in most cases. Yet it was often ineffective. Usually the treatment had an immediate negative impact, and often gave rise to persisting problems. These were not merely physical, since there was also the psychological impact of having undergone a lengthy period of treatment suffering very difficult side-effects, seeing its effect on partners, family, close friends and work, only to learn it had all been futile. Though the disease itself might not yet have resulted in significant fibrosis, for anyone treated who had the persisting after-effects of treatment with interferon, or interferon and ribavirin, highly unpleasant and sometimes devastating symptoms remained. The reasons for thinking that a clear line could be drawn between Stage 1 and Stage 2 in terms of symptoms and effects on life could no longer be maintained. It was far more a matter of degree. The Agency Agreement was slow to reflect these developments, by recognising that a distinction should be drawn between the

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[1] Initials or names are reproduced in this submission as stated in the Infected Blood Inquiry Report.

levels of payment for those who were comparatively asymptomatic, or whose symptoms were limited, and those who, though not (or not yet) cirrhotic, had significant symptoms. It was amended in 2012, though the amendment was relatively limited: the definition of when a Stage 2 payment should be given now included the infected person developing B-cell nonHodgkin's Lymphoma where that had arisen after the person contracted Hepatitis C"

The introduction of self-assessment in Scotland following the Clinical Review in respect of regular payments as part of SIBSS was a recognition in particular of the psychological impact of infection.

The psychological impacts were highlighted particularly powerfully by the Inquiry's psychosocial expert group, which stated as follows:

"The psychological impacts arose from a range of issues. Many witnesses report long-term physical and emotional changes due to the acquired infections and the associated treatments. Early treatments of HIV and hepatitis C led to very severe and multiple physical and mental side effects. These treatments were described by recipients and their families as "brutal" and as "a blunderbuss type of treatment" that often led to extreme fatigue, severe pains, nausea and feeling depressed, aggressive and in some cases, suicidal. For hepatitis C, even if patients and their families managed to cope with the side effects and completed the course of interferon (usually 48 weeks), this was not always effective, with the virus remaining active. If the treatment was successful, patients also continued to experience ongoing side effects, including depression and developed a variety of conditions associated with being immune compromised, leading to the view expressed by several witnesses that their treatments had probably done as much, or even more harm, as the hepatitis. Even when hepatitis C infection had cleared, witnesses still worried about fears of re-occurrence, which resulted in ruminative thoughts and surveillance of body symptoms, both of which can have detrimental effects on emotional well-being (Almeida et al, 2019)."

The Inquiry's report states at page 23 of volume three that "Whereas less than 20% of Hepatitis C patients experience the typical symptoms of acute hepatitis, such as malaise, fatigue and jaundice, the virus can persist in the liver and silently begin to cause liver inflammation and scarring. After 20 years, approximately 20 to 30% develop cirrhosis. After 30 years it is 40% and after 40 to 50 years 60%. (Roughly, therefore 1 to 2% per year). Between 2 and 8% a year of those who have cirrhosis will develop liver cancer: successful treatment for Hepatitis C will reduce, but not eliminate the risk of cancer to around one third of these figures."

There is therefore an ongoing worry on the part of those who are infected about developing cancer as an impact. This was a feature of the Inquiry evidence and a factor in the Inquiry recommending ongoing monitoring.

The bandings must therefore recognise the varied, extensive and wide ranging impacts as highlighted above including extra hepatic and psychological consequences. The stage of liver disease alone should not determine the severity band that should be applied when calculating the awards under the compensation scheme.

Arguably, the proposed compensation scheme has not implemented Recommendation 5 of the Second Interim Report viz.:

Inquiry Recommendation 5: “I recommend that infections eligible for compensation should be classified in the following manner:

... b) the stages and degrees of severity for each disease should be defined by an independent clinical expert advisory panel, by reference to clinical professional consensus...”

There is medical consensus amongst experts but the clinicians advising the government and therefore informing the compensation scheme appear out of touch with this consensus.

4. Financial loss

As a consequence of the clinical assumptions made by the expert group regarding the impact on ability to work due to severity of the condition and effective management date, loss of earnings will NOT be paid at the full Median National Earning Rate + 5% (£29,567) for every year from infection. Instead, there will be many years of infection where the loss of earnings figures will be only a, sometimes small, percentage of the full £29,567 figure.

Unhelpfully, the document only offers worked examples in respect of claims by estates on behalf of deceased infected victims. In the case of a deceased victim, their estate will only receive the full £29,657 for the last 4 years of their lives. For the 6 years before that period, they will receive 60% or 80% of that figure depending upon whether that 6-year period was before or after the 'effective management' date. For all periods before that 6-year period, only 20% or 40% of that figure will be awarded depending upon the effective management date. The examples on pages 36 and 37 of the government document distributed in advance of the recent meetings with Sir Robert see the estates receiving only 40% of £29,567 for 31 years.

It is not entirely clear what the position will be for living Infected claimants. What if a claimant has had cirrhosis for 4 years at the time of applying? Will their award be calculated on the assumption that they move to the third stage in 2 years’ time and from that point receive 100% of £29,657 until their 'healthy life expectancy'? If a claimant is at the first stage at the time of applying, will the compensation scheme calculate their healthy life expectancy and then 'work backwards' as they do in estate claims? If those are the approaches, then that will result in different applicants being treated quite differently for potentially fairly arbitrary reasons.

There are many factors that the compensation scheme is not currently considering that will impact on an Infected victim’s ability to work. They include:

- The significant side effects of treatment such as Interferon
- The psychological impact of being diagnosed with Hepatitis B and/or C and/or HIV
- The loss of employability that may be suffered if a lengthy career break for health reasons meant that the victim lost their job and had to find alternative employment
- The social impact of diagnosis including the prejudice of the public and prospective employers against people living with Hepatitis B and C and HIV.

All of these factors will have impacted a person’s earnings.

Page 144 of volume 2 of the Inquiry's final report highlights that "Infection with HIV or hepatitis has severely impacted upon people's ability to secure or remain in employment. A significant number of people faced obstacles to obtaining work because they were required to declare their infections"

Page 145 highlights that there were difficulties in obtaining work because of the long periods of sick leave.

Stigma was also a factor at work. Page 153 of Volume 2 states as follows "Robert Fraser describes the stigma of Hepatitis C affecting his working life and finances: as word of his illness spread at work, people began avoiding him ("for instance, they would get out of the lift when I got in") and his employers began a termination process. His intention was to take his case to an employment tribunal but he could not afford to continue to fight and was forced to settle out of court: "The illness not only impacted my mental health and consequently all my relationships but it affected me financially as well."

The psychosocial expert group report commissioned by the Inquiry states that:

"For those who survived into adulthood, many described a range of negative psychological issues linked to working life. Frequent periods of ill health, together with fatigue, made it very difficult not only to attend work regularly, but also to perform well in the workplace. As a result, many infected adults reported reduced job opportunities and job prospects".

For those not currently admitted to an IBSS, the compensation scheme should be receptive to all forms of evidence as to how a claimant has been affected in the round, by their infection and be prepared to adjust the awards made to such people, on the basis of the evidence they present. This should incorporate evidence of concomitant medical conditions whether they be physical or psychological in nature.

In light of the above analysis of the wide ranging impact of infection on a person's ability to work, we would suggest that wage loss should be assessed at 100% of the median wage plus 5% for all chronically infected individuals for all of their working lives from the date of infection.

As per paragraph 9.93 of Sir Robert Francis' report, the lump sum payable under the support scheme should be paid to new applicants to bring parity with existing beneficiaries of support schemes and should be disregarded in assessment of compensation awards.

5. Care Costs

There is a similar issue with care costs. Under the proposed compensation scheme care costs are not paid for the whole of the claimant's life from infection. Instead, as shown in the table on pages 33 and 34 of the proposed scheme, care will paid for between 10 and 24 years depending upon the supposed severity banding and progression of the infection. It is equally not clear how care costs will be allocated to a living applicant. Will the compensation scheme calculate their healthy life expectancy and work backwards? The care costs are not taking into account the significant impacts of infection and the care that may be required as a result of these impacts throughout the period of infection.

6. Affected claimants - financial loss

The award for widows under the compensation scheme will in some (many) instances be less than under the Infected Blood Support Schemes. Under the support schemes they receive 100% of payments that were made to their partner in life for the first year after death and thereafter 75% for the whole of the widow's life. Under the compensation scheme, they will receive £16,682 per annum up to the healthy life expectancy of the deceased Infected victim. Widows therefore face two significant differences under the compensation scheme as compared to their entitlement under the support schemes – they will receive a lesser amount each year for a lesser period of time. The government recognise the problem that they have created because the document says:

"For bereaved partners registered with a current support scheme: In the event that the IBCA assesses that compensation through the scheme would be lower than would otherwise have been paid through continued IBSS support payments, an additional top-up payment will be provided to bring the compensation up to the level of the support payments. This will ensure that no one will receive less compensation through the scheme than they may have otherwise expected to receive through payments under existing schemes. Any top-up payment awarded will take into account other compensation payments that a person has received through the compensation scheme in their own right and, if applicable, as an estate beneficiary."

As suggested above in relation to support scheme payments, an option would be for individuals to be given the choice to waive assessment of future financial losses in exchange for continued receipt of the support payments (as envisaged at paragraph 2.54 of Sir Robert's Compensation Study).

In terms of Care Cost awards, the compensation scheme offers only one method of calculating the annual cost which is based on the commercial rate of hiring in professional carers. There are many examples of spouses of Infected victims being forced to give up their jobs and their careers to care for their Infected loved one, particularly during the period when the social stigma associated with HIV and Hepatitis infection was at its highest. In civil litigation such loss of earnings is classed in damages as a care cost claim. To satisfy Recommendation 8 of the Second Interim Report the compensation scheme must allow care costs to be calculated by reference the lost earnings of a spouse who gave up work to care for an Infected victim at least under the supplementary route.

The position where care is provided by a spouse was eloquently summed up in the evidence of Robert Mackie as quoted in the Inquiry report at page 122 of Volume 2 of the final report, where he said that "The worst and saddest thing that this disaster has brought to me is that my wife has given up so much and made the ultimate sacrifices in her life. She has given up her right to have children and her career ... Even after my wife has made all these sacrifices, she is still with me after all these years – this most of all to me is the ultimate sacrifice".

7. Availability and number of claims under the supplementary route

It is also worth considering the 'Supplementary Route' to compensation whereby an applicant can have their circumstances considered on a bespoke basis rather than under the tariff-based approach envisaged by the compensation scheme. It is not clear the extent to which the supplementary route will be open to applicants to pursue. On one reading it will be quite limited to high earners and individuals whose circumstances were such that they required more care than the tariff model presumed. It does not appear as if an individual who seeks to argue that the impact of interferon meant that they could not work for an extended period could follow the supplementary route. In short, the government document implies that the supplementary route is to challenge only specific aspects.

If the alternative is true and any applicant, for any reason, can pursue the supplementary route it appears self-evident that the vast majority of applicants will do so due to the issues with the tariff system described above. This, in turn, will defeat the purpose of creating a tariff-based approach in the first place. Whereas, if the former is true, for all of the reasons set out above and expressed eloquently by the infected and affected at the meetings with Sir Robert the compensation scheme will have failed to deliver the justice that Sir Robert and Sir Brian recommended, and the government promised.

For a tariff-based approach to work significant changes are required to the proposed scheme particularly in respect of the clinical assumptions proposed by the expert group. We have suggested an alternative approach to wage loss above.

8. Interest/inflation

The proposed compensation scheme does not comply with Inquiry recommendation 11 in respect of interest or inflation on past financial and care losses.

Inquiry Recommendation 11: I recommend that interest be payable on awards for past financial losses and past provision of care, from the date of infection to the date of the award, in accordance with the practice in personal injury damages claims; alternatively, that such awards are uplifted for inflation during that period.

9. Eligibility

We refer to the provisions of recommendation 3 which are based on Sir Robert's Compensation Study recommendation 4 which state that *"in general a presumption is applied that statements of fact made by an applicant are correct"*. This should be read as applying to all matters which form part of a claim made by an applicant.

We would suggest that as an additional layer of security for the complaints scheme, where a family member or family members are providing evidence about conversations with their deceased relative, this evidence could be provided by way of affidavit, with the cost of obtaining this met by the scheme.

10. Levels of Tariffs

We consider that the tariffs need to be reviewed and increased. The evidence heard by the Inquiry identified lack of consent to treatment and failure to provide information about the risk of treatment with blood and blood products, lack of consent to testing and involvement of haemophiliacs in medical research. This evidence justifies in particular a higher autonomy award.

We have reviewed the three Horizon Compensation Schemes for Sub-Postmasters. The schemes collectively provide Sub-Postmasters with £600k for their wrongful conviction in addition to providing full pecuniary loss, if that can be established with evidence. Thus, the £600K appears to be only for injury and is therefore more than is being offered to the Infected victims of the Contaminated Blood Scandal. Given the extent of the scandal as revealed by the Inquiry final report, this is strong evidence that the tariffs are currently too low.

11. Tariffs - Impact of Campaigning

Page 53 of the Second Interim report – "It has been submitted to me that the impact on individuals of their campaigning should be borne in mind. I agree this deserves to be taken into account. I leave it to the Chair of the compensation scheme to determine how it is most appropriate within the categories of loss to recognise it, since it might easily be a factor in determining an appropriate award under any or all of the first three categories of loss."

This does not appear to have been taken into account under the proposed scheme. Long term campaigners have suffered an additional loss, which should be reflected in the scheme.

On the impact of the lack of accountability, volume 2, page 94 of the Inquiry final report highlights this as follows:

"People's mental health was affected by the failure of those in power to take responsibility for the infections. This was an aspect highlighted by the Psychosocial Expert Panel when its members gave evidence. It has been emphasised in the Inquiry's two interim reports and is discussed in the chapters about Response of Government. Delay in accepting accountability – and with it a lack of recognition, of vindication that concerns were justified – inevitably brings with it consequences for the individual."

The evidence of the wife of one campaigner is quoted at page 96:

Christine Norval described the impact of her husband Bruce's campaign work: "it's the first thing that he will speak about in the morning and it's the last thing he will speak about before he goes to bed, and within the day, no matter what the conversation is, we don't go half an hour without him discussing it, without somebody phoning up, without him looking on the internet and no matter where we go, what we do, he's constantly speaking to people, looking at things, putting two and two together, and he's done this from his bed a lot of the time'"

12. Legal representation

We echo the discussions at meeting with legal representatives on 24th June about complex matters requiring advice for example, a decision on whether to take provisional damages or settle on a final basis, periodic or lump sum payments.

This advice should be funded by the compensation scheme, at a level that recognises the work involved in giving advice on these complicated matters.

The scheme should also make provision for funding of work required regarding estates due to the likelihood for the requirement for advice on these matters, including for executors to be appointed and advice on estate distribution.

13. Appeals

Appeals should be on matters of both fact and law and provision should be made for legal representation.

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