EVIDENCE TO THE TREASURY COMMITTEE BY STUART BERNAU AND IAIN CORNISH, SPECIALIST ADVISERS TO THE COMMITTEE IN RELATION TO THE FCA/PRA REVIEW INTO THE FAILURE OF THE HBOS GROUP.

1. Introduction

1.1 The FCA/PRA Review into the failure of the HBOS Group (the 'Review') is due to be published on 19 November 2015. Based on an extensive programme of work, we have concluded that the findings in the report are a fair and balanced reflection of the available evidence. However, getting to that point has not been straightforward and we have made a number of observations about the process and matters of concern which we raised during the course of our work.

1.2 We were appointed by the Treasury Committee (the 'Committee') on 25 February 2013 to act as its specialist advisers in relation to the Review. Sir Nicholas Monck was also appointed with us but resigned shortly after for reasons of ill-health. We are grateful to Sir Nicholas for the valuable advice and guidance which he gave us in the early stages of our work.

1.3 Our terms of reference (set out in Appendix 1), required us to report to the Committee on the extent to which the Review is a fair and balanced reflection of the available evidence in relation to its coverage of the failure of HBOS, and in relation to its coverage of the regulatory and supervisory activities of the FSA. We included within the scope of our work consideration as to whether the specific questions put to the FCA/PRA by the Parliamentary Commission on Banking Standards ('PCBS') had been addressed adequately. Our original terms of reference also required us to consider the Review's assessment of the FSA's enforcement investigations which was originally within the scope of the Review. However, partly on our recommendation, this became the subject of a separate and independent report by Andrew Green QC. We have had no role in the production or oversight of his report but we comment further on this issue in a later section.

1.4 Our terms of reference also required us to invite the FCA/PRA to reconsider aspects of the Review prior to its publication where we felt it appropriate to do so, and to report to the Committee where this has led to significant and substantive alterations, or where we had been unable to reach agreement with the FCA/PRA. We were also invited by the Committee to raise any matters related to our work which we thought to be appropriate.

2. Our Conclusions in relation to the Review

Background

2.1 In essence, the Review concludes that HBOS failed because it had a flawed business model which focused excessively on market share, asset growth and short-term profitability, and insufficiently on risk, to the point that it made itself extremely vulnerable to failure in the financial crisis. The specific balance sheet vulnerabilities which precipitated the failure are highlighted by the Review as being a large funding gap and dependence on wholesale funding, together with significant lending concentrations in lower quality and highly cyclical asset classes in the Corporate and International Divisions, together with what turned out to be insufficient capital to support credit losses. Moreover, the Review concludes that these failings were the product of a Board which failed to establish an appropriate strategy, failed to instil an appropriate risk culture and failed to challenge effectively the executive, and which also took certain decisions which aggravated the overall risk profile. The Review also identifies the specific responsibilities of the former HBOS Chairman and CEOs in relation to these matters.

2.2 In relation to FSA supervision of firms, the Review concludes that the Board and senior management of the FSA adopted, and did not challenge sufficiently, an approach which relied too much on firm's senior management, was under-resourced and was insufficiently focused on prudential issues. It also concludes that FSA senior management were insufficiently engaged with firms and with supervision teams. The Review identifies the specific responsibilities of the former Chairman, one of the CEOs and the Managing Director of Retail Markets in relation to these matters.

2.3 These findings are set against the context of the prevailing economic, political and international regulatory climate of the time.

2.4 In our view the Review is an important one, not least because of the cost to the public purse arising from the failure of HBOS, but beyond this, the causes of the ultimate failure of what was a relatively straightforward bank were severalfold, and they built up over an extended period of time. A number of the flaws in the HBOS business model and its execution were also identified by the FSA, but it did not intervene sufficiently in a benign environment to prevent the bank's demise in the financial crisis. It therefore provides a multi-faceted case study with lessons both for financial institutions and for regulators.

How we carried out our work

2.5 We have been engaged on this assignment for nearly three years. During that time we have read a significant proportion of the key source documents available to the FCA/PRA Review team (the ‘Review Team'); reviewed and commented in detail on numerous drafts of the Review; conducted 20 interviews principally with former HBOS and FSA staff (and in some cases their legal representatives), but also with Lloyds Banking Group, KPMG and the Financial Reporting Council (the ‘FRC'); and had numerous interactions with the Review Team and the Steering Committee responsible for its oversight. In addition, we have used external lawyers (Simmons and Simmons LLP) who, under our direction, have conducted extensive formal testing of the Review and the processes which have been used in its production, including testing of some of the key themes arising from the Maxwellisation process. The testing approach used by Simmons and Simmons LLP is described in Appendix 2. The verification of financial information and basic data items was carried out by Grant Thornton on behalf of the Review Team and we have not repeated that work ourselves.

2.6 Whilst we placed significant weight on the results of the formal testing, our overall conclusions are based on a consideration of all the different strands of work which we have carried out.

2.7 Work on the Review did not begin until September 2012 and the initial project plan envisaged that it would be published in June 2013. Consequently we originally expected that our work would last about six months and planned it accordingly. The fact that the timetable has shifted several times and to such a great extent, undoubtedly made our own work harder to schedule and also inefficient as we ended up having to repeat work and reconcile testing over a number of drafts, although we do not believe that this has ultimately compromised our findings.

2.8 One of the reasons for the delay in the production of the Review was that the preliminary drafts of the Review indicated to us, and to others, that significant further evidence gathering and analysis were required (we submitted over 1,000 detailed comments at this stage). This work took some time, and as a result of this, in effect we have been engaged at a fairly detailed level with the Review Team for an extended period (and indeed at one stage it was mooted that we might take over authorship of the Review). This engagement at what turned out to be a relatively formative stage of the Review has meant that areas where differences of view might otherwise have emerged were generally identified and addressed before they crystallised as hard differences.

2.9 We have identified in the following sections the types of comments and concerns which we raised with the Review Team, of which there were a large number. As we go on to describe, in our view these have been properly considered by the Review Team and as a consequence we believe they have helped to shape the Review. However, we would not wish to imply that without our intervention the Review would necessarily have failed to address all these issues. Throughout the period of our involvement we were working in parallel with the Steering Committee, which was raising its own comments on the various drafts, and in general we were reassured by the rigour of the Steering Committee and the diligence with which it reviewed and challenged the work of the Review Team.

2.10 Whilst we have been largely reliant on the Review Team for the provision of information we have been careful to maintain our independence, and the primary point of contact for all our detailed testing has been between the Review Team and Simmons and Simmons LLP. We can confirm that at no point have the Review Team, the Steering Committee or any other party involved in the production of the Review sought to influence the direction or scope of our work and we were provided with the support and information which we requested (with some minor exceptions where records were missing or where the resources required to obtain the information would have been significantly out of proportion to their value to our work).

2.11 The potential conflict of Mr Cornish as an independent director of the PRA between February 2013 and March 2015 was a matter of public record from the outset and he took no part in PRA Board discussions relating to the Review.

2.12 During the course of our work, the suggestion was put to us that the Committee has 'orchestrated' the Review. We have seen no evidence to support this view. We ourselves have had a small number of meetings and other contacts with the Chairman of the Committee during the course of our work, generally at our request, to provide an update on progress or to discuss specific issues, such as the handling of the review of enforcement action. Beyond setting our terms of reference, we have received no direction from the Chairman on how we should carry out our work or on the conclusions we should reach, and indeed we have been strongly encouraged to look at whatever we deemed appropriate and to insist on whatever support we felt necessary. We are, of course, fully aware of the findings of the PCBS review into the failure of HBOS, but our conclusions have been based solely on our consideration of the very extensive 'raw material' which is available, which extended beyond that available to the PCBS, as well as on the outcome of our detailed testing activities. Throughout our work, the lawyers acting for some of the former HBOS staff, and, separately, Mr Paul Moore, were the only parties to the Review who sought directly to influence how we should interpret our terms of reference. Whilst being willing to consider any substantive items of evidence from them (as we were with all parties), we were very careful to resist these attempts and to form our own judgement on how to discharge our terms of reference.

Our Observations and Conclusions on the Review's findings on the failure of HBOS

2.13 Aspects of the Review relating specifically to the failure of HBOS are summarised in Part 1 of the Review and covered in detail in Parts 2 and 3 ('How did HBOS fail?' and 'Management, governance and culture in the failure of the firm').

2.14 During the Review process we made a large number of detailed comments on these sections of the Review. The more significant ones (which were made relatively early on in the process) included:

- the need for a more detailed analysis of the Corporate and International Division loans, and the link between asset quality and losses;
- the need for more comparative analysis to demonstrate the relative quality of the HBOS Corporate Division portfolio;

- the need for a clearer explanation of the evolution of the Treasury investment and liquidity portfolios;
- a request for a theoretical assessment of how the Corporate portfolio might have behaved under a stress scenario foreseeable at the time (i.e. by reference to earlier commercial property cycles) to inform further what level of losses might reasonably have been anticipated at the time;
- the need for more extensive analysis of the strategic and risk management processes within the International Division;
- the need to test the extent to which 'the prevailing economic climate' was or was not a mitigant to HBOS failings identified by the Review;
- the need to explore as fully as possible the extent to which the CRD IV framework might have prevented this failure;
- the need for the Review Team to reach its own conclusions on the management, governance and culture of HBOS, which we regarded as central to the Review, rather than relying on work by external consultants which we viewed as being of mixed quality; and
- the need for the Review to be clearer on which judgements have been made in hindsight, and which by the standards of the day.

2.15 Ultimately we were satisfied that the Review Team gave adequate consideration to these points and incorporated them in their work appropriately.

2.16 More generally we also made a large number of drafting suggestions which we thought would improve clarity and readability, and identified a number of less significant areas which we felt required more evidence or analysis.

2.17 As described in the previous section we also tested formally a large number of points covering the relevant sections of Parts 1, and the entirety of Parts 2 and 3. This testing was carried out on a pre-Maxwellisation draft of the Review. In total we raised around 190 questions arising from our review of this draft on which we required a response from the Review Team. Just over half of these questions resulted in amendments or deletions to the text of the Review, partly reflecting the relative immaturity of the work contained in early drafts of the Review. Subsequent drafts were then tracked to ensure that the conclusions from of our testing remained valid.

2.18 We also looked in more detail at a number of important themes which we considered either to be important components of the overall story, more complex to understand and/or which were the subject of significant challenge during the Maxwellisation process. The thematic testing was carried out on post-Maxwellisation drafts of the Review. These themes encompassed conclusions reached by the Review in respect of:

1. Failings by the Chairman and CEOs;
2. Failure of the board and committees to offer effective challenge;
3. A Board culture which failed to balance risk and return appropriately; excessive focus on market share, asset growth and short-term profitability;
4. Limited board involvement, and weaknesses in the strategy formulation process;
5. Ineffective risk and control functions; and
6. Poor asset quality in Corporate and International Divisions, and resultant impairment losses.

2.19 Our own general and thematic testing overlapped significantly with issues raised in Maxwellisation representations, but we did carry out some additional testing of how the Review Team had considered representations, where we did not think they had been covered adequately in our other work. These representations included instances which Maxwellisation representations considered were examples of:

1. Careless and selective use of evidence;
2. Factual inaccuracies and lack of context;
3. Express or implied criticism of individuals which was not substantiated;
4. Undue reliance on the evidence of certain individuals;
5. Incorrect and unfair explanation of the relationship between the Group and its Irish and Australian operations;
6. A mischaracterisation of provisioning, impairments and losses;
7. A mischaracterisation of the strategic planning process as 'bottom-up' and lacking in robustness; and
8. Inaccurate portrayal of events surrounding the 2008 Corporate impairment loss figure.

2.20 In relation to the thematic and Maxwellisation testing we reviewed a sample of the source documents which the Review Team had identified as supporting particular conclusions they had reached in relation to 'specimen' representations. Overall, we were satisfied that the conclusions reached and the presentation of those conclusions was consistent with the underlying evidence, although in a small number of cases we identified inconsistencies between the conclusions and the underlying evidence and further minor changes were made to the text of the Review based on our observations.

2.21 We also looked in some detail at the processes adopted by the Review Team to ensure that Maxwellisees had an adequate opportunity to make representations, and that representations were properly considered and where appropriate (and only where appropriate), changes made to the Review. We were satisfied that these processes were reasonable and robust.

2.22 Overall the conclusion which we have reached is that in respect of Parts 1 (as it relates to the failure of HBOS), 2 and 3 of the Review, are, in their final form, a fair and balanced reflection of the available evidence and that the processes which the Review Team went through to develop its findings and to consider representations during the Maxwellisation process were reasonable ones.

2.23 We note in reaching these conclusions some of the limitations in the underlying evidence. Partly because of the significant passage of time between the end of the Review period and the commencement of the Review, there are conflicting recollections and interpretations of important episodes, and judgements about 'hindsight' become harder to make. This is particularly unfortunate because records, and in particular board and committee meeting minutes, were frequently not sufficiently full to provide a definitive record of what happened, and in some cases are missing altogether. One consequence of this is that there has probably had to be greater circumspection around some of the conclusions reached than might otherwise have been the case. Our own experience was also that some items of evidence were more helpful than others. For example, we found our interviews with most (but not all) former HBOS staff to be much less helpful because of the guarded and defensive tone adopted by interviewees. We also note that the Review Team did not, from the outset, seek to consider every potential source of evidence.

2.24 However, given that these were the circumstances, we are satisfied that the Review has examined sufficient evidence to support its conclusions, that these conclusion are reasonable and that where the available evidence is inconclusive, or judgements need to be caveated or contextualised, the Review has highlighted this appropriately.

Our Observations and Conclusions on the Review's findings on FSA Supervision

2.25 The Review's conclusions in respect of FSA Supervision are summarised in Part 1 of the Review, and set out in detail in Part 4. We followed the same broad approach to testing described in previous sections. We were particularly conscious of the risk of 'regulators

marking their own homework' in relation to this part of the Review and therefore we also carried out additional due diligence which we report on in this section.

2.26 We made a large number of comments and observations on the early drafts of the Review, the most substantial of which included:

- the need to present more evidence and analysis to support the conclusions drawn;
- the need to examine in more detail FSA board decision making and oversight processes;
- the need to set out how the FSA had reached decisions on some key issues (e.g. the removal of the capital 'add-on' it had imposed in 2004 in response to governance weaknesses, and Basel II credit model approvals); and
- the need for further examination of the role of James Crosby on the FSA Board (and as Chair of the FSA Audit Committee).

2.27 We also raised a number of drafting points similar in nature to those described in previous sections.

2.28 Overall we were satisfied that the Review Team addressed these initial observations and have reflected them appropriately in the Review.

2.29 The early draft also included an assessment of the FSA's approach to enforcement. This was the section over which we had the greatest concerns. It was not clear to us that it addressed the reasons why enforcement action had excluded a broader range of individuals or why the investigation had seemingly been narrowed down at a very early stage. We were also given to understand that the section had been drafted in the main by those involved in the decision making at the time, which was clearly inappropriate. For these reasons we identified the need for independent scrutiny of this aspect of the work which we were not qualified to give. We therefore recommended to the Chairman of the Committee that this be subject to a separate independent review.

2.30 In subsequent drafts of the Review we made further, and what we regarded as important comments in relation to Part 4. These related primarily to what felt to us to be an imbalance of tone between the HBOS sections and the FSA section of the Review. The latter draft appeared to us to combine conclusions with points of context and potential mitigation in such a way as to soften the conclusions inappropriately, and in a way which had not been adopted in the sections of the Review relating to HBOS. We noted, and were reassured that at least one member of the Steering Committee made a similar observation. We also asked the Review Team to substantiate more fully a provisional conclusion that the supervision team broadly met the standards of the day, when we felt there were examples where the supervisory process, irrespective of its deficiencies, had not been followed.

2.31 Whilst we were ultimately satisfied that these points were adequately addressed in the Review, it did serve as a clear illustration to us of the risks associated with an internal review.

2.32 In our formal testing of the relevant sections of Part 1 and the entirety of Part 4, on a pre-Maxwellisation draft of the Review, we raised nearly 80 questions. In around half of the cases this resulted in amendments or deletions to the text (again reflecting the formative state of the Review at this point). Testing results were then tracked through subsequent drafts to verify that they remained valid.

2.33 We drew out the following themes from the Review for specific testing on post-Maxwellisation drafts of the Review:

1. Criticisms of named individuals;
2. Weaknesses, and a limited board role in the strategy formulation process;
3. Failure of the Board and ExCo to challenge or review adequately the approach to the supervision of systemically important processes; and
4. Lack of continuity and experience in the supervision team, and a lack of senior management support and engagement.

2.34 Having reviewed a selection of the underlying documentation we were satisfied that the conclusions presented are a reasonable reflection of the underlying evidence, but noted again that our testing led to some minor amendments to the text.

2.35 Maxwellisation representations by former FSA staff were limited in number and generally straightforward in content therefore we did not specifically test any of the representations, although our thematic and general testing covered many of the issues raised in Maxwellisation.

2.36 In addition to the general testing of the Review's processes, we looked specifically at how the Review Team had approached its assessment of FSA supervision in order to address some of our concerns highlighted above. Specifically, we examined how the Review had identified and managed potential conflicts of interest. We noted in particular that the project manager for a large part of the Review had been a manager in the FSA Banking Sector Team during part of the period covered by the Review, and in this role had been involved in briefings to the FSA Board covering banking sector stability. We brought this to the attention of the Steering Committee.

2.37 On reading the transcripts of interviews with former FSA staff carried out by the Review Team, we also noted the more informal and sympathetic tone with which some of them appear to have been conducted with individuals who, in some cases, were former colleagues, in contrast with those carried out by Grant Thornton with former HBOS staff. We raised this issue with the Head of the Review Team who reviewed the interviews. We reviewed all the interview transcripts ourselves, and we tested the agenda prepared for one of the interviews, against the transcript of the interview. Although it revealed a more relaxed and informal interview style, the agenda was ultimately appropriate and the majority of it was covered. We also interviewed a number of the key FSA staff ourselves.

2.38 Overall the conclusion which we have reached is that the relevant section of Part 1 and Part 4 of the Review are, in their final form, a fair and balanced reflection of the available evidence. We also concluded that the Maxwellisation and assurance processes in the latter phases of the Review were robust, but aspects of the Review process (which we have highlighted), predominantly in the initial phases of the work, were clearly not satisfactory.

2.39 As in the previous section, we note the same uncertainties and limitations of the Review arising from the delay in starting the Review. In particular we note the poor quality of record keeping by the supervision team from 2006 until the crisis, which makes it difficult to piece together the full story at a critical period. However, the evidence which is available, together with the openness of former FSA staff and their generally greater willingness to reflect on failings, in our view, means that the conclusions reached by the Review are soundly based.

2.40 We had one residual area of disagreement. We felt that as a Senior Manager (as categorised by the Review) there was a case to identify the Head of Department, who was in post throughout the Review period and who, in our view, was in a pivotal role between front line supervision and ExCo members. The Steering Committee has declined to do this, partly for ongoing operational reasons. Consideration of the merits of this are beyond our remit.

Our Observations on the role of KPMG and the Financial Reporting Council

2.41 KPMG were HBOS's external auditors throughout the Review period and their involvement is covered in detail in the Review although, consistent with its terms of reference, the Review has not sought to opine on whether KPMG met the required standards. However, the FCA/PRA did invite the FRC to consider whether there were grounds to investigate KPMG, relevant senior KPMG people, and relevant senior HBOS management in relation to the audits of HBOS's financial statements for 2007 and 2008. Our understanding is that the FRC's initial conclusion is that the criteria for commencing an investigation have not been met but that they have undertaken to consider any new information in the final Review.

2.42 We have discussed the basis for this decision with the FRC but have not investigated the matter in detail. We would observe that the circumstances surrounding the audit process, whilst not a root cause of the HBOS failure, were an important aspect of the overall story and certainly bear thorough scrutiny by the FRC. For this reason we think it is important that the FRC should consider its final conclusion very carefully and that there should be transparency in relation to its decision making. We would suggest that this may be a matter in which the Treasury Committee would wish to take a continuing interest.

Our Conclusions on responses to issues raised by the PCBS

2.43 The PCBS identified a number of issues which it asked the FCA/PRA to expand on as part of its Review. The Review Team’s responses to the PCBS questions are set out in Appendix 4 to the Review.

2.44 We incorporated consideration of the responses to these issues in our general and thematic testing. The initial responses at an early stage of the Review were in our view insufficiently detailed and we requested the Review Team to provide fuller answers and analysis, which they have done.

2.45 In the main we believe that the responses provided are reasonable, and that they address adequately the questions posed by the PCBS. We did focus additional specific testing on one PCBS question which queried the extent to which regulatory decision making at all levels was '...*influenced by protests of HBOS senior management*'. The Review concludes that it has found '... *no evidence that the significant judgements that the FSA made during the period were abnormally influenced by protests from HBOS senior management’*, and this view is also supported by former FSA senior management. It is nonetheless striking, that some of the most vigorous pushback by HBOS was in relation to issues which were subsequently critical in the events which followed.

3. **Wider Observations**

Observations on process

3.1 Whilst we have concluded that the Review is a fair and balanced reflection of the available evidence in relation to the failure of HBOS and the supervision of HBOS by the FSA, we would not agree that the Review has got to that point in anything like an optimal way. Indeed the exercise has been a good illustration of why any report of this nature should be produced independently, under the framework of the specific provisions in the Financial Services Act 2012.

3.2 The records we have seen seem to suggest that the FSA did not decide to undertake the Review until July 2011 and work did not begin until 2012, four years after the failure. We understand that the FSA considered that it was not appropriate to launch a wider review until the conclusion of certain enforcement proceedings. We are not qualified to comment on this, but it is extremely unfortunate that there was such a long delay in starting the

Review and, as we mention elsewhere, it is hard to believe it has not had an adverse impact on its overall quality.

3.3 It was perhaps inevitable that this would be a longer and more complex review than that carried out into the failure of RBS, partly because there were arguably more facets to this Review, and partly because the greater criticism of individuals was likely to lead to a more protracted Maxwellisation process. The Review Team have worked extremely hard and with great diligence over a long period of time. However, in our view, the scale of the task was significantly underestimated at the outset, resulting in initial drafts which demonstrated the need for much more analysis than originally envisaged. The length of time this took created its own problems as members of the Review Team moved on and others had to pick up the threads which is disruptive no matter how well managed. We would also observe that members of the Review Team were drawn to a large extent from the PRA's Supervisory Oversight Function. Consequently, whilst the Review Team were very experienced in business model analysis and prudential supervision, they did not necessarily have as strong a background in all of the other disciplines which are equally important to a review of this nature (the nature of some of the interviews with former FSA staff are an illustration of this point). We would speculate as well that the diversion of time and resource from an important function within the PRA, which this Review has entailed, may not be desirable in future.

3.4 We did examine the assurance processes employed in the production of the Review, and we observed the challenge process first hand through attendance at a number of Steering Committee meetings. At these meetings we observed no shortage of healthy and robust challenge, debate, guidance and support at all stages, but especially during the processing of representations resulting from the Maxwellisation process.

3.5 In conclusion, the Review has taken far longer to produce and at a significantly greater cost than originally budgeted. However, it tells an important story and its success should also be judged against whether it provides the public with a clear explanation of why HBOS failed.

4. Recommendations

4.1 We support the recommendations for firms contained in the Review and think it is important that they find their way into relevant supervisory communications and guidance so that they receive proper attention. However, we note that many regulatory changes have already been made as a result of the financial crisis and collectively these changes intend to address many of the failings identified in the Review.

4.2 We also support the recommendations for regulators. In our view the 'will to act' where it is warranted, even in benign times and against apparently successful firms, is perhaps the most difficult and important future regulatory challenge and in our view this should be a constant area of vigilance for the Boards of the regulators.

4.3 We also make two additional observations which in our view arise from the Review:

- Stress testing is rightly a key pillar of the current approach to prudential regulation. However, as the Review illustrates, neither HBOS nor the FSA understood the quality of the firm's assets until it was too late to make any difference. Asset quality encompasses quantitative, qualitative and judgemental elements, and without an accurate understanding of asset quality, stress testing is of fundamentally limited value. We would suggest therefore that it is essential for Boards of firms to ensure that their capital planning and stress testing processes are built on a comprehensive and accurate view of underlying asset quality.

- As well as a 'systemic' failure of regulation and supervision, the Review identifies operational failings in the delivery of supervision which might have been identified by better engagement and more effective oversight on the part of the Board and senior management of the FSA. Whilst regulatory governance has changed significantly with the introduction of the PRA and FCA, we nonetheless think it important that Boards of regulators reflect on the lessons which the Review holds for their own risk management and oversight frameworks to ensure that operational failings of the type identified in the Review do not occur again. The PRA and FCA have recently, and rightly, raised the standards against which boards and senior management of banks and insurers will be held to account and it could be argued that many of those standards are equally relevant to those charged with governance and oversight of regulators.

4.4 Our final recommendation is that in the unfortunate event that a Review of this type is required in the future, it should be conducted completely independently, begun as quickly as possible after the event and resourced and managed so that it can be completed within a far shorter timescale.

APPENDIX 1: TERMS OF REFERENCE FOR THE INDEPENDENT REVIEWERS

Stuart Bernau, Iain Cornish and Sir Nicholas Monck have been asked by the Treasury Select Committee to review the report that the Financial Services Authority is preparing on the failure of HBOS.[1]

The review of the report has the following terms of reference, to which the PRA/FCA has agreed:

To review and report on the extent to which the Report on the failure of HBOS is a fair and balanced reflection of the available evidence.

To review and report on whether the PRA/FCA's report is a fair and balanced summary of the Authority's regulatory and supervisory activities in the run up to the failure of HBOS.

The PRA/FCA will take all reasonable steps to ensure that the review team has access to such documents and persons as they consider necessary to undertake this review.

As part of the reviewers' consideration of the PRA/FCA's work, the PRA/FCA will provide the reviewers with drafts of the report. If they consider it appropriate, the reviewers may invite the PRA/FCA to reconsider aspects of the report before it is published. Instances where the reviewers' work has led to significant and substantive alterations in the published report will be reported to the Committee. The reviewers will also report to the Committee instances where they have suggested alterations to the draft report which they have been unable to agree with the PRA/FCA.

The reviewers may include observations about the completeness of the PRA/FCA's work.

The reviewers will be able to raise with the Committee any matters related to their work that they think appropriate.

Evidence or advice given to the Committee will be subject to the procedures governing select committees. Such evidence or advice is subject to parliamentary privilege; it is confidential to the Committee and may only be published by the Committee.

The PRA/FCA will provide the reviewers with reasonable resources. The PRA/FCA will bear the cost of employing such advisers as the reviewers may require, including the cost of legal representation in any proceedings in which they are involved as defendant or plaintiff relating to the review. Those advisers will report to the reviewers. The PRA/FCA and its staff will provide the reviewers with all reasonable staff support and cooperation.

[1] As well as studying the failure of HBOS itself, the PRA/FCA's report will include a high level analysis of the balance sheets of the Bank of Scotland and Halifax in 1998–2001, and of the merged HBOS balance sheet in 2001–05, focusing on capital and leverage ratios. It will not examine the particular causes and consequences of the Lloyds/HBOS merger itself, but will examine the quality of the HBOS loan book in 2008, considering both what was known before October 2008 and what subsequently came to light.

APPENDIX 2: WORK CONDUCTED BY SIMMONS & SIMMONS

The PRA instructed Jonathan Melrose, partner of Simmons & Simmons LLP, to assist the Independent Reviewers in carrying out their functions under their terms of reference.

The due diligence work conducted by Simmons & Simmons LLP and provided to the Independent Reviewers included the following:

- Test Exercise – this included testing statements made in the HBOS Report and selected underlying documentation, on a targeted sample basis as agreed with the Independent Reviewers. This testing did not seek to cover every statement made in the HBOS Report, nor did it seek to be a full verification or re-verification exercise of the conclusions reached in the HBOS Report.

- Key Themes Exercise – this included testing the key conclusions drawn in the HBOS Report and selected underlying documentation, on a targeted sample basis as agreed with the Independent Reviewers. This testing did not seek to cover every statement made in the HBOS Report, nor did it seek to be a full verification or re-verification exercise of the conclusions reached in the HBOS Report.

- Maxwellisation Exercise – this included a limited exercise testing the process adopted by the Review Team for considering the Maxwellisation and re-Maxwellisation representations.

- Process Exercise – this included requesting assurance and materials from the Review Team relating to the process of the drafting of the HBOS Report.

Simmons & Simmons LLP also provided further assistance to the Independent Reviewers as agreed.