

**Infected Blood Compensation Study**



**Compensation and Redress for the  
Victims of Infected Blood -  
Recommendations for a Framework**

**Sir Robert Francis QC**



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# COMPENSATION AND REDRESS FOR THE VICTIMS OF INFECTED BLOOD - RECOMMENDATIONS FOR A FRAMEWORK

## Introduction

### Terms of Reference:

Give independent advice to the Government regarding the design of a workable and fair framework for compensation for individuals infected and affected across the UK to achieve parity between those eligible for compensation regardless of where in the UK the relevant treatment occurred or place of residence. While the Study is to take into account differences in current practice and/or law in the devolved nations, it is not asked to consider whether delivery of that framework should be managed centrally or individually by the devolved administrations.

To Submit to the Government its report and recommendations as quickly as possible and no later than the end of February 2022 [amended to 14 March 2022], to provide the Government with advice on potential options for compensation framework design.

### *The voices of those who have suffered*

**1.1** It is only right to start this report with the voice of people who have been infected or affected by the tragedy as a result of the administration of infected blood and blood products, in the course of what should have been lifesaving and enhancing treatment. Therefore, I reproduce just a few quotations from the many who took the trouble to contact us, in some cases altered slightly to preserve their anonymity.

*“The day of my diagnosis everything came crashing down. A big black full stop appeared before me and with it came the stigma of having HIV. I could tell no one, I could not get the answers to life that I sought, I feared touching people in case they found out. I lost all physical contact with the world around me. With my family and friends. I felt dirty, the world around me felt I was dirty. I had to live in the shadow of fear and ignorance. My heart ached for someone to guide me to hold me and say it would all be ok but I could not approach anyone with this dirty secret.”*

*“When we were told our mum had contracted Hepatitis C, we didn't understand. My mum had always been healthy, we had never heard of Hepatitis C and we certainly didn't realise its severity as we were misled. My mother went from an out-going pillar of the community, to someone who cowed in her home, wishing to avoid all human contact convinced she had AIDS. I attended her treatments and watched as they drew litres upon litres of fluid from her chest and abdomen daily. I sat with her as she had her treatments. She would squeeze my hand and scream as they inserted a needle at least 10 inches long into these areas so they could draw off the build-up of*

*fluid. Her screams remain with me to this day and I felt traumatised by what I saw and heard, I'd push my feelings aside to ensure my mum didn't feel she was alone."*

*"My husband was both parent to our children and at the same time my carer ... I missed so much of [my children's] lives as I was either in hospital, rehabilitation or convalescing, I am also unable to lift and cuddle my grandchildren and care for them like a normal grandparent ... I had not dreamed I would still be unwell all these years later. Hepatitis C has taken my life and affects my family's life every day."*

*"[My son] was [a teenager] when my husband died. He grew up with the knowledge that his father was going to die and he has been affected physiologically ever since... I had to force him to come to say goodbye to his father when my husband was dying in a hospice and my husband and I had to hold him down for AIDS tests when he was only [very young]. He saw my husband deteriorate over many years and not to have a proper father. I was both mother and father to him . I had to give up teaching to care for my husband..."*

*"Thank you also for highlighting the needs of affected children. They were very forgotten..."*

*"There were constant rumours and people asking my what did Dad die from. I was told to never tell the truth of the matter. Do not get me wrong. I was never bullied, picked on or singled out. But I lived knowing that if the truth came out I would be."*

*"There are many of our community who although will no longer be around for the final days of the inquiry, the knowledge of knowing that their loved ones will be properly compensated, when they are gone, will give many some peace of mind before they pass."*

*"My sole wish now [in my 80's] is that everything can be brought to a quick conclusion and payments made in time to still benefit those of us who have survived until now."*

*"I am increasingly conscious of the fact that my life may be cut short by the ravages that my body has had to endure over the past 5 decades. This feeling never goes away. I am aware of my mortality in everything I do."*

*"Hopelessness, and hurt have a deep and lasting effect on people, and the feeling that we have been abused and ignored for so long makes those feelings all the more distressing."*

*"Being successfully treated has made no difference, as having been infected with the virus at all, has to be declared in all aspects of life."*

*"I never fully experienced the joy of parenthood. My lasting memories of this stage of my life are clouded by melancholy numbness and guilt. I was unable to fully engage with my children..."*

**1.2** These are typical of the many contributions made to me by people who have had to live with the unimaginable illness and anguish caused either by being infected through what was meant to be lifesaving treatment, or being close to someone who was. The determination of so many to

help me in the work I have been commissioned to undertake has been truly moving, and has been enormously helpful in guiding me towards what I hope are the beginnings of a pathway to providing them with financial and other support they desperately need, and have been waiting so long for. I want to start this report with my acknowledgment and gratitude for their willingness to participate in the Study, and to assure them that whether their particular contribution is referred to in the report or not, and the overwhelming majority of them have not for reasons for time and space, I have learned a great deal from all of them. I sincerely hope that they find that the points they wanted me to consider have been taken into account.

## *Background*

**1.3** In July 2017, the Government set up the Infected Blood Inquiry under the Inquiries Act 2006, with Sir Brian Langstaff as its Chair. That Inquiry continues, and is not expected to report until 2023. The first term of reference is:

*“To examine the circumstances in which men, women and children treated by national Health Services in the United Kingdom (collectively, the “NHS”) were given infected blood and infected blood products, in particular since 1970...”*

**1.4** The Inquiry is required to look at many aspects of the provision of this treatment, and the aftermath, and to examine issues of responsibility and culpability for what is widely acknowledged to be a disastrous episode in the history of the NHS.

**1.5** The Inquiry is tasked among other matters to:

*“... ascertain, as far as practicable, the likely numbers of people who have been infected (directly or indirectly)”*,

by infected blood or blood products. Thus, it is noteworthy, that at the time of writing this report on compensation, it is not possible to know the potential numbers of people who might conceivably be eligible for compensation were a scheme to be set up.

**1.6** Further, paragraph 4 of the Terms of Reference requires the Inquiry to examine the impact of these infections on all who were affected either physically or socially:

*“To consider the impact of infection from blood or blood products on people who were infected (“those infected”) and on partners, children, parents, families, carers and others close to them (“those affected”), including:*

*a. the mental, physical, social, work-related and financial effects of:*

*i. being infected with HIV and/or HCV and/or HBV in consequence of infected blood or infected blood products;*

*ii. the treatments received for these infections;*

*b. the extent to which treatment, medical and dental care for other conditions was compromised by perceived infective status;*

*c. the impact of these infections on partners, children, parents, families, carers and others close to those infected, including the impact on those who suffered*

*bereavement; children who were taken into care; those who were advised to, or did, terminate pregnancies; and those who had to take difficult decisions about whether or not to have children;*

*d. the wider social impact on those infected and affected, including the stigma associated with a diagnosis of HIV and/or HCV and/or HBV.”*

**1.7** Under paragraph 8 of the Terms of Reference, the Inquiry will consider among other things the adequacy of the support offered to infected and affected people:

*“To consider the nature and the adequacy of the treatment, care and support (including financial assistance) provided to people who were infected and affected (including the bereaved), including:*

*a. whether and to what extent they faced difficulties or obstacles in obtaining adequate treatment, care and support;*

*b. the availability and adequacy of any counselling or psychological support for those infected or affected;*

*c. the actions of the various Trusts and Funds set up to distribute payments;*

*d. the differing criteria for eligibility for financial assistance applied by the various Trusts and Funds, the justification (if any) for such differences and whether such differences were or are equitable;*

*e. the appropriateness of preconditions (including the waiver in the HIV Haemophilia Litigation) imposed on the grant of support from the Trusts and Funds;*

*f. the extent of any differences in the arrangements made for financial assistance between England, Wales, Scotland and Northern Ireland;*

*g. a broad consideration of the extent to which support is and has been comparable with support for those similarly infected and affected in other countries, for example, Canada and EU nations, such as France and Ireland.”*

**1.8** I was appointed to conduct this Study by the then Paymaster General, the Rt Hon Penny Mordaunt MP, on 8 July 2021. My Terms of Reference are at Appendix 1. As is made clear, the intention has been that this Study should be entirely independent and the result of my own judgement, unfettered by any preconceptions. I am happy to confirm that I have been supported assiduously by the Cabinet Office to undertake this Study, and am grateful for the assistance of their Inquiry Team led by Sue Gray. I have received support in terms of information whenever I required it, and no inhibition has been placed on how I could conduct the Study, or on what conclusions I should reach. For the sake of transparency, I should record that I have met on one occasion each, Ms Mordaunt, when Paymaster-General, to discuss my appointment, and her successor, the Rt Hon Michael Ellis MP, to report on progress.

### *The status of the Study*

**1.9** The understanding is that once I have submitted my report, and the Government has decided its response to my recommendations, both will be submitted to the Inquiry for its consideration and will be in the public domain. It is, therefore, important that I do not purport to prejudge the findings or recommendations of the Inquiry under its terms of reference. It follows that any recommendations I make have to be highly conditional on the outcome of the Inquiry, and that I am considerably limited in the conclusions I can safely draw about many matters relevant to the context of a possible compensation scheme. I have also rightly been limited in the time I had to complete this Study through the imperative to allow, so far as possible, for a scheme to become operational within a short time of the Inquiry publishing its report. To balance these limitations, the process has the advantage that the interested parties, most of whom if not all are also core participants in the Inquiry, will have the opportunity to express their views on this report and the Government's response, and in this way help shape not only the Inquiry's conclusions and recommendations, but also the outcome with regard to the structure of the scheme.

### *The pressures of time*

**1.10** Unfortunately, a disadvantage from the point of view of those who might be eligible for compensation, is that there is little or no prospect of the scheme getting going before the conclusion of the Inquiry. This is unfortunate for the many potentially eligible applicants who are now of advanced years or worryingly unwell. There are those who fear they will not survive long enough to see, let alone enjoy, the fruits of an award of compensation. This is a principle reason why I have recommended the unusual measure of an immediate interim award to those infected persons who are already beneficiaries of the existing support schemes, in anticipation of, but before, the scheme has been set up. If at all possible, it is a matter of justice that so far as possible the infected likely to receive compensation can receive at least a significant part of it in time to make a disposition of the award as part of their assets before they die. To do that, of course, requires a consideration of the range of awards which might be made by way of compensation, and that I have sought to do. I must emphasise that any figures I have included in this report are for illustrative purposes, and subject to the effect of the Inquiry's better understanding - through its assessment of the wealth of evidence it possesses - it will gain of the nature and extent of the injuries and losses suffered. However, I have recommended a framework which I hope will be helpful in assisting the expert panels I have suggested arrive at appropriate figures for each of the categories in it.

### *Independence*

**1.11** That there is a rationale for compensation has implicitly been accepted by the Government in setting up this Study, and thereby giving rise to expectations on the part of the infected and affected community that their demand for compensation, as opposed to 'support', will be met. Unhappily, so low is the level of trust on the part of some, doubts were expressed as to the authenticity of the Government's intentions. I am personally satisfied from my meetings with Ms Mordaunt, and her successor Mr Ellis, that they are genuinely committed to seeing that this community receives fair and proportionate redress. Obviously, though, neither they nor I can offer in advance a commitment on behalf of the Government as to the shape that might take.

*The conflicting needs for speed and personalisation*

**1.12** As all those who have offered me submissions as to the nature of a compensation scheme have accepted, the task I have been given is a challenging one. Understandably, there is a demand for swift and readily accessible remedies. So much of the injury and suffering, of which complaint is made, started a very long time ago. Since then, many of those involved have spent their lives fighting for what they perceive is justice. Many have died. There is a groundswell of dissatisfaction at the 'support' offered to date, and distress at the hurdles - as they see it - put in their way to obtaining even that. However, there is also a demand for a bespoke assessment of suffering and losses. Given the complexity and variability of the consequences of these infections, it would be very challenging to deliver such assessments within a very short period. Therefore, meeting the two demands may require a degree of compromise between these two needs and the wide range of people who have been directly and indirectly impacted who potentially could be entitled to make a claim.

*How I have used information and evidence*

**1.13** It is important to emphasise that I have been asked to conduct a Study, not an inquiry. Accordingly, while I have placed great importance on the information gathered at the many meetings I have held, I have also done a great deal of reading, not all of which will be referenced in this report. Much key material has been available through the Inquiry, on whose website are the transcripts and witness statements of many of the infected and affected communities, in addition to evidence from practitioners, experts, administrators and ministers. I have read a small proportion of what is there, seeking out evidence relevant to the issues of compensation, rather than the broader questions of interest to the Inquiry to do with the reasons why infection was able to be transmitted through blood and blood products, and how those infected were treated. I naturally focussed, in terms of the written evidence, on the statements of those I met, seeking as I did, to avoid requiring them to repeat often distressing details about their experience. In summary, therefore, the information on which this report is based divides into the following categories:

- General research into material relating to other compensation schemes and the background to the issues involved;
- Selected written and oral evidence to the Inquiry;
- Submissions and statements made directly to the Study, either at their own request or mine, among others, by members of the infected and affected communities, representative organisations and legal representatives, scheme managers and relevant government and NHS departments and organisations; and
- Information obtained at meetings with interested persons, in groups and individually.

**1.14** A summary of those whom I have met is at Appendix 3. For reasons of confidentiality, I have avoided identifying individual infected and affected persons who have contributed to the Study.

**1.15** Overall, I met with over 100 infected and affected people as part of my discussion forums, and a range of representative organisations, recognised legal representatives and small campaign groups. There were others who wanted to see me, but unfortunately time did not permit me to arrange sufficient meetings to accommodate all. I believe, however, that I saw a sufficient number

of those involved to obtain a reliable general impression of their needs for compensation and their experiences of the support schemes. I emphasise that it is not part of my role to offer findings on the adequacy or management of these schemes or on the history relating to them. Still less do the Terms of Reference require me to pass judgement on either the amount of compensation which should be awarded to any of them or the injuries, suffering and losses for which any individual should be compensated. The purpose of listening to their stories and reading their statements, has rather been to understand the range of claims that might be made in order to advise how a scheme might be devised to address such of those claims as it might be considered appropriate to recognise.

### *The shape of my recommendations*

**1.16** I believe that I have obtained sufficient information to allow me to make recommendations as to the overall shape of a scheme, how it might be delivered, and what relationship it might have with the existing support schemes. The aim of my recommendations is to produce a framework which allows for a standardised approach, based on preset ranges of possible awards, while at the same time allowing a more bespoke approach to the assessment of at least some financial losses. This should mean that most applicants should be able to start from a shared basis for compensation, but their individual circumstances are also recognised, using wherever possible tools which simplify the process.

**1.17** As many contributors have realistically recognised, this is a challenging task, as it will be for the Government in deciding its response. The expressed needs and expectations of the infected and affected conflict almost irreconcilably. For some, the priority is speed of resolution, to enable them to seek closure and settlement before they die. Others desire the ability to claim large awards, not just as detailed compensatory recognition for every physical, mental, financial and social injury they have suffered as a result of infected blood or blood products, but as a visible sanction for what they see as gross misfeasance and violation of their rights on the part of the State and its agencies. Others seek remedies for loss and grievances not readily attributed to categories of damage recognised by the law.

**1.18** Inevitably, my recommendations will be seen as a compromise which may not completely satisfy all these and other aspirations, but then the same could be said of the common law approach to personal injury damages, which I have explained in a little detail. It is also a compromise between the need to deliver justice to wronged individuals, and the public interest in proportionality and a recognition of the need for certain limits on what type of injury should qualify as a matter of policy for compensation. I have sought to propose a framework which allows for some extension beyond easily recognisable categories of damages recoverable in law, balanced by a restriction on the scope of eligibility for those indirectly affected to those with a demonstrably close relationship with an eligible infected person. I have sought to respond to the need for swift delivery of remedies by suggesting the introduction of an interim payment for some, and a standardised approach to some categories of injury and loss, while offering the option of more detailed bespoke assessments in others. I have stressed the need to respect applicant's right to choose what to claim by way of an award, and how to receive it, and recognised that compensation is not just a matter of money, but includes the provision of support, and above all, restoration of dignity.

**1.19** Clearly, what I have suggested is not the only possible solution, and indeed better ones may emerge from the scrutiny this report will receive at the Inquiry. For example, while I have not

accepted it as the preferred way forward for reasons I have explained, an administratively and legislatively credible alternative would be to adopt a scheme very similar to the Republic of Ireland's Hepatitis C and HIV Compensation Tribunal. This would, however, result in longer, more complex processes for applicants, and more administrative and legal expenses for the public purse. While the outcome in terms of the total awards obtained might be tempting, the experience of the process to get there might be more than many could tolerate.

#### *A cautionary note about language*

**1.20** It is always challenging, when writing about matters so deeply distressing to those who have personally gone through the experiences which give rise to the demand for compensation, to avoid language which might inadvertently appear insensitive to their suffering or their individuality. That has naturally been far from my intention. For example, I will refer, as does the title of this report, from time to time to "victims". I recognise that some would prefer to be seen as people living with an infection and its results. However, an entitlement to compensation implies that, whether through fault, negligence or otherwise a wrong has been suffered which deserved compensation. It is in that sense I use the word. I will also use the phrase frequently adopted at the Inquiry, "the infected and the affected". There is a risk when grouping individuals together in this way to forget their individuality, and even their humanity. Obviously, that is not my intention or, I am sure, that of anyone else who uses this phrase. It is inevitable that people who have suffered similar, but not identical, experiences are seen as a group when considering their needs for compensation or support. There is no other way of achieving a level of consistency and fairness in approach. Indeed, many have obviously seen themselves as part of different groups, and have argued for different approaches and separate recognition for their specific circumstances and entitlement to compensation. As some have acknowledged, this may sometimes have led to an impression of antagonism between groups. I sincerely hope that nothing in this report will exacerbate that. All those who have suffered as a result of this tragedy, whether through HIV or hepatitis, whether through direct infection, or through association with someone who has been infected, whether because of treatment for haemophilia or after an accident or some other reason, share common causes for what has happened. It is the objective of compensation to give redress for an undesired outcome and, so far as possible, to ensure consistency in the compensation awarded in each case. Inevitably, that involves grouping issues and experiences together. It does not, however, mean we should ever forget the individuality of each person, and no shorthand term is intended to do that.

#### *Acknowledgements*

**1.21** First and foremost, I must acknowledge the contribution made by those who have suffered to the Study. Many have offered their views at considerable personal cost. Some were visibly distressed in recalling what had happened to them and their loved ones. Others, understandably, complained at having to repeat accounts they have given countless times before. Some did so in spite of very low levels of trust in the process. I have been very conscious of the obligation to respect the effort it has taken for all to come forward as they have.

**1.22** Secondly, I would like to thank all those legal and other representatives who have taken the trouble to offer thoughtful and constructive contributions, often after consulting widely with their clients or members. Their help has been invaluable and ensured that the information base on which I could proceed was much wider than it would otherwise have been.

**1.23** Thirdly, I acknowledge the assistance the various managements of all the devolved support schemes, NHS Resolution and the DHSC have provided in obtaining information about the history of the schemes, their services and the status of litigation in this field.

**1.24** Fourthly, I am very grateful to Dr. Sonya McLeod for her personal assistance to the Study, not to mention her monumental work with Christopher Hodges, *Redress Schemes for Personal Injuries*, without which the work of this Study in considering other compensation schemes would have been very much more arduous. I must make it clear that any description of other schemes in this report is entirely my responsibility, not hers.

**1.25** Finally, I am grateful for the support provided by Brian Williams and his Cabinet Office team in liaising with the Infected Blood Inquiry. And I cannot end this introduction without acknowledging the contribution of David Kirkham, seconded to provide liaison with the Cabinet Office, in addition to secretarial and administrative support to the Study, and Amy Street, barrister, who has provided me with legal advice and research assistance. I could not have completed this report without their dedication and hard work, but the responsibility for the report is entirely mine.

A handwritten signature in black ink, appearing to read 'Robert Francis', with a horizontal line underneath.

**Sir Robert Francis QC**

14 March, 2022

## Executive Summary

### Rationale

#### *A definition of 'compensation'*

**2.1** It was striking that few participants in the Study were able to describe clearly what their concept of compensation was. Referring to dictionary definitions, it is clear that compensation is not a term limited to an award of money, that it involves a process of determining what should be awarded, and recognises that a person has suffered an injury or loss for which compensation is intended to redress. While liability in the sense of a legal wrong may be involved, fault, negligence or an unlawful act are not necessary preconditions for compensation. However, compensation is a recognition of adversity which should not have happened.

**2.2** My definition for the purposes of this Study is:

*“An award of money or some other remedy to persons who have suffered injury or loss directly or indirectly from infected blood or blood products found to be eligible for such an award to provide them with redress for and recognition of the adverse experience they have suffered.”*

#### *A moral case?*

**2.3** The rationale for the various past and current support schemes has not been easy to pin down, and no coherent rationale was offered by contributors to the Study. A government's responsibilities for its citizens does not begin and end with legal liabilities, but includes the duty to protect them from the most serious misfortunes of life. However, there was a clear consensus among contributors to the Study that there was a difference between 'compensation' and 'support', and a notion that the suffering of this group and the wrong done to them was so serious that their case was elevated above the minimal requirements for support given to the merely unfortunate.

**2.4** Indications of the general rationale for a compensation scheme can be obtained from the conclusions of the various inquiries, ministerial and judicial pronouncements, and the support schemes themselves. The factors that are capable of providing a rationale include: suffering, hardship, public sympathy, the wide range of people affected, and recognition of the unique circumstances, the humanitarian imperative, and the unfairness of the wrong from which they suffered, caused by a state agency.

**2.5** Without prejudging the outcome of the Inquiry, my conclusion is that there would be a strong moral case for compensating this group, independent of any issue of legal liability or culpability, in relation to their complaints, if the following points were accepted:

- It is likely that in hindsight, the transmission of infection to these patients could have been avoided.
- The harm caused has been devastating and lifelong.

- Those who have been injured have lacked reliable information about the infection, treatment, or not given informed choices.
- They have endured a rollercoaster of raised and then dashed expectations with regard to support and recognition of their plight.
- Legal redress, even if obtainable, would be likely to be an inadequate response.
- The State has over a long period recognised that this group has been deserving of support not available generally, and has gradually recognised the inadequacy of what has been offered previously.
- In a civilised and humane society, it is right for governments to recognise and offer a remedy for those who have suffered through no fault of their own from the actions of the State, or indeed natural disasters.
- In the circumstances of the infected, and at least some of the affected, a special case has been made out for compensation over and above the support offered to date.

### *Principles*

**2.6** Having considered submissions as to the principles or characteristics which should underpin a compensation scheme, I suggest they should include:

- Remedial
- Respect for dignity
- Collaborative
- Choice
- Individualised
- Inclusive
- Non-technical
- Accessible
- Ease of proof
- Broad
- Improving
- Complementary
- Holistic

### **Coverage of compensation**

#### *HCV and HIV*

**2.7** The principal viruses infection for which the compensation scheme must offer redress are clearly HCV and HIV.

## *HBV*

**2.8** While HBV is often also involved, either separately or in conjunction with HCV and/or HIV, it has not been a ground for eligibility under the support schemes - a special case for including it as a separate ground of eligibility for compensation is not made out. This conclusion derives from the impression that generally its effects are mild, there is treatment available to suppress the infection and avoid its most serious consequences, and more serious consequences are perhaps more likely when there is co-infection with HCV and/or HIV. In the latter cases, it would be difficult to separate out the causative effect of HBV. There may be a case for an exception for chronic HBV infection with serious symptoms requiring treatment for cirrhosis. The Inquiry will have the advantage of considering much more evidence than I have had the time or ability to take into account and, therefore, this conclusion should be reviewed in the light of the Inquiry's findings.

## *HDV*

**2.9** This is also not a separate category in the support schemes and appears to occur only in the presence of HBV. My conclusion is the same.

## *vCJD*

**2.10** This is a rare disease for which there is a separate compensation scheme. It is unlikely, therefore, that a separate category is justified in this scheme. However, many of the infected have been warned there is a risk of their having vCJD. Assuming that risk, insofar as it exists, is shared by all who have received blood or blood products in the relevant period, there is no special case for taking it into account in this scheme.

## *Other infections*

**2.11** A moral case may emerge in respect of other infections. Therefore, the recommended categories should be reviewed on a regular basis in the light of developing knowledge.

## **Current Practice**

**2.12** It is unnecessary to consider the existing support schemes in detail, but since 2017 the support available has been largely equal across the UK and details of payments and eligibility are set out.

## **Scope Of Compensation**

### *Eligibility for infected persons*

**2.13** The conditions for eligibility for the directly infected should be:

1. the applicant has been diagnosed as being infected with either or both of HCV or HIV [the relevant disease].

2. the applicant received one or more blood transfusions or blood products known to be capable of transmitting one or more of the relevant diseases [the relevant treatment].
3. the applicant received the relevant treatment within - or from stocks created within - the periods of eligibility employed by the current support schemes,

OR

a period to be defined [subject to any findings of the Inquiry with regard to such dates] during which in retrospect, and without necessary attribution of culpability or negligence, in the light of the knowledge at the time or subsequently, the relevant technology or science could have been available to avoid infection/contamination of blood or blood products and/or of transmitting such infection to patients [the relevant period].

4. the applicant's infection was likely to have been caused by the administration of a relevant treatment.

**2.14** Indirectly infected persons should be eligible if they were infected by transmission of the infection from an infected person who meets or would have met the conditions of eligibility for a directly infected person.

#### *Proof of eligibility*

**2.15** Where possible, eligibility should be automatic for those who have already been accepted as eligible for regular support by one of the existing support schemes, or any of the preceding schemes. Where that is not possible, it is important that a sympathetic and sensitive attitude is taken to the processing of applications without rigid adherence to legal concepts of proof. The search for supportive evidence should be proactively conducted by the scheme administration in collaboration with the applicant. Where possible, existing medical information should be relied on, and assumptions made in favour of the applicant from surrounding information where direct evidence on a relevant matter is absent. Generally, the recollections of the applicant should be accepted as true, unless there is overwhelming evidence to contradict them. Rejection of eligibility by a support scheme, or absence of symptoms during any particular period, should not automatically exclude an applicant.

#### *Estates of deceased infected persons*

**2.16** Where an eligible infected person has died, a claim may be brought on behalf of their estate for compensation for the injury and loss suffered during their lifetime, by the deceased's personal representatives.

#### *Eligibility for affected persons*

**2.17** It is advisable to place some limit on the categories of eligibility for those who have been indirectly affected by their association with an infected person, in order to ensure the scheme is proportionate, not unduly complex, and avoids having to consider large numbers of potential

claimants who have had only a remote connection with the infected person. It is suggested that entitlement to claim should be extended to:

- Those who are, or have at a relevant time been, in a marital or comparable relationship with an infected person.
- Children, and those treated as children, of the infected person.
- Parents, and those regarded as parents, of infected persons whose infection started before they reached the age of 18.
- Siblings, and those regarded as siblings, of an infected person where the sibling was under the age of 18 when the infection started, and they have lived in the same household as the infected person for a minimum period after the onset of the infection.

#### *Eligibility for carers*

**2.18** Persons who have provided unpaid care and support to an infected person, required because of the infection, in addition to the care and support that person would normally have expected to have provided to them.

#### *Discretionary eligibility for affected persons*

**2.19** There are likely to be others who have been seriously affected because of their relationship with an infected person, particularly mental injury. The criteria by which the discretion should be exercised are difficult to define, not only because of the wide variation of family and social circumstances, but because the entitlement to compensation under the scheme will extend beyond the normal limits of recoverable damages for personal injury. It is suggested that the limit of entitlement could be defined as extending to a person who:

- Is a member of an infected person's family or a long term friend of the infected person;
- Has since the onset of the infection maintained a close relationship with the infected person for a continuous period of at least two years; and
- Has in fact suffered a mental or physical injury as a result of the infection or its consequences.

#### *Deceased affected persons*

**2.20** A claim should be allowed to be brought on behalf of the estate for any compensation for injury, loss or damage incurred during their life to which the deceased person would have been eligible.

*Dependency on deceased infected persons*

**2.21** Where an infected person has died because of the infection, their dependents - as defined in the Fatal Accidents Act 1976 - should be eligible to claim for the financial loss of dependency. The dependents for whom a claim could be brought are essentially, spouses or equivalent partners, cohabitees of two years standing, parents, children and other descendants and siblings.

**Categories of Injuries and Loss**

**2.22** The principle areas for which the infected and the affected have informed the Study they want compensation to cover are:

- Pain and suffering from the physical and mental injury and damage caused by the infection, its consequences, and the side effects of treatment, including the effect on the abilities of the infected and their quality of life.
- The stigma and social isolation suffered by both the infected and the affected and the associated distress and inconvenience.
- The grief of the affected following the loss of an infected loved one.
- Loss of earnings and job opportunities suffered by the infected.
- Cost of care, in time and money, for the infected and those who cared for them without remuneration.
- Reduction in the ability of the infected to obtain financial services.
- Miscellaneous additional expenses.
- Interference in the autonomy of the infected through lack of informed choice and consent.
- Exemplary and aggravated damages.
- Ease of access to counselling and other support services.

**Possible Models for Compensation**

*A bespoke model of individual assessment*

**2.23** It would be possible to introduce a scheme, like the Irish Hepatitis C and HIV Compensation Tribunal, which processed claims and made awards in a similar way and under similar heads of claim to a court awarding damages. To do so would involve a complex gathering of evidence, including medical and financial information and expert evidence. The process would be complex and burdensome for applicants, uncertain in outcome and productive of disputes.

*A more standardised tariff based model*

**2.24** It is, therefore, suggested that the framework should offer categories representing the types of infection, and their various stages, and for each category, defined degrees of severity. The assessor would place each applicant in the appropriate category and degree of severity, and determine an award within the standard range for awards prescribed.

**2.25** It would not be appropriate for me, acting alone and with limited information, to determine how the prescribed ranges within which awards for this type of impact should be made. I suggest that two independent expert panels be appointed, one medical and psychological, and one legal. The medical panel would be tasked to arrive at a consensus description of the typical course of each infection and define the range of severity likely to be encountered. The legal panel would then assess the range of awards which should be applicable in each category, and degree of severity, having regard to the techniques applied to the assessment of personal injury damages, and by applying comparable principles to any area not the subject of recoverable damages. By way of illustration only, an example of what the resulting matrix may look like is offered.

**2.26** The aim of such a system would be to enable applicants and assessors to understand, and hopefully agree, the appropriate level of award from a relatively simple account of the case. It should be possible to separate out from the many consequences of an infection, areas where a formulaic or standardised approach may be preferable to a drawn out process of individual complexities.

*No waiver of litigation rights required*

**2.27** It is recommended that it not be made a condition of an award under the scheme that it be accepted as in full and final settlement of any legal claim. The freedom of choice of the infected and affected to choose to seek a further court based award should be preserved, but the availability of a scheme award should be taken into account in any court proceedings, both with regard to the size of damages and costs.

*The common law approach*

**2.28** There are disadvantages to litigation in this area, not least the protracted nature of proceedings and their uncertain outcome, but how damages are assessed may be a useful starting point to guide the formulation of the scheme. A personal injury award for an infected claimant would be divided into:

- Non-financial loss:
  - Damages for pain, suffering and loss of amenity: this would include physical and mental injury. It might include the shock and distress arising from the failure to inform a patient of a condition;
  - Damages for a loss of a chance to have a spouse or partner in life;

- Damages for invasion of human rights.
- Financial loss:
  - Special damages: past losses;
  - Future losses.

**2.29** Damages awarded for the affected would be more problematic: while persons indirectly infected by an infected person might be able to recover damages in the same way as a directly infected person, it will only be in limited circumstances that a claim could be made for the indirect effects of association with an infected person.

**2.30** A claim could be made by the estate of a deceased infected person on behalf of their dependents.

**2.31** Having considered the common law approach to personal injury damages, it can be seen that claims adopting this approach in its entirety are likely to be complex, requiring a process hard to follow without the benefit of legal support. Given the demands made by the infected and affected communities, a common law approach is unlikely to meet their needs.

#### *Exemplary and aggravated damages*

**2.32** It is not recommended that exemplary damages should be available under the scheme, as it would be premature to do so in advance of the Inquiry findings and recommendations. In any event, it is difficult to see how scheme assessors could make the necessary judgements. This is a matter on which judges, acting within a court procedure, are best equipped to adjudicate. On the other hand, the demand for aggravated damages can be met by the scheme recognising categories of award and injuries, not obtainable at common law, in addressing the very particular sources of distress suffered by the infected and affected. This can be achieved by an award for interference with autonomy and private life.

#### **Measure for Compensation**

**2.33** It is instructive to review the effectiveness of other compensation schemes of which there are many examples. There are many to look at, but those UK schemes which offer particularly useful learning points, from their successes and failings, are the Criminal Injuries Compensation Scheme, the Windrush Scheme, and the vCJD Compensation Trust. From abroad, instructive points can be obtained from the September 11 Victim Compensation Fund and the Republic of Ireland Compensation Tribunal.

**2.34** With the possible exception of the Irish scheme, none of the schemes examined could be applied directly, but they do offer valuable learning points which can be taken into account in a tailor made scheme.

## Types of Award and Method of Assessment

**2.35** A framework is suggested which recognises the strong moral case for such a scheme. I do not anticipate that the framework I recommend will require major alteration following the Inquiry's findings as to the experiences of the infected and affected and any allocation of responsibility or culpability.

**2.36** It is proposed that the objective of offering fair and proportionate compensation for the suffering and losses of the infected and affected, can be addressed under the following heads of potential claim:

- Awards for the eligible infected:
  - An injury impact award for past and future physical and mental injury;
  - A social impact award for past and future stigma and social consequences;
  - A care award for past and future paid and unpaid care needed (where an equivalent family care award has not been made to an eligible affected person);
  - An autonomy award for the aggravation of the distress and suffering caused by the direct physical and mental impact, through interference with family and private life and autonomy;
  - A financial loss award for past and future financial losses.
  
- Awards for the eligible affected:
  - An injury impact award for past and future physical and mental injury caused by their experience of the relevant infection, its consequences and/or of the death of the infected person, where a recognised consequence of a close and established association with the infected person;
  - A social impact award for the stigma and social consequences of being associated with the relevant infected person;
  - A family care award: where a claim has not been made by the relevant infected person for a care award, an award for past and future unpaid care needed by the relevant infected person and provided by the affected person;
  - A bereavement award payable to defined family members where the death of the deceased has been caused by the infection or its consequences;
  - A bereaved family loss award to redress loss of dependency.

## Flexibility

### *Options of lump sum or periodical payments*

**2.37** Applicants should have the choice of taking awards for future regular financial loss as a lump sum or by way of periodical payments.

### *Past waiver of litigation rights relevant not a bar to a claim for compensation*

**2.38** There have been negative experiences of feeling unduly pressured into accepting inadequate settlements in the past. It is recommended that no such settlement should be a bar to an application for compensation, but that any sum received should be taken into account as a deduction from any lump sum awarded for past financial losses or provision of care. If it is not possible to identify the loss for which the settlement was intended to redress, it should be disregarded.

### *No waiver of litigation rights required to claim compensation*

**2.39** As requiring a waiver is likely to be counterproductive, and distressing, the freedom of choice of eligible persons should be supported by recognising their freedom to choose to litigate if so advised. However, any compensation award should be taken into account in the award of damages and liability for costs in court proceedings

## A Tariff Approach

**2.40** As suggested above, a medical panel with involvement of the infected communities, should be appointed to produce a description of the range of conditions and symptoms that can be suffered throughout life with each disease, and differentiate between mild, moderate and severe types of the infection. The legal panel will then decide, in respect of each degree of severity described for each infection, a range of appropriate awards for the injury impact award and the social impact award.

### **Award for Impact on Life - the Injury Impact Award**

**2.41** The process will require consideration of all the principles by which personal injury damages are awarded, adapted for the purposes of this scheme, any relevant guidelines and comparable awards by courts and compensation schemes.

**2.42** By way of illustration only a grid showing possible ranges of award for the injury impact award has been prepared.

## Social Impact Award

### *Stigma and social effects of infection*

**2.43** The purpose of this award is to compensate the infected person for the stigma and social effects of these infections. These impacts will affect different people in different ways, but it is suggested that they are essentially shared by all, regardless of how they manifest themselves. It is appropriate that this award is a lump sum to cover the past as well as the future, but, subject to some reflection of the length of time during which the social effects are suffered, the sum awarded should be common to all applicants. For the purposes of suggesting illustrative figures, it is assumed that the severity of the social effects is commensurate with the severity of the disease suffered, but this is a matter which should be reviewed by the medical panel on the basis of the available psychosocial evidence.

### *Inability to form marriage and equivalent long term relationship*

**2.44** While awards are not generally made for the breakdown of a marriage or similar relationship, it would be right to include an uplift in the social impact award for eligible infected persons for the loss of ability or prospects of forming such a relationship, where there is specific evidence in support of this.

### *Loss of chance to have children*

**2.45** A further uplift should be made to the social impact award for the loss of the chance to have children in accordance with the Judicial College guidelines.

## Care Award

**2.46** Many of those who have spoken to the Study have described the care that they have received often from members of their families. It seems likely that the need for care as a result of the infections will be variable, both between different infected persons and over time.

**2.47** The common law approach to damages for care needs is to award either the actual reasonable costs incurred or, where the care has been provided unpaid, for example by a family member, by reference to the 'commercial' hourly rate which would be charged for similar care, less a percentage to reflect the tax and other expenses that are not payable by a family member. These damages are recoverable by the injured person and held on trust to be distributed to those who have provided the care. The carer could not claim directly from the defendant. In such cases, it is common for experts to be instructed to work out how many hours care has been, and will be, delivered in this way and then apply complicated hourly rates, differentiating between night and day time care, weekdays and weekends, etc.

**2.48** It is suggested that to conduct such a detailed exercise for each applicant could be time and resource consuming, and that it would be preferable for the purposes of this scheme to devise a broader and more generalised approach, although the applicant could be left with a choice of a broad brush and a detailed assessment. The criteria for such an approach could be for:

- the applicant to show a reasonable need for care attributable to the infection and its consequences; and
- a broad description of the amount of unpaid care and paid for care provided in different periods, to which a prescribed general range of rates could be applied (see below).

#### *Lump sum and periodical payment alternatives*

**2.49** The applicant could be given the option in relation to future care needs to receive a lump sum reflecting the anticipated period of future need, or periodical payments of a guaranteed inflation proofed amount for the duration of the period.

#### *Prescribed scale of care hours required and commercial costs*

**2.50** It is suggested there should be a prescribed scale of hours and rates fixed by the expert panels for each level of severity of each infection. The experts should not be required to assess each case individually, but provide a matrix by which scheme assessors could identify the appropriate level of compensation for each applicant.

#### *Exceptional cases*

**2.51** There may be exceptional cases for which awards in excess of the prescribed hours and rates are appropriate, and the scheme should allow a discretion to make such an award.

### **Financial losses**

#### *Status of support payments*

**2.52** In response to the overwhelming demand of the recipients, the existing support payments should be continued either through the continued support schemes, or by merging the support and compensation schemes. Because of their ex gratia and charitable status, they should not be taken into account in assessing past financial losses for the purpose of this scheme. However, they should be taken into account against awards for future financial losses.

**2.53** To facilitate this, all annual support payments (which include the heating allowance) should be brought up to at least a level 5% above net national median earnings, and those already at that level should be increased proportionately to maintain the differential between categories of award. A lump sum supplement should be added to all annual payments of, say £10,000, to cover other items such as increased insurance costs, additional transport costs and so on.

**2.54** Such payments should then be guaranteed for life. They can then fairly be taken into account against any claim for future loss of earnings, with a further award only being made for losses proved to be in excess of the support payment. The current arrangements for disregarding the support payments for benefits should be maintained.

**2.55** Where a claim for loss of earnings is made, the applicant should either have to prove an actual loss by reference to a pay or employment history, or where this is not available, by reference to relevant statistical evidence in relation to the class of employment they would have had but for the infection. Where the prospects of the applicant are too speculative, such as in the case of young children, resort would have to be had to general median earnings figures - which should already be covered by the support payments.

#### *Loss of earning capacity*

**2.56** Those infected persons in employment should be enabled to claim for the financial loss attributable to the loss of a chance of better employment or pay.

#### *Taking account of previous court awards or legal settlements of damages claims*

**2.57** In the few cases where settlements have been received, a deduction should be made on a like for like basis against an award under the scheme, where it is possible to identify the elements making up the settlement.

#### *Other possible heads of financial loss*

**2.58** There are numerous other possible losses that could be incurred as a result of these infections. The supplement I have recommended for the support payment should cover many of these, but the scheme should allow for discretionary awards where an applicant shows a specific future loss which is not adequately covered by the supplementary support payment. It should generally not be permissible to claim for goods and services which are available free of charge, unless good reason is shown for not using them.

#### *Assessment of future losses*

**2.59** Past losses will be assessed by reference to actual costs. Future losses should be calculated by identifying the probable annual cost, multiplied by a multiplier representing the number of years over which the loss will be incurred, discounted for acceleration of receipt. Alternatively, at the option of the applicant, appropriate periodical payments could be calculated.

### **Compensation for the Eligible Affected**

#### *Injury Impact award*

**2.60** While this would be assessed in accordance with the general principles applicable to the infected, these have to be modified to recognise that any physical, and, more likely, mental injury has a different origin. It is suggested that the award for the impact of any such injury is assessed by reference to the guidelines and comparables as would be used in a personal injury claim, but subject to a maximum of the amount awarded under this head to the infected person, or which would have been awarded had they made a claim.

*Social impact award*

**2.61** It should be recognised that the stigma and social effects on the affected are likely to be similar to those suffered by the relevant infected person, but to a lesser extent. Therefore, it would be reasonable to restrict the award for the affected to no more than half that appropriate for the relevant infected.

**2.62** Only spouses or the equivalent would be eligible for uplifts in relation to the loss of prospects of partnership or children.

*Family care award*

**2.63** An affected person should only be able to claim a care award where one has not been made to the relevant infected person, and only in respect of past care.

*Bereavement award*

**2.64** This should be an amount equal to the statutory award under the Fatal Accidents Act, and payable to the estate for sharing among dependants.

*Bereaved Family Financial Loss Award*

**2.65** This should be calculated and payable as would a loss of dependency award under the Fatal Accidents Act.

**Options as to the Form of the Award**

*Final and provisional awards*

**2.66** Because of the time elapsed since most infections were contracted, the prognosis, including the risks of deterioration faced by most infected persons should be capable of being assessed with sufficient accuracy to allow for commensurate compensation. It is, therefore, suggested that offering provisional awards is an unnecessary complexity.

*Lump sum/periodical payments*

**2.67** Periodical payments could be made available for anticipated continuing financial loss and care costs and provision, as an alternative to lump sums at the option of the applicant.

*Interest*

**2.68** Interest should be payable on past financial losses or an uplift for inflation allowed.

### *Interim payments*

**2.69** There is a compelling case for awarding interim payments as soon as possible to the infected who have already been accepted as eligible for the support schemes. Many wish to be able to settle their affairs before they die. Challenging though it is to do this before the scheme has been set up and is fully operational, and before the conclusions of the Inquiry are available, I suggest that such a payment should be made now, reflecting the minimum any infected person could be expected to receive under the scheme. I have suggested this is unlikely to be less than £100,000 in any case. Naturally, any such payment would be on account of any final award, and may suffice for some who might not wish to proceed further.

### **Relationship with Current Schemes**

**2.70** I have recommended that no account be taken of previous payments under the support schemes or their predecessors. They were ex gratia and/or charitable, and in any event not easy to work out to what type of loss, if any, they related. Future support payments should be taken into account in future financial loss and care awards.

### *Deduction of benefits*

**2.71** No deduction should be made from compensation awards for past support payments, but these should be taken into account in assessing awards for future loss and care needs. Attendance allowance should be deducted from any care award, past or future, unless the disability for which it was granted is unrelated to the infection. Income support should be treated as it would in a personal injury action under the Social Security (Recovery of Benefits) Act 1997.

### *Taxation*

**2.72** A compensation award should not be chargeable to income tax or taken into account for the purpose of council tax reduction. Consideration should be given to adding the amount of any lump sum award to the inheritance tax allowance for a deceased infected person.

### *Entitlement to benefits*

**2.73** The exemptions currently in place disregarding support payments in calculating means tested benefits should remain in place for them or their equivalent in the compensation scheme.

### **Options for Administering the Scheme**

#### *Independence*

**2.74** In order to maintain trust in the independence of the compensation process, it should be administered by an Arm's Length Body set up for the purpose, accountable to Parliament.

### *Scheme administration*

**2.75** Among the functions of the administration will be:

- Promotion of the scheme to all potentially eligible persons;
- Processing of applications as simply, sensitively, 'trauma informed' and undemanding as possible. The objective should be to offer all applicants the best chance of establishing their entitlement, rather than to be a search for reasons to exclude them;
- Managing a tiered system of assessment and the expert medical and legal panels;
- Payment mechanism;
- Review and appeal processes;
- Advice and advocacy services;
- Coordination or delivery of support services.

### *Expert panels*

**2.76** The medical panel will require relevant independent clinical experts including psychologists. And act in consultation with the infected communities. The legal panel will require qualified lawyers, or judges experienced in personal injury cases.

**2.77** In what will be a UK-wide scheme, funded by the UK Government, the panels will be setting standards and aiming for parity for the whole country, but they will need to have regard to the context of each devolved nation and will, therefore, require as members lawyers qualified in each jurisdiction.

### *Assessment of awards*

**2.78** I suggest that assessment would be best handled by a small team of lawyers with experience of personal injury cases, or at the very least well trained claims officers. Wherever possible, they should be enabled to develop and maintain personal contact with the applicants whose claims they are assessing, with a single assessor or small team responsible for each case throughout. There is a need for effective quality assurance to ensure consistency. The process of assessment should be conducted as close to the applicants as possible and, therefore, should be located in each of the devolved nations as are the support schemes.

### *Appeal process*

**2.79** Where applicants are dissatisfied with their assessment, they should have access to an internal review and after that an independent appeal panel. This should be independent, with an easy to understand procedure, and preferably be a panel consisting of a judge, a person with relevant lived experience and a relevant clinical practitioner. It could be a standalone panel set up

for the purpose, or a tribunal set up by legislation, with an appeal from it to the High Court on matters of law.

*Support Services: Advice and advocacy*

**2.80** There should be a commissioned advice and advocacy service to assist applicants navigate the process and ensure that their needs and claims were fully articulated and understood. For cases of particular sensitivity or complexity, the scheme should have the discretion to fund legal representation, and the costs of guardians, attorneys and Court of Protection proceedings where necessary.

*Support Services: Financial and associated advice*

**2.81** The scheme should also have the capacity to offer financial and associated advice to mitigate difficulties in obtaining financial services and in managing awards. The support schemes offer some such support on an informal basis now.

*Support Services: Access to health and care services*

**2.82** Some of the schemes, including the UK support schemes, facilitate or expedite access to required health and care services. The compensation scheme should be enabled to offer referrals to appropriate services, and to take steps with the NHS to ensure appropriate counselling services are available.

*Reporting and accountability*

**2.83** The accounting officer for the scheme should be obliged to report annually to Parliament.

*Should the compensation scheme be delivered locally or nationally?*

**2.84** The infected and affected in the devolved nations have a strong preference for retaining the support schemes and their local administration, probably because of the ability to have a personal relationship with case handlers. The need for personal contact between the scheme and applicants suggests that the compensation scheme should be delivered locally alongside the support schemes. The two schemes should be merged into one organisation - the Arm's Length Body - under legislation or a memorandum of understanding, defining the responsibilities of the UK and devolved governments.

*Confidentiality*

**2.85** Confidentiality is very important for applicants, and their awards, but applicants should be free to identify themselves if they want to.

*User involvement in the Scheme*

**2.86** Victims' groups should be involved in offering feedback on the running of the scheme through a forum or committee with membership representative of all relevant conditions and all devolved nations. The scheme should be obliged to have regard to the views of this body in its management.

*Non-financial support*

**2.87** The scheme should have a support unit to provide or arrange for the provision of medical, psychological and social support to infected and affected persons. The Archer Inquiry recommendation of a card entitling beneficiaries to benefits not freely available on the NHS should be revisited to consider whether such a facility should be made available via the compensation scheme or otherwise. Where such services are available, to a standard recognised as being in accordance with contemporary standards, applicants should not be awarded the cost of obtaining such services privately.

**Other Issues**

Legal Support

**2.88** For cases where legal support is required, it could be provided by a support unit staffed by lawyers and paralegals working independently of the general scheme administration, or independent lawyers could be funded to provide advice and representation for a fee. In either case, it is vital to avoid a breakdown of trust and to avoid the scheme missing information important for its work, that the funding is sufficient to enable adequate support to be provided.

## Recommendations

### Recommendation 1:

I recommend that the Government accepts that, irrespective of the findings of the Inquiry, there is a strong moral case for a publicly funded scheme to compensate both infected and affected victims of infected blood and blood products infected with HCV or HIV, and that the infections eligible for compensation be reviewed on a regular basis in the light of developing knowledge.

### Recommendation 2:

I recommend that the scheme should offer redress to those infected with HCV and/or HIV, and defined serious cases of HBV [relevant diseases], and defined categories of persons indirectly affected by such infections [relevant affected persons].

### Recommendation 3:

I recommend that the conditions of eligibility for admission of relevant infected persons to the scheme should be that:

- a) they have been diagnosed as being infected with one or more of HCV, HCV, or HBV of the defined level of severity;
- b) they received one or more blood transfusions or blood products known to be capable of transmitting one or more of the relevant diseases [the relevant treatment];
- c) the patient received the relevant treatment within - or from stocks created within - the periods of eligibility employed by the current support schemes **or** a period to be defined (subject to any findings of the Inquiry with regard to such dates) during which in retrospect and without necessary attribution of culpability or negligence, in the light of the knowledge at the time or subsequently, the relevant technology or science could have been available to avoid infection/contamination of blood or blood products and/or of transmitting such infection to patients [the relevant period], alternatively, after the relevant period using blood or blood products likely to have been collected or made during it; and
- d) their infection was likely to have been caused by administration of the relevant treatment **or** they fulfil condition a) above and their infection was likely to have been transmitted to them by a person who fulfils conditions a) to c) above.

## Recommendation 4:

I recommend that the scheme should, so far as possible, avoid legalistic and adversarial concepts of the burden and standard of proof: establishing eligibility under the scheme should be either:

a) automatic in the case of infected persons already accepted for eligibility under the support schemes;

or

b) a collaborative process in which:

- the applicant is sympathetically supported by the scheme in obtaining any required information and documentation;
- in general a presumption is applied that statements of fact made by an applicant are correct;
- applicants are not required to repeat information already provided to the support schemes.
- eligibility is accepted if the information available points towards eligibility and there is no strongly persuasive evidence which contraindicates eligibility.

## Recommendation 5:

I recommend that the following relevant indirectly affected persons should be admitted to the scheme:

a) spouses, civil partners and long term cohabitantes (for at least one year) of living or deceased eligible infected persons;

b) children of an eligible infected person;

c) parents of eligible infected persons whose eligibility started in childhood;

d) siblings living, while under the age of 18, as a family with an eligible infected person;

e) providers of care to an eligible infected person, as a result of the infection;

f) members of the family, or friends of an eligible infected person, whose relationship with them was so close that it could reasonably be expected that their mental or physical health would be seriously affected by the consequences of the disease, and who has in fact suffered a mental or physical injury as a result;

g) the estates of deceased affected persons who would, if alive, have been an eligible affected person for the compensation to which they would have been entitled during their lifetime; and

h) dependants (as defined by the Fatal Accidents Act) of deceased infected persons whose death was caused by the infection or its consequences.

### **Recommendation 6:**

I recommend that infections eligible for compensation should be classified in the following manner:

a) there should be defined categories for each type of eligible infection, and the stages through which it progresses, and for each category defined degrees of severity to which a range of possible awards for the impact of the disease can be applied;

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.

c) the range of potential awards for the impact should be determined by an independent legal expert advisory panel, to be consistent with what would be awarded in common law personal injury litigation.

### **Recommendation 7:**

I recommend that, with reference to aggravated and exemplary damages:

a) the scheme should allow, as part of the autonomy award, for eligible infected persons an award equivalent to aggravated damages for the aggravated distress caused by interferences in their autonomy and private life such as lack of informed consent, information about the risks of treatment, and about diagnosis, treatment and testing; and

b) the issue of exemplary damages be reviewed in the light of the findings of the Inquiry.

## Recommendation 8:

I recommend that the following available heads of award should be available to eligible infected persons, recognising that while guided by them, compensation will need in some instances to be of broader scope than permitted by the principles of common law, to recognise the particular social and psychosocial impacts relevant to the relevant infections:

- a) an **injury impact award** for past and future physical and mental injury caused by the infection and its consequences injury;
- b) a **social impact award** for past and future social consequence of the infection including stigma and social isolation;
- c) a **care award** for the past and future care needs of the eligible infected person;
- d) an **autonomy award** as additional redress for the distress and suffering caused by the impact of the disease, including interference with family and private life, including where relevant: loss of marriage/partnership prospects, loss of chance to have children, personal autonomy, the right to informed consent and candour from healthcare professionals and providers; and
- e) a **financial loss award** for past and future financial losses incurred by the eligible infected person because of the infection.

## Recommendation 9:

I recommend that the following heads of award should be available for eligible affected persons, recognising that while guided by them, compensation will need in some instances to be of broader scope than permitted by the principles of common law, to recognise the particular social and psychosocial impacts relevant to the relevant infections:

- a) an **injury impact award** for past and future physical and mental injury caused by their experience of the effect of the infection on the relevant eligible infected person;
- b) a **social impact award** for the adverse social consequences of being associated with the eligible infected person;
- c) a **family care award**, available where a Care Award is not made to the eligible infected person directly, for care provided free of charge to the infected person or likely to be provided by them in the future;
- d) an **autonomy award** for interference with family and private life;
- e) a **bereavement award** to the eligible affected persons in categories a) to c) above (recommendation 5, above) in the event of the death of the relevant eligible infected person by reason of the disease; and

e) a **bereavement financial loss award** to the eligible affected persons in categories a) to c) above (recommendation 5, above) in the event of the death of the relevant eligible infected person by reason of the disease, for the loss of financial benefits they would have enjoyed but for the death.

### **Recommendation 10:**

I recommend that the Government should set out a framework of tariff based compensation for eligible infected and affected persons, at rates which broadly reflect comparable rates of common law damages and other UK compensation schemes, and in addition allowing an assessed basis for defined financial losses. The factors described in this report should inform the matters for which compensation is awarded. The rates of compensation should be based on the advice of the independent clinical and legal panels.

### **Recommendation 11:**

I recommend that, with reference to the status of awards:

- a) eligible infected and affected persons should not be required to accept the offer of an award in full and final settlement of any right to pursue legal actions related to the infection;
- b) any accepted scheme award should be set off against any entitlement to damages for the same subject matter;
- c) the availability of an award under the scheme should be a factor to which the court could have regard when determining liability for costs in any court proceedings related to the infection.

### **Recommendation 12:**

I recommend that, with regard to the type of award made:

- a) all awards should be final;
- b) at the option of the eligible person, awards be made in a lump sum, or, in respect of awards for continuing future losses, by way of guaranteed periodical payments uplifted annually for inflation for life, or the predicted period of the loss, if earlier.

### **Recommendation 13:**

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.

### **Recommendation 14:**

I recommend that the Government should immediately consider offering a standard figure by way of substantial interim payments, on account of awards likely to be made under the scheme, to infected persons currently in receipt of support under any support scheme. The figure offered should represent broadly the minimum amount an infected person could be expected to receive by way of a final award.

### **Recommendation 15:**

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;
- d) such deductions as would be made from damages under the Social Security (Recovery of Benefits) Act 1997, but no other, should be made in respect of equivalent awards under the scheme;
- e) awards of financial loss should be made net of tax, but the awards themselves should not be liable to taxation, and should be regarded for tax purposes as if they were support payments;
- f) any lump sum award under the scheme should be made exempt from inheritance tax by an equivalent addition to the inheritance tax free allowance of the recipient.

### **Recommendation 16:**

I recommend that an Arms Length Body (ALB) should be set up to administer the compensation scheme, with guaranteed independence of judgement and accountable directly to Parliament for the expenditure of public funds and the fulfilment of its terms of reference, and with a procedure in accordance with the principles set out in this report and in particular which:

- a) have regard to the need of applicants for simplicity of process, accessibility, involvement, proactive support, fairness and efficiency;
- b) create a review and independent, preferably judicially led, appeal process;
- c) involve potentially eligible persons and their representatives in the review and improvement of the scheme, for example, by way of an advisory forum;
- d) has access to the records held by or on behalf of any previous publicly funded support scheme.

### **Recommendation 17:**

I recommend that the scheme should include provision of the following support services:

- a) an advice and advocacy service, supplemented where necessary by discretionary access to independent legal advice and representation, to assist and advise applicants;
- b) a financial advice and support service to assist recipient in the management of awards and in accessing financial services; and
- c) facilitation of access to appropriate health, care and counselling services.

### **Recommendation 18:**

I recommend that the compensation scheme should be delivered locally within each devolved nation. Consideration should be given by the UK and devolved governments to entering an agreement under which either a partnership board is created to oversee the compensation scheme's ALB, into which the administration of the local support schemes be merged, or the ALB commissions or delegates the local administration of the compensation scheme to the devolved support schemes.

**Recommendation 19:**

I recommend that the proposals for the design and administration of the Scheme, contained within this report, should be reviewed by the Government in the light of the findings and recommendations of the Inquiry, and thereafter, on a periodic basis and reported on to Parliament.

## Rationale for Compensation

### Term of Reference:

To consider the rationale for compensation as a matter of general principle and in relation to any particular classes of compensation, recognising that it is not for the Study to pre-empt the determination by the Infected Blood Inquiry as to what, if any, rationale is supported by the evidence it has received.

## Rationale for Compensation

### Definition of Compensation

**4.1** What does the term 'compensation' mean? When participants in our meetings were asked, few were able to describe clearly what their concept of compensation was. Therefore, it may be helpful to set out the way in which it is intended to use the term in this report.

**4.2** To start with, for the common use of the word, we can refer to an online dictionary definition:<sup>1</sup>

*“something, typically money, awarded to someone in recognition of loss, suffering, or injury”*

**4.3** Other dictionary definitions include:<sup>2</sup>

*“money that is paid to someone in exchange for something that has been lost or damaged or for some problem:*

*something that makes you feel better when you have suffered something bad*

*the act or process of making amends for something”*

**4.4** A number of features should be noted - compensation:

- Is not limited to an award of money;
- Involves a process;
- Recognises that a person has suffered from an injury or loss;
- Is intended to redress that injury or loss.

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<sup>1</sup> Oxford Languages:

<https://www.google.com/search?client=safari&rls=en&q=meaning+of+compensation&ie=UTF-8&oe=UTF-8>.

<sup>2</sup> Cambridge Dictionary: <https://dictionary.cambridge.org/dictionary/english/compensation>.

**4.5** It is not a necessary feature of compensation that a wrongful or unlawful act has been committed or that any person or organisation is at fault or legally liable to give redress, although obviously liability in that sense may be a feature.

**4.6** For the purpose of this study, I shall adopt the following definition:

*“An award of money or some other remedy to persons who have suffered injury or loss directly or indirectly from infected blood or blood products found to be eligible for such an award to provide them with redress for and recognition of the adverse experience they have suffered.”*

### **A Moral Case?**

*“I cannot imagine what it was like to be diagnosed with HIV at the start of the AIDS crisis aged just 12 years old. To spend several years with no one to talk to about it, while watching on TV and in the media the unfolding horror story of this new virus that the wisdom of the time thought to be a death sentence. To be strong-armed into signing away a right to take legal action for next to no money by your own government. To eventually find a group of 17 young men all in the same position and watch every one of them die and to live with the guilt of being the only one today who has survived. To have spent decades hiding from most people that you were living with HIV because the stigma still feels so great. To know that your government is hiding the truth from you about why you contracted HIV and then after four decades to watch an inquiry prove that it could all have been avoided.”*

**Terrence Higgins Trust CEO, Ian Green**

**4.7** While the above quote referred to HIV infection from medical treatment intended to be beneficial and its terrible consequences, much the same could be said for HCV infection in similar circumstances. At first sight, it might seem obvious that anyone who has been infected by administration of a contaminated treatment provided by the National Health Service should be entitled to compensation. Indeed, the Terms of Reference, while asking me to consider the rationale, more or less assume that the infected and affected should be compensated. However, even if that assumption is accepted, the reasons why there should be compensation will inform the nature of the scheme that is created and the range of recipients, injuries or losses which should qualify for compensation.

**4.8** The Archer Inquiry, while emphasising that they were not purporting to make findings on culpability, made it clear that there was a strong case for compensation:

*“... we are impressed by the arguments which have been presented to us for more generous assistance to mitigate the financial hardship endured by many victims ...*

*... we believe that in this situation legal argument addresses the wrong questions... First it focuses on marginal issues, such as whether proceedings are barred by the limitation Act 1980, or whether the claimants have in some way renounced their right to bring proceedings. Secondly the outcome is often decided by such chances as whether proper records were kept and are still available, or whether a vital witness is still alive. And thirdly it often fails to address the real issue, namely of human need.*

*The purpose of the civil law is not to punish negligence or wrongdoing, but to compensate for undeserved suffering...*

*We believe that the real foundation of the case for Government action is that a Government has a duty to ensure to all its citizens, so far as possible, a reasonable life, free from the “five giants” expressed in the Beveridge report, in 1942, one of which was poverty....*

*The very purpose of Government is to protect its citizens, so far as possible from life’s vicissitudes, and to afford the best achievable quality of life. It is not in the position of a citizen who may, if he chooses, remain indifferent to the misfortunes of a neighbour in which he had no hand...<sup>3</sup>*

**4.9** Lord Archer was emphasising that a Government’s responsibility to its citizens did not begin and end with its legal liabilities. The report quoted with approval a speech by the distinguished House of Lords judge, Lord Ackner in which he said:

*“... how does the [minister] differentiate between this case and the extensive compensation paid for victims of crime? There is no obligation on the government to provide a penny piece for victims of crime, but in the past... many millions of pounds are provided for victims of crime, why is there is a difference between them and the haemophiliacs whom we are discussing?”<sup>4</sup>*

**4.10** The All Party Parliamentary Group (APPG) on Haemophilia and Contaminated Blood in its 2015 report<sup>5</sup> described the reason for the then current ‘patchwork’ of support as follows:

*“Infection with one, or both of these viruses has had a devastating effect on the people infected, not to mention their families, who have often had to invest heavily in their care, many of them unable to return to work in the modern-day labour market upon the deaths of their partners. That is why successive Governments, in response to lobbying efforts by campaigners, have gradually expanded a patchwork of support to help meet their needs.”*

**4.11** The APPG was clear that this did not meet the needs of the infected and affected:

*“Despite the gradual expansion of support under numerous Governments, those affected by the tragedy are still deeply unhappy with the support they receive from these “five trusts”, as they are known throughout this report. Many of these people are now growing older, and a great deal have sadly already passed away. Those who remain want desperately to see a full and final settlement reached which will at last achieve closure and allow them to live the rest of their lives in dignity.”<sup>6</sup>*

**4.12** They set out some “striking issues” with the then current arrangements:

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<sup>3</sup> Archer *Independent Public Inquiry Report on NHS Supplied Contaminated Blood and Blood Products*, (2009) pages 90 and following.

<sup>4</sup> Ibid page 92-93.

<sup>5</sup> *Inquiry into the current support for those affected by the contaminated blood scandal in the UK*, (January 2015) APPG on Haemophilia and Contaminated Blood.

<sup>6</sup> Ibid page 9.

- Many beneficiaries were in poverty, in particular the spouses of deceased HCV infected persons, those with chronic HCV, and the dependents of HCV stage 2 sufferers.
- The processes by which support had to be applied for and awarded amount were “*demeaning and onerous, and some have been reduced to tears because of it*”.
- Many had been left unaware of their entitlements.
- There had never been a “*comprehensive and holistic assessment of the precise level of payments and resources necessary to sufficiently provide for those affected*”<sup>7</sup>.

**4.13** The APPG expressed the hope that changes would be made which would:

- Provide HCV infected widows/widowers with the same support as those of HIC infectees.
- That payments would go beyond “*a rudimentary measure of poverty... instead accounting for both the additional costs of living with [HCV, HIV or haemophilia], and providing sufficient recompense to live a comfortable life, rather than one just above the poverty line.*”<sup>8</sup>

**4.14** The perceived need for a compensation scheme must be seen against the background of the ‘support’ schemes set up for the benefit of this group in the past or which are continuing today. It is of interest that in the various meetings with individual recipients of support from these schemes, and with representatives of the various groups of infected and affected, no coherent consensus view was offered on what ‘support’ or ‘compensation’ was for, what the difference between the two was, or the reasons why either should be made available. There was, however, a clear view that compensation was different from support, and that justice or recognition of what had been suffered required compensation as well as support.

**4.15** While there is a common recognition among the infected and affected that they should be compensated, there is rather less clarity about the reasons why this group should be dealt with differently from others who have suffered injury arising out of medical treatment.

**4.16** In order to establish whether there is such a rationale, and if so, what it should be in this case, I have considered the expressed views of relevant ministers, some judicial pronouncements, the expressed objectives and approach of the support schemes and the views of the infected and affected themselves. However, we need to start with our understanding of the term ‘compensation’.

## Ministerial Thinking

**4.17** The evidence to the Inquiry of Lord Clarke of Nottingham, former Secretary of State for Health, was not welcomed by many of the infected and affected who took part in our meetings, but he did offer important insight into Government thinking around the issue of support and compensation while he was the accountable Minister. He suggested that the Government’s thinking in 1989 was based on a pragmatic expression of the understandable public sympathy for this particular group by treating them as a special case, while balancing the perceived need to do

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<sup>7</sup> Ibid page 10.

<sup>8</sup> Ibid page 11.

so against other demands on the public purse and the risks of creating a precedent. He said that a “key consideration” in increasing support funding in 1989 would have been (emphasis supplied):

*“the scale of the average payment; we were looking for figures that would make a difference. We would have discussed what seemed a reasonable sum and balanced that against how much could reasonably be taken out of the Department’s other commitments.”*<sup>9</sup>

*“Looking back, it seems the amounts offered were the best solution available. **There was no mathematical calculation or objective needs assessment; it was an exercise of a broad judgement** in which the overall sum of £24,000 per family seemed to be a reasonable outcome, having regard to the size of the funds that would have to be made available by the Department. **We shared the widespread public sympathy for the victims of this terrible tragedy and wanted to do what was possible.**”*<sup>10</sup>

**4.18** He regarded the £20 million as “a palliative”<sup>11</sup>, although he claimed this was difficult to find within existing resources and there was a risk of setting a precedent:

*“Such exercises were always difficult, not only because funds were finite but also because of the potential for similar claims be made by other patients on the grounds that they, too, had suffered after receiving licensed treatments (my letter to the PM mentioned Copper 7 inter-uterine devices and benzodiazepines as “waiting in the wings”; that was in the context of litigation, but the same parallels could also be drawn with respect to making ex-gratia funding available).”*<sup>12</sup>

**4.19** At the time, the likely cost of settling the litigation was estimated at £86 million or more<sup>13</sup>. Therefore, it was perceived that any acceptance of moral, let alone legal, liability should be avoided. A minute of a meeting between the then Mr Clarke, the Prime Minister Mrs Thatcher and the Chief Secretary to Treasury recorded that it was (emphasis supplied):

*“desirable, as well as avoiding any acceptance of legal liability, to avoid conceding any moral obligation. Rather **the emphasis should be on the special circumstances of this particular case - although distinguishing the position of the haemophiliacs from other difficult cases like vaccine damage was not easy.** It was also reasonable to point out that, without the treatment they were given with the blood products, many of the haemophiliacs would have died...”*<sup>14</sup>

**4.20** In the end the decision was a political one. For example, it was agreed that these payments should be disregarded for purposes of social security and legal aid eligibility because it was thought that to do otherwise would be politically unacceptable<sup>15</sup>. However, Lord Clarke also recognised that, while distinctions were difficult, there was a need to alleviate this group’s suffering and hardship:

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<sup>9</sup> Kenneth Clarke, 2<sup>nd</sup> witness statement WITN0758012 §31.1.

<sup>10</sup> *Ibid* §32.2.

<sup>11</sup> *Ibid* §31.3.

<sup>12</sup> *Ibid* §32.3.

<sup>13</sup> *Ibid* §31.2.

<sup>14</sup> *Ibid* §31.11-12.

<sup>15</sup> *Ibid* §32.4-5 quoting from the same minute.

*"It seems to me that they [the support payments] were a reasonable means of responding to and alleviating suffering and hardship. The sum of £20,000 represents a little more than £44,000, in today's money, which is a substantial sum. It was coupled with (i) the continuing ability of the Macfarlane Trust to make payments on the basis of need; and (ii) social security assistance. It has to be set against the background of the constraints on public funds and that there were many groups of people who suffered terrible diseases without being able to claim additional support from the State - including other sufferers from AIDS. The argument had been that the payments to haemophiliacs could be 'ring-fenced' on the basis that haemophiliacs were already disadvantaged because of their illness [WITN0758057]; but clearly this was difficult terrain."*<sup>16</sup>

*"To the best of my memory, we knew that the litigation was unlikely to be ended by the increased payment to the Trust. As for other countries' provision, the documents referring to this show that the suggested payment of £20,000 was broadly in line with the "better European schemes", even if Canada was expected to announce the payment of £60,000 over four years as an out of court settlement of litigation. **Essentially, we tried to find a sum that, viewed overall, was reasonable and offered real assistance, taking into account all the arguments.** I do not think that I can break the elements down any further ... **we had the responsibility of looking at the whole picture, balancing all the demands on public finances whilst trying to recognise the needs of those for whom we all had the greatest of sympathies**"*<sup>17</sup>

**4.21** During Lord Clarke's term of office, he received advice from the Chief Medical Officer, Dr Acheson who expressed the hope that government could find a way to make an *ex gratia* payment (emphasis added):

*"I hope Secretary of State [sic] will take account of my view that the problem of HIV infection in haemophiliacs can in fact be regarded as a unique catastrophe. **The key feature ... is that HIV infection in addition to almost inevitably causing a very unpleasant progressive illness and death results in a substantial proportion of cases in infection of the female sexual partner and also on average one quarter of the subsequently conceived children. In both wife and children the infection will also prove fatal.**"*<sup>18</sup>

*"... the tragedy goes beyond anything which has ever been described as a result of a therapeutic accident and is very likely indeed never to occur again.*

*I hope therefore, that for humanitarian reasons the Government will find some way to make an *ex gratia* settlement to the infected haemophiliacs in relation to this unique tragedy. I cannot personally see how this could be regarded as implying any responsibility for other accidents such as benzodiazepine dependence, cerebral palsy following obstetric misadventure, etc."*

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<sup>16</sup> Ibid §43.2.

<sup>17</sup> Ibid §43.4-5.

<sup>18</sup> 20/7/89 note to Kenneth Clarke and Virginia Bottomley Minister of State: Lord Clarke witness statement 2 §48.2 [the original minute is at HS000017025\_004].

**4.22** Mr Clarke gave evidence of his reaction to this note<sup>19</sup>:

*“I agreed broadly with the points he was making about the strength of the humanitarian needs and I shared the desire to help victims if we could. But I did also have to remember all the other worthwhile claims for health expenditure, and my overall responsibility for public funds. Furthermore, I doubt that others who were pressing parallels with other claims or categories of medical accidents would have accepted the distinction he was trying to draw, between the haemophiliacs and such other cases.”*

**4.23** It is worth noting that the Regional Medical Officers recorded their view at about the same time in similarly robust terms that a generous settlement was justified (as quoted in the same transcript):

*“accepting that the treatment given was in good faith, and that before this treatment was available the life expectancy of the haemophiliacs was greatly reduced. **Nevertheless, RMOs do not believe that given the appalling human tragedy visited upon the haemophiliacs, this excuses the Government from making a generous settlement ...”***

**4.24** More recently, in 2012 Ann Milton, the then Minister of State for Health, linked the changes made in 2011 closely to the particular impact of the infection on this group. She stated in Parliament:

*“When people were infected with hepatitis C and HIV, it also had a significant effect on their families. **We often forget that such issues have a massive ripple effect, not just on immediate family but on distant family.** In January 2011 the Secretary of State announced that we would provide additional support, not just for haemophilia patients, but for anyone infected with HIV or hepatitis C by NHS blood transfusion ... The support will also make £300,000 available over three years for counselling services ... The combination of fixed and discretionary payments provides flexibility to enable them to be tailored to meet individual personal needs.”<sup>20</sup>*

**4.25** In 2015, following the publication of the Penrose Report<sup>21</sup>, the then Prime Minister, David Cameron, made a statement of apology in the House of Commons (emphasis supplied):

*“I know that many Members on all sides of this House have raised the question of infected blood, and I have spoken about how constituents have been to my surgeries. While it will be for the next Government to take account of these findings, **it is right that we use this moment to recognise the pain and the suffering experienced by people as a result of this tragedy. It is difficult to imagine the feelings of unfairness that people must feel at being infected with something like hepatitis C or HIV as a result of a totally unrelated treatment within the NHS.** To each and every one of those people, I would like to say sorry on behalf of the Government for something that should not have happened.*

***No amount of money can ever fully make up for what did happen, but it is vital that we move as soon as possible to improve the way that payments are made***

<sup>19</sup> Lord Clarke witness statement 2 §48.10d.

<sup>20</sup> 8/2/2012 Hansard Col 132.

<sup>21</sup> The Penrose inquiry - Final Report, (March 2015) SG/2015/15.

**to those infected by this blood. I can confirm today that the Government will provide up to £25 million in 2015-16 to support any transitional arrangements to a better payments system. I commit that, if I am Prime Minister in May, we will respond to the findings of this report as a matter of priority.**<sup>22</sup>

**4.26** It is clear that the Prime Minister was linking the Government's action in providing additional funding for support of victims to an acceptance that they were suffering from "something that should not have happened." While that is not the same as an acceptance of legal liability, it may be read as an acceptance that at least in moral terms the infected had been wronged.

**4.27** More recently, Mr Matt Hancock, the then Secretary of State for Health, came close in his evidence to the Inquiry to a governmental acceptance of responsibility for the particularly horrific consequences of the administration of infected blood and blood product and the need to provide appropriate redress for this (emphasis supplied):

*"I did have this sense, and I have it today, and this guides my actions as Secretary of State, that many people felt and I'm sure many people still feel, that **the Government needs to ... make sure ... that those of us in positions of responsibility ensure that all past actions and decisions in this area are scrutinised and perhaps, even more than that, that we acknowledge ... I acknowledge - the pain and the suffering not only of the initial - the errors that led to this harm on people's lives but also a sense that redress wasn't properly considered and that people felt their voices weren't heard.***

*I want to make sure those voices are heard and so, ... I was determined that the direction and the work of the Department would be to be fully transparent, open, ensure that all the history could be accessed and, crucially, that **we should try to reach a fair support scheme for the future and I hope that we can do that...***

*... **It is hard to imagine the consequence of that especially because so many people had their lives cut short or ruined by something completely outside of their control when, you know, they were given a medical procedure, perhaps a transfusion, all sorts of different medical procedures, that led to this enormous and terrible consequence for them.***<sup>23</sup>

**4.28** This impression is strengthened by his tentative justification for the omission of HBV from the infections for which support could be obtained in the existing schemes; he appeared to be suggesting that the HBV infection was not unavoidable in contrast to HCV:

*"... **what I would say is there is the distinction of whether an effective test was available, because effective tests are now available for - to test blood for other diseases.** And there is a regime within all medicine for when things go wrong, where there is an agreed processes [sic]. But I also understand, of course, what this situation looks and feels like from the point of somebody infected with infected blood or affected by that with hepatitis B as distinct from hepatitis C or indeed HIV."<sup>24</sup>*

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<sup>22</sup> Hansard 25 March 2015 col 1423 this:

<https://publications.parliament.uk/pa/cm201415/cmhansrd/cm150325/debtext/150325-0001.htm#15032574000004>.

<sup>23</sup> Oral evidence of Mr Hancock Transcript 21/5/21 pages 97-99.

<sup>24</sup> Ibid page 146.

**4.29** The theme of avoidability recurred in the evidence of Mr Vineall, Director of NHS Quality, Safety and Investigations at DHSC, when he justified the ‘cut-off date’ for support as September 1991, on the ground that there was “an effective test” available after that date and that this was therefore an “accurate and sensible” end point for entitlement to support<sup>25</sup>. Mr Vineall also accepted as the rationale for excluding HBV from the support scheme was that there was effective testing for it from 1972 and therefore it followed that:

***“... the rationale for making payments to those infected with hepatitis C or HIV is an acceptance that the regimes in place to protect patients from those viruses was not effective prior to September 1991.”***<sup>26</sup>

**4.30** Mr Hancock, referring to the announcement of this Study, said:

*“... it is very important that we have a proper process around coming to a fair and just way of ensuring that people are supported.”*<sup>27</sup>

**4.31** The perceived connection between the particular suffering of this group and the need for better redress was amplified by the evidence of Mr William Vineall, setting out his impression of the position at a ministerial meeting 2019:

*“I took three things away from that first meeting, which was there was a lot of suffering and hardship that was evident, first of all; people wanted more recognition than they were getting; and, thirdly, which we will probably come on to later, we needed to do things as quickly as we could, because it was a group of people who were growing older.”*<sup>28</sup>

**4.32** However, as Mr Vineall accepted, there had never been a full scale needs assessment for this group<sup>29</sup>. EIBSS payments, for example, were set by reference to an inflation index applied to the payment structure inherited from the Alliance House schemes, and a drive towards parity between the devolved nations<sup>30</sup>. There had been no payments for past losses, which Mr Hancock explained as being due to the previous schemes being for ‘support’ not ‘compensation’<sup>31</sup>.

**4.33** A similar point was made by Mr Hancock in justification of the limitation of payments to the bereaved to spouses and partners, and not extending them to the wider family:

*“... this is a support scheme for redress of financial hardship as a consequence of this tragedy, as opposed to a compensation scheme to compensate those who have suffered a wider injustice and loss.”*<sup>32</sup>

**4.34** Clearly Mr Hancock would regard a compensation scheme as being a means of redress for ‘injustice’ and to have a wider scope than support, which focussed more on hardship. With regard to what he meant by ‘injustice’, in his concluding remarks he referred to this as:

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<sup>25</sup> Ibid pages 147-148.

<sup>26</sup> Ibid pages 196-197.

<sup>27</sup> Ibid page 125.

<sup>28</sup> Oral evidence of Mr Vineall Transcript 21/5/21 page 102-103.

<sup>29</sup> Ibid page 123.

<sup>30</sup> Ibid page 122-124.

<sup>31</sup> Ibid page 126.

<sup>32</sup> Ibid page 149.

*“a tragedy which should never have happened.”*<sup>33</sup>

**4.35** On the point of the scope of compensation, it will be a matter for Sir Brian’s Inquiry to comment on its relevance more generally, but it is to be noted that the objects clause of the Macfarlane Trust deed included *“needy spouses, parents, children and other dependants...”*<sup>34</sup>

**4.36** When taxed with the *ex gratia* nature of the current schemes, and the uncertainty about the security of payments generated by that, Mr Hancock came close to a commitment that the support scheme would be maintained permanently (emphasis supplied):

*“Counsel: ... that's common, I think, to the other schemes as well, it's always been expressed as ex gratia, and that's defined in terms in EIBSS's materials as being something the Government does voluntarily. Of course, that which the Government does voluntarily can be taken away. Does the Department understand, and indeed Mr Hancock, do you understand and appreciate, the uncertainty and insecurity experienced by those who depend upon such money and the absence of a long-term assurance or commitment may significantly increase their suffering and distress and anxiety?”*

*Mr Hancock: Well, as I said in my earlier answer, that is not how I think the situation should be interpreted and I am very happy to give a commitment that, as long as I have anything to do with it, it won't be. And those commitments are made by Government to those affected for as long as they're needed...*

*... The best way to make it permanent is for the Secretary of State responsible to declare that it should be and will be permanent and I'm very happy to do that.”*<sup>35</sup>

**4.37** It should also be noted that Mr Hancock volunteered that if it was the outcome of the Inquiry that “substantial compensation” was required, the government would provide it<sup>36</sup>.

## Purpose of Support Schemes

**4.38** As is clear from the powerful criticism of the Alliance House support schemes by the APPG, the intention of the schemes was to lift infected and some affected out of poverty. An examination of the objects of some of the trusts involved confirms this.

### *Macfarlane Trust*

**4.39** The Macfarlane Trust was set up in 1985 with government funding to provide a degree of support for the infected and affected. The objects of the Trust were, among other things:

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<sup>33</sup> Ibid page 202.

<sup>34</sup> Ibid page 152.

<sup>35</sup> Ibid pages 132-133.

<sup>36</sup> Ibid page 191-192. The relevant question and answer read:

*“Ms Richards: ... we can go back to the terms of the Paymaster General's letter to the Chancellor in September, if you like, but do you agree with the position she expressed in that letter and with the Scottish, Northern Irish and Welsh Ministers, that it is inevitable that the Government will need to provide substantial compensation?”*

*Mr Hancock: I think that - I go further than that. I think that, should that be the outcome of this Inquiry, then we will.”*

*"to relieve those persons suffering from haemophilia who as a result of receiving infected blood products in the United Kingdom are suffering from Acquired Immune Deficiency Syndrome or are infected with human immunodeficiency virus and who are in need of assistance or the needy spouses, parents, children and other dependants of such persons and the needy spouses, parents, children or other dependants of such persons who have died".<sup>37</sup>*

**4.40** Christopher Fitzgerald, the Trust's Chair between 2007 and 2012 observed that:

*"The principle underlying the Trust's establishment by the Department of Health was to provide further assistance (lump sum "ex gratia" payments having previously been made to the infected beneficiaries of the Trust both to infected beneficiaries and those related to and/or dependent on them) but on the basis of 'need' as that term was recognized under charity law, i.e. by the Charity Commission.*

*... However, non- discretionary purposes were fundamentally incompatible with the charitable purposes of both Trusts. It was in any event the clear intention of the Response to move away, at least so far as infected individuals were concerned, from the concept of charity. MFET was therefore established as the vehicle for making such payments to those qualifying as infected beneficiaries both of the Trust and of the Eileen Trust."<sup>38</sup>*

**4.41** He explained the justification for non-discretionary payments:

*"Lord Archer's Report was widely welcomed as a vitally important step towards providing necessary support for the victims of the Infected Blood calamity in an appropriately respectful manner. The emphasis on non-discretionary support was intended, at least for the infected community, to remove the necessity for beneficiaries to establish that they were in "need" in order to qualify for discretionary support from the Trust."<sup>39</sup>*

**4.42** Therefore, Mr Fitzgerald acknowledged the desire to move away from the concept that financial support as a matter of charity, or demonstration of need, to one of entitlement. The critical view of the Macfarlane Trust expressed by the Archer inquiry are worth quoting (emphasis supplied):

*"This method of providing relief was flawed in two ways. First, to provide money on an ad hoc basis to beneficiaries who could point to specific needs **savoured strongly of poor relief**. Victims, some of whom before they were infected had enjoyed high living standards and were capable of substantial earnings, were now **required, as they saw it, to go cap-in-hand and beg for discretionary relief**. However sympathetic and sensitive the trustees, the victims felt patronised. Secondly, victims of HIV also continued to feel that there remained an element of **stigma** attached to the condition, and sometimes felt embarrassed in discussing it."<sup>40</sup>*

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<sup>37</sup> Fitzgerald WITN5261001. [NB This objects clause was amended later - see Fitzgerald ws §144-145; MACF0000015\_044 (not read or located)].

<sup>38</sup> Fitzgerald WITN5261001 §§9, 12.

<sup>39</sup> Ibid §64.

<sup>40</sup> Archer, Independent Public Inquiry Report on NHS Supplied Contaminated Blood and Blood Products (2009) page 77.

**4.43** Ms Hithersay, Director of MFT from 1997, describing the apparent reluctance of the initial trustees actually to distribute the money, expressed disagreement with their approach, arguing that the Government was responsible for the infections and therefore responsible for helping those in need as a result:

*“My view was that the fund needed to be replaceable by Government and that we should be giving more generous individual grants to patients contaminated with blood products, for specific purposes. Previously the MFT had only rarely given individual grants. However, my view was that the Government was responsible for infecting these patients and we needed to find a way to provide grants to those in need.... my view was that the money from the Government should be spent and not kept in an investment fund gaining interest. Unfortunately, my views regarding running the fund were not always supported by the Trustee Board.”<sup>41</sup>*

**4.44** Her description of the then attitude of the trustees suggested they took a somewhat more conservative approach:

*“When I initially took on the role at the MFT, I may have had the impression from the Trustee Board that they felt the regular payments that had been initially set up with the Trust should have been enough for beneficiaries except for in exceptional circumstances which is where grants were provided. They felt that beneficiaries deserved those regular payments to make their lives easier, under the impression at the time that they would not have long lives. Knowledge at the time told them this was a terminal condition and that within three or four years practically everyone would have died ... So they hoped that regular payments were large enough to make the last three or four years of their lives comfortable.”<sup>42</sup>*

#### *Haemophilia Society*

**4.45** Ms Hithersay became a Trustee of the Haemophilia Society and found a more generous attitude there, informed by trustees with lived experience of the infections:

*“When I was appointed as Trustee at The Society, I found the Board to be much more realistic and sympathetic than at the MFT. This was because the Trustees either had haemophilia themselves or had children with the condition. Therefore, they had a far greater understanding of the problems and issues faced than the majority of the MFT Trustees...”*

*The money the Society had could be spent on those with haemophilia, and their focus was not on how fast you could gain interest on the fund, as at the MFT. We gave haemophiliacs their own voice and we were campaigning for a better deal for them. Those dying had died in awful circumstances; those living, lived in poverty. Those infected were denied the ability to work and have the life that they wanted for no other reason than unknowingly receiving contaminated blood products.”<sup>43</sup>*

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<sup>41</sup> WITN3206001\_0003-4 §§9, 11.

<sup>42</sup> WITN3206002\_0061 §164.

<sup>43</sup> WITN3206001\_0007.

Eileen Trust

**4.46** An annual report of the Eileen Trust indicated the great importance put on the needs generated by infection in noting that:

*“It was agreed that the cost of living directly attributable to HIV is a considerable burden, irrespective of health or means, and this is recognised by payment on a continuous basis to anyone with HIV who requests it. The extra burden to those on lower incomes, particularly those living entirely on benefits, is also considered as justifying a graded addition to this basic payment; and the rapidly escalating costs of advancing sickness is calling for a further supplement over whatever basic or higher payment is made.”<sup>44</sup>*

**4.47** An example of this was the support given beyond school age, where education had been interrupted by the death of one or both parents from an infection:

*“[question] There are 13 children dependent on the Trust or Trust Registrants for financial assistance, a number of whom have been badly traumatised by the death of one or both parents from HIV-related illness. Trustees have agreed that where children's education has been interrupted by trauma, support from the Trust may continue until completion of further education, though this may be delayed beyond the normal expected age of graduation. So do we understand from these documents that the Trust policy was for a child who had lost either one or both of their parents, they could be provided with support beyond the usual age of graduation, if that was appropriate?”*

*[answer]. Yes, exactly.”<sup>45</sup>*

## Litigation

**4.48** The litigation brought by the infected has been on the basis of allegations of either legal liability under product liability legislation, breach of statutory duty or negligence. In both cases, formidable obstacles have always stood in the way of potential claimants by way of proof of negligence or defects, causation of injury, limitation, and in some cases, the difference the infection made to an already compromised health. However, litigation has been the setting for some comments on reasons for compensation both within and outside the legal system. A theme that emerges is that this is a tragedy for which conventional litigation is really ill equipped to provide an effective remedy.

**4.49** Mr Justice Ognall, a highly experienced judge in personal injury cases, while presiding over coordinated litigation relating to HIV from infected blood brought by hundreds of plaintiffs, in June 1990, took the exceptional step of writing to the parties an open letter eloquently urging settlement in terms which resonate today when considering the rationale for compensation. He said:

*“But when all those factors are taken into account, [and he has talked there about legal issues and legal uncertainty], it seems to me that for a number of reasons, it is*

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<sup>44</sup> DHSC0002779, p2 (as read in Phipps evidence transcript 12/3/21 p20-21).

<sup>45</sup> Phipps Transcript 12/3/21, p37.

*not an abuse of language to describe these actions as unique in their surrounding circumstances. I hope that I will be allowed to identify some of those circumstances.*

*A government which takes upon itself the role of public provider of medical advice and clinical services is in a very different position to any commercial organisation. It is clearly arguable that their duty to innocent citizens who suffer injury under the aegis of such treatment has a moral dimension to it which should distinguish their assessment of their position from that criteria to be adopted by other defendants of a corporate character. Government owes a duty under this to its shareholders or insurers. It should also mean that the public may be entitled to expect from government an appraisal of their position which is not confined solely to legal principles to be found in the law of negligence, or problems of proof.*

*... The plight of the plaintiffs - or many of them - is a special one:*

*(a) All of them suffer from or live in the shadow of a fatal condition for which there is presently no known cure. I am told that the evidence will suggest that the 'incubation' may be as long as 15 years. Meantime, I suppose, most believe that sooner or later they will succumb.*

*(b) Many have already died, and in the nature of things many more will die without knowing the outcome of this litigation. It seems to me, at least, that this factor who'd [sic] be treated as cardinally important. It also sets it apart from any other action in my own experience. At best, these plaintiffs will die uncertain as to the outcome. At worst they will die deprived of money to comfort their last days, or with the knowledge (for those with dependants) that they will bring a measure of financial security.*

*(c) With the best will in the world it may be the end of 1991 before the legal process affecting the main cause of action has been exhausted. That is two and a half years since the proceedings began - or more. It may then be necessary - in the event that plaintiffs succeed - to set 'benchmarks' with quantum, again no doubt with appeals.*

*(d) It is common ground that all plaintiffs are entirely blameless.*

*...*

*It is in these circumstances that I have thought it proper that the advisors to all parties should be invited to convey to their respective clients these observations. It might be said that I have raised considerations of a political rather than a purely legal character. I acknowledge that. But I believe that the legal profession has a duty to do its best to see that the legal system does not become a scapegoat in the eyes of the public for what I fear may be perceived as the unjust and inhumane denial of any significant measure of compensation to the plaintiffs. 'The law must take its course' is not an attractive principle.<sup>46</sup>*

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<sup>46</sup> Oral evidence of Lord Kenneth Clarke Transcript 28/7/21, page 205-208. Some context relating to the litigation can be gleaned from an appeal judgment relating to disclosure, *Re HIV Haemophilic Litigation*, Court of Appeal (Civil Division), [1990] 9 WLUK 61, 20 Sep 1990.

*AA and others v National Blood Authority*

**4.50** Apart from the general statements, which may point to several rationales for compensation, there is a more legal basis which may be advanced in respect of some, at least, of the cases which have concerned the Inquiry. Liability for damages was established for at least some cases in *AA v National Blood Authority and others*<sup>47</sup>. Mr Justice Burton considered claims for damages arising out of infection with Hepatitis C from blood and blood products from 1 March 1988. They alleged liability under the Consumer Protection Act 1987. The court considered both the issues of liability and damages. The earliest date of infection with which the court was concerned was 1 March 1988, i.e. the date on which the 1987 Act came into force. It must be emphasised that the cause of action alleged was not negligence, but statutory liability for injury caused by defective products - the use of which was in breach of the Act, as construed to accord with the European Union Product Liability Directive of 1985. The statute - or rather the Directive which was to be read into it - established liability for defective products without proof of fault. There is also a limitation period which is now likely to have expired.<sup>48</sup>

**4.51** It is unnecessary to consider the detailed and complex legal arguments in the case but the judge ruled that:

- It was not arguable that the consumer (i.e. the patient receiving the blood or blood product) had an actual expectation that it was not 100% clean or that it was likely to be infected with HCV<sup>49</sup>. Doctors and surgeons knew of the risk but did not tell patients unless asked.
- The Directive was intended to eliminate proof of fault or negligence, or that the lack of safety was avoidable. Otherwise, a substantial burden of investigation would fall on the claimant<sup>50</sup>.
- If the product carries a known risk, the producer continues to supply it at their own risk, even if the producer is unable to identify in which, if any, of their products the defect will occur<sup>51</sup>.
- Producers are protected in relation to liability for development risks, i.e. risks which are not the subject of knowledge accessible anywhere in the world. If such knowledge exists somewhere, it is no defence for the producer to claim they did not know themselves.
- The blood products relevant to the case were unsafe by virtue of the harmful characteristics they had and defective because the public at large was entitled to expect that the blood transfused into them would be free from infection:

*“They were ... defective because I am satisfied that the public at large was entitled to expect that the blood transfused to them would be free from infection. There were no warnings and no material publicity, certainly none officially initiated by or for the benefit of the Defendants, and the knowledge of the medical profession, not materially*

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<sup>47</sup> [2001] EWHC QB 446.

<sup>48</sup> See s11A Limitation Act 1980. In essence, a claimant has three years to bring a claim alleging that a defective product has caused personal injury. The three year period starts to run either from the date of the injury, or from the date when the claimant knew enough to justify bringing the claim, but the maximum period overall is 10 years from the date the product was supplied.

<sup>49</sup> Judgment §55.

<sup>50</sup> Judgment §57-58, 63, 68.

<sup>51</sup> Judgment §74.

*or at all shared with the consumer, is of no relevance. It is not material to consider whether any steps or any further steps could have been taken to avoid or palliate the risk that the blood would be infected.*<sup>52</sup>

**4.52** We understand from NHSR that there were a total of 281 claims in this litigation, of which 113 were settled with damages paid and 168 closed without such payment. It is not possible to draw any inferences from any figures involved, partly because some claims were for provisional damages, and in part because issues of causation and extent of injury will have influenced the figures and the details of this have not been made available.

**4.53** NHSR have also informed us that they have records of a number of negligence claims which have been brought against various health authorities and trusts in respect of incidents of infection with HCV occurring between 1974 and 1999. We were told there had been 116, in 30 of which no damages were made and in 86 claims a total of £1.1 million in round figures had been paid, an average of £12,790 for each case. Only two settlements were in six figures. I infer that this low level of 'success' for claimants may be attributed to the difficulties in establishing legal liability.

*CN v Secretary of State for Health [2022] EWCA Civ 86*

**4.54** In this recent case, the Court of Appeal affirmed a first instance judgment that it was not even arguably unlawful discrimination for HBV sufferers to be denied support under the EIBSS on the grounds that their circumstances were different from HCV and HIV infected. In the former case, screening had been available since 1972, whereas in the latter screening was unavailable until 1985 and 1991 respectively. The Court observed that the support scheme as it exists now was an exception to the regime of fault based liability and had been:

*“... put in place to respond to a pressing moral claim.”*<sup>53</sup>

and

*“... the Secretary of State was trying to address the major social problem created by those affected by HIV and HCV from unscreened products.”*

**4.55** The Court accepted that the Secretary of State:

*“... had to draw the line somewhere to make the cost affordable. The court cannot second guess that political judgement.”*

## **General Observations Offered to the Study**

**4.56** In the course of the Study, I have heard and read many moving stories from the infected and affected, and those that support them, many of which I have quoted and summarised in my formal response to the Terms of Reference consultation exercise, and some of which are quoted within this report, but in considering the rationale for compensation it is also worth pausing to consider some of those views now:

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<sup>52</sup> Judgment §80.

<sup>53</sup> Ibid §43.

**4.57** From a Core Participant to the Study:

*“how anyone listening to the testimony of the infected and affected, the panels of experts setting out the psychological damage, the emotional burden, stigma experienced, the pain, the suffering, the missed opportunities the ability to integrate into society without having to consider the infectious is a powerful conclusive rationale for compensation and this is just on an individual level. If we move on to the level of society and Governmental rationale for compensation, I do not believe you would find many within society who would not agree looking at the evidence provided to the Infected blood inquiry that compensation would be the very least each of the infected and affected community [should receive]. The systemic failings by the Government surrounding this tragic incident in our nation’s history has thus far been kept from the infected blood community and the general population. This intensifies the societal shame and stigma carried by each and every one of the infected Blood Community. The government has continually been liberal with the truth... in simple terms we the infected and affected [are impacted] in every way imaginable ,physiologically, emotionally, physically, opportunistically and financially...”*

**4.58** From a survivor of HIV, HCV and the threat of vCJD as to what compensation would mean to them:

*“It means that it’s been recognised that through no fault of my own I’ve been harmed by the NHS. It will give me peace of mind ...”*

**4.59** From a bereaved fiancée:

*“Fair compensation means justice at last. Aged nearly 60 and not in good health as a result of the stress of my partner’s illness, I will be able to finally afford a cleaner.”*

**4.60** From a sceptical infected person:

*“The term compensation is essentially meaningless as in my opinion we can never be compensated for what has happened since receiving infected blood products. However, we can be recompensed for the trauma, stigma, pain, suffering, lies, deceit, anger, loss of opportunity, loss of earnings, loss of self. We also need to be confident that our future needs are met compassionately, speedily, medically, comprehensively, without compromise. Our partners and dependents are looked after emotionally, financially, educationally, fully. All of the above will go some way to making right the countless wrongs.”*

**4.61** In considering these striking submissions of opinion, it is also relevant to note the Terrence Higgins Trust’s proposed principles for compensation, the first of which is:

*“Compensation must reflect the extremely poor treatment of the infected blood community. It must take account of the damage done not just to those infected with HIV as a result of infected blood products but also to their families. Compensation must reflect 40 years of justice delayed, the trauma of an HIV diagnosis when so little was known about the virus, the impact this had on life chances of those infected and their families, and the stigma of living with the virus still after four decades.”*

**4.62** I have heard similar complaints about HCV.

**4.63** And the much earlier comments of the Archer Inquiry:

*“The shattering effects of contracting Hepatitis or HIV are frequently exacerbated by the consequential loss of earning capacity and pension rights, and the increased expenses of everyday living. The patient may require additional heating, a special diet, and assistance with transport. Health, travel and life insurance may be refused, or offered only at enhanced premiums. There may be consequent inability to meet existing commitments, such as mortgages. Patients are often unable to share household chores, and there may be a need for domestic help. Nor are the consequences confined to the patient. They may extend throughout the family.”<sup>54</sup>*

## Conclusions on Rationale

**4.64** Although no government has, so far as I am aware, gone so far as to accept there is a legal liability for the tragedy experienced by the infected and affected, there has been a growing acceptance of a moral case for compensating this particular group. I suggest that there is in fact a strong moral and social justification for doing so, even if this will result in them receiving redress not available to the many others who have suffered harm from the adverse consequences of medical treatment where negligence has not been demonstrated. In short, there are in my view compelling arguments for treating this group as a special case.

**4.65** This case is independent of whatever findings the Inquiry may make with regard to the culpability of professionals, organisations or the Government, in either permitting the administration of tainted blood or blood products, or in the care offered to the sufferers afterwards. Indeed, it might be suggested that the perceived need to protect public money through defending allegations of legal liability has distracted from the overwhelming case this group has for special treatment.

**4.66** Firstly, leaving aside whether or when any responsible person or organisation knew or ought to have known that blood or blood products were at risk of transmitting infection, I do not consider it is prejudging the outcome of the Inquiry to suggest that for most if not all of those infected, this could, with hindsight, have been avoided, either by offering alternative safer treatments, or more rigorous screening of donors and/or of the blood or blood products before their use. All recipients of blood or blood products could, with hindsight, have been better informed of the risks and the choices available to them. To the extent that this is correct, and where avoidable harm has been caused by a public service, albeit unintentionally, there is a moral case that those who are injured should receive redress.

**4.67** Secondly, the harm suffered by the infected, certainly those infected with HCV and/or HIV, has ruined their lives. In addition to the devastating physical and psychological injuries suffered by many, even those who have been more fortunate have had to live with the fear of worse to come. Many have lived their lives in fear of premature death - and an unpleasant one at that. Most have suffered serious social effects from the stigma generated by these diseases. Most observers are likely to agree that this group have suffered exceptionally appalling injuries, all from treatment provided by the state which they justifiably believed would be safe.

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<sup>54</sup> Archer, *Independent Public Inquiry Report on NHS Supplied Contaminated Blood and Blood Products*, 2009 chapter 9.

**4.68** Thirdly, the injuries caused by these infections are lifelong. Even now, when much improved treatments are available, those themselves come with distressing side effects. There is the fear that the beneficial effects may wear off. Therefore, these injuries come within a category of exceptional seriousness, being a condition which affects both body and mind throughout life and invading all aspects of it - social, work and family.

**4.69** Fourthly, whether by accident or design, many if not all of the infected have suffered over many years from a lack of reliable, comprehensible and consistent information about their initial treatment, its consequences and what can or has been done to mitigate them. While no doubt the inquiry will have a view on the extent to which any of this amounted to a lack of informed consent, or an unwarranted interference with family life, it is clear even from the limited contact I have had with the infected that many sincerely believe they have not been in control of what has happened to their own bodies or indeed their own destinies. This in itself singles out this group from most of those who suffer iatrogenic<sup>55</sup> injury.

**4.70** Fifthly, they have endured a rollercoaster of raised and then dashed expectations with regard to support and recognition of their plight. Many have had to spend their lives fighting for that recognition, either for themselves or members of their families. That struggle has included the effort necessary for many to obtain the treatment and care they have needed.

**4.71** Sixthly, it is clear from even a brief examination of such litigation as there has been, that the conventional avenues to obtain legal redress are unable to satisfy the needs of this group for justice and recompense.

**4.72** Finally, there has now been a long period of time during which the State has in various forms recognised that this group are worthy of support over and above that generally available to injured or disabled persons, and has, stage by stage, recognised that what has been offered previously has been insufficient to meet their legitimate needs and expectations.

**4.73** In a civilised and humane society, it has been a natural reaction and response to tragedy which has been endured by part of our society through no fault of their own, but as a result of actions of the State - or indeed where there have been natural disasters - for governments, on behalf of society as a whole, to recognise their particular needs and take action to provide a remedy and some form of redress. What form this takes will depend on the particular circumstances. Examples, some of which will be examined in some detail in this report, include the Criminal Injuries Compensation Scheme and the Windrush scandal. What is required to meet the wrong suffered is variable, in part due to the circumstances, and in part due to the perceived imperative to help the victims and restore their quality of life. While a perception or acceptance of fault on the part of the State may lie behind some of these schemes, it is not a necessary precondition for compensation to be offered. In some cases there are other imperatives.

**4.74** It is my firm conclusion that a special case is demonstrated here for compensation to be made available to the infected and to at least some of those who have been indirectly affected. I shall address the categories of those I will recommend should be eligible for compensation later in the report, but I must first consider what infections should give rise to eligibility.

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<sup>55</sup> Iatrogenic: relating to illness caused by medical examination or treatment.

## Principles

**4.75** Having considered the rationales proposed for compensation, as opposed to support, I turn to consider the principles which should underpin a compensation scheme. I received helpful submissions from many contributors, but in particular the solicitors and associations representing many of the infected and affected communities. A selection of the principles they have suggested are included in this report at Appendix 2. A good case could be made for almost everything in those lists, but this is my distillation of what is required of the scheme:

**Remedial:** The aim of a compensation scheme is, so far as can be achieved by provision of money, support and services, to provide eligible persons who have suffered injury or loss directly or indirectly from infected blood or blood, with proportionate redress for, and recognition of, the adverse experience they have suffered.

**Respect for dignity:** The scheme must restore and preserve applicants' dignity and treat them with respect and confidentiality.

**Collaborative:** The scheme should be collaborative with, and supportive of, applicants and, so far as possible, avoid an adversarial approach to claims: applicants should be believed unless the contrary is proved.

**Choice:** The scheme should respect and enhance the autonomy of applicants, including offering a choice of how remedies are delivered.

**Individualised :** Awards should reflect, in a proportionate and consistent manner, the individual circumstances and experience of applicants.

**Inclusive:** The scheme should recognise the direct impact of the infection and its consequences on the infected person, but also the indirect impact of the infection on those close to the infected person.

**Non-technical:** There should be no bar to eligibility based on technical issues, such as limitation through the passage of time since the onset of the infection and its consequences.

**Accessible:** The scheme must be as readily accessible, understandable and free of complexity and stress to all potentially eligible persons, as is reasonably possible with appropriate assistance.

**Ease of proof:** Unjust, distressing and disproportionate requirements of proof and evidence should be avoided.

**Broad:** Measures of compensation should be designed, so far as possible, so that they are easy to apply and represent broadly fair, proportionate compensation for the injury and loss suffered as a result of the infection, with due consideration of but, without being bound by, the boundaries of entitlement to damages in law.

**Improving:** No claimant for compensation should be worse off than they would be without such a scheme, and an award of compensation should not prevent the pursuit of any entitlement to bring legal proceedings for the same subject matter.

**Complementary:** The continuing payments under the existing support schemes should be continued, and made more secure regardless of any claim for, or award of, compensation.

**Holistic:** Compensation is not just about money, but should also include consideration of material means to compensate for what has been lost.

## Coverage of Compensation

**4.76** It is clear that the features which mark out the victims of infected blood and blood products apply most clearly to those who have been infected with HCV and/or HIV. Clearly, any compensation scheme must provide a remedy to those infected with either of those two diseases by use of blood or blood products. There are, however, three other infections to be considered: HBV, HDV and vCJD.

### *HBV*

**4.77** Hepatitis B is not a qualifying infection for the support schemes<sup>56</sup>, and so far as I am aware has not been included in any preceding or devolved nation's schemes.

**4.78** HBV was first identified in 1965 largely as a result of screening blood samples from multiply-transfused individuals. HBV antibody testing was introduced for blood donors in addition to surface antigen testing in 1980, and vaccination against it was introduced for special at risk groups in 1982<sup>57</sup>. In contrast, blood donor testing for HCV was not introduced until 1991. Testing of blood donations for hepatitis infections is mandatory and this has reduced the risk of an infected donation passing through the screening to a very low level, about 1.04 per million donations, or one donation every 6 months; the risk in relation to HCV is even lower: once in 90 years<sup>58</sup>. The risk of that rare infected donation actually transmitting an infection is even lower.

**4.79** The 'vast' majority of HBV infections are symptom-free and resolve spontaneously. However, 5-10% of infected adults will develop a chronic carrier state<sup>59</sup>; this can last for life. Exposure to HBV in childbirth or early childhood usually occurs without any symptoms, but 90% of that young age group will go on to develop chronic infection<sup>60</sup>. The lifetime risk of people infected in infancy is estimated at 15-40%. In older children and adults infected with HBV, there is an acute stage in which symptoms and signs occur in 30% of those infected. Where there are symptoms they can be mild, for example, nausea, loss of appetite, fatigue, and vague abdominal pain. Some suffer a skin rash, muscle aches and joint pain, also jaundice, tenderness over the liver and a rash. In HBV these may occur between 6 weeks and 6 months after exposure to the virus. They usually resolve spontaneously after one or two weeks - rarely lasting more than 2 months. Most symptomatic infection can be dealt with by GP treatment, although occasionally they may be sufficiently severe for attendance at an A & E department.

**4.80** The small minority who go on to suffer chronic HBV infection may be symptom free for many years or not experience any symptoms at all. Without treatment, however, some will develop cirrhosis of the liver and one in 20 of those will go on to develop liver cancer.

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<sup>56</sup> See the definition of infected individual in the specification for the EIBSS.

<sup>57</sup> Expert Report to the Infected Blood inquiry: Hepatitis §15.3.

<sup>58</sup> Blood and Safety and quality Regulations 2005; Expert Group Report to the inquiry: Hepatitis page 8.

<sup>59</sup> For adults who exhibit acute symptoms the risk of going on to a chronic infection is less than 5%, report page 24.

<sup>60</sup> Ibid report page 26.

**4.81** Where an HBV infected individual is coinfecting with HIV, it would appear that there is a faster progression of disease<sup>61</sup>. Likewise, the outcome appears to be more severe for those who are coinfecting with HBV, HDV and HCV<sup>62</sup>.

**4.82** There appears to be no “cure” for HBV, but it can be suppressed by treatment and thereby avoid continuing damage to the liver<sup>63</sup>.

### Conclusions on Coverage

**4.83** Of necessity, this very generalised view of the impact HBV can have is based on a reading largely of the expert evidence to the Inquiry. It was not a subject which the infected raised at our meetings, although I have been pressed in written submissions to include HBV infections as a category of eligibility.

**4.84** On the basis of the description of HBV and its effects, which I hope is a fair one, I am unable to recommend that this infection be included in a compensation scheme as a separate category, with one exception. I consider a number of factors distinguish HBV from HCV:

- Generally, the effects of HBV - while it may be a long lasting infection - are mild or even non-existent, so far as the impact on the quality of life of the infected is concerned. Compensation in such cases would be likely to be low and it is possible the costs of processing claims for it would be disproportionate.
- There is available effective treatment which is likely to suppress the disease and avoid the more serious consequences with regard to the liver.
- Many cases where there are more serious consequences are likely to be where there is HBV/HCV or HBV/HIV co-infection. In such cases, the joint impact of the multiple infection could be taken into account in assessing compensation, and it would be difficult if not impossible to separate out the causative significance of each.
- In the absence of the more serious infections it may be difficult to establish causation.

**4.85** The exception relates to the HBV sufferers who develop a chronic infection with serious symptoms who require treatment to prevent cirrhosis, or who have actually contracted cirrhosis.

**4.86** I am acutely conscious that in this area the Inquiry will have had the advantage of considering in depth far more evidence than I have had the time or ability to accomplish. Therefore, I do recommend that my conclusion be reviewed in the light of the findings of the Inquiry based on all the evidence it has heard.

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<sup>61</sup> Ibid report page 50.

<sup>62</sup> Ibid page 51.

<sup>63</sup> Ibid page 54.

## *HDV*

**4.87** Hepatitis D is not a separate category in the support schemes. It only occurs in the presence of HBV as it requires the latter to replicate<sup>64</sup>. I was unable to detect in the expert evidence any distinction relevant to compensation to differentiate it from HBV and therefore my conclusion is the same.

## *vCJD*

**4.88** NHS guidance<sup>65</sup> suggests there are only five people who are currently known to have actually contracted vCJD from blood transfusions, up from the four referred to in the latest National CJD Research and Surveillance Unit (NCJDRSU) annual report from 2020<sup>66</sup>. Three are said to have exhibited symptoms while the remaining two were only found to have the infection on post mortem after dying of other causes. Therefore, the number of cases within this category is likely to be very small indeed. There is also a separate compensation scheme specifically for those who have contracted vCJD<sup>67</sup>. In the light of that scheme, it seems unlikely that the addition of this category can be justified and indeed consideration will need to be given as to whether any award of that scheme should be taken into account in compensation under this one.

**4.89** A number of infected persons have received written warnings that there is a risk of their having contracted vCJD. However, the distress and suffering caused by being informed of the risk of contracting this disease is not compensatable under the vCJD scheme: this is a risk shared with all those who have received all relevant blood products, whether or not they have been infected with the principle infections with which my terms of reference are concerned. Therefore, I suggest that, apart from the extent to which the general concern about the risk of vCJD applies to all infected persons otherwise eligible for compensation, this disease is left out of account in this scheme.

## *Other infections*

**4.90** I note that the inquiry has heard evidence of other infections, such as Cytomegalovirus (CMV) and Epstein Barr Virus (EBV). It is possible that a moral case emerges in favour of other diseases similar to that I have suggested should be accepted in relation to HCV and HIV. I have not seen material which would justify their explicit inclusion in this scheme at this stage as separate categories of infection. That is not to say such evidence does not exist, or will not do so in future. Therefore, the recommended categories should be reviewed on the basis of the Inquiry findings and regularly thereafter in the light of developing knowledge.

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<sup>64</sup> Expert report, page 15.

<sup>65</sup> <https://www.nhs.uk/conditions/creutzfeldt-jakob-disease-cjd/prevention/>.

<sup>66</sup> <http://www.cjd.ed.ac.uk/sites/default/files/report29.pdf>.

<sup>67</sup> See the description of this scheme.

## **Recommendation 1:**

I recommend that the Government accepts that, irrespective of the findings of the Inquiry, there is a strong moral case for a publicly funded scheme to compensate both infected and affected victims of infected blood and blood products infected with HCV or HIV, and that the infections eligible for compensation be reviewed on a regular basis in the light of developing knowledge.

## Current Practice

### Existing Support Schemes

**5.1** For the purpose of this Study, it is unnecessary to set out a detailed history of the several support schemes which preceded the current versions. The experience gained through all the support is mainly relevant to the consideration of how a compensation scheme might be administered to avoid the problems said to have been encountered. A broad understanding of the current schemes is helpful in considering what if any account of support payments should be taken by a compensation scheme.

**5.2** In January 2016, the English Department of Health undertook a public consultation exercise<sup>68</sup> on reform of the then existing UK-wide infected blood support schemes, collectively known as the "Alliance House Organisations" (Macfarlane Trust; Eileen Trust; Caxton Foundation; MFET Ltd; and Skipton Fund Ltd), following criticism that the systems had become complex and confusing. The intention of the reforms was to make the system more accessible and equitable, with a focus on the welfare of the infected. A similar review was undertaken by the Scottish Government, following a commitment in response to the Penrose Inquiry, with its conclusions set out in the 2015 report by the Financial Review Group<sup>69</sup>.

**5.3** Following the outcomes of these review processes, between April and November 2017 four new support schemes were established, one for each of the devolved nations, to replace the previous Alliance House Schemes. The Scottish Infected Blood Support Scheme (SIBSS) took over for Scottish beneficiaries in April 2017. Likewise, the Wales Infected Blood Support Scheme (WIBSS) was established in October 2017; and both the England Infected Blood Support Scheme (EIBSS) and the Infected Blood Payment Scheme for Northern Ireland (IBPSNI) were operational from November 2017.

#### *Existing support*

**5.4** The existing payment schemes currently offer the following types of support:

- Infection with Hepatitis C (Stage 1 / Chronic) - one-off lump sums; annual payments;
- Infection with Hepatitis C (Stage 1 'plus' / Special Category) - annual payments;
- Infection with Hepatitis C (Stage 2 / Advanced) - one-off lump sums; annual payments;
- Infection with HIV - one-off lump sums; annual payments;
- Co-Infection with Hepatitis C (Stage 1 / Chronic) and HIV - one-off lump sums; annual payments;

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<sup>68</sup> "Infected Blood: Reform of Financial and Other Support" and "Infected Blood: Government Response to Consultation on Reform of Financial and Other Support", both Department of Health (2016).

<sup>69</sup> "Contaminated Blood: Financial Support: Conclusions and Recommendations" by the Scottish Government's Financial Review Group (2015).

- Co-Infection with Hepatitis C (Stage 1 'plus' / Special Category) and HIV - annual payments;
- Co-Infection with Hepatitis C (Stage 2 / Advanced) and HIV - one-off lump sums; annual payments;
- Bereaved partners / spouses - one-off lump sums; annual payments (either discretionary top-ups or a percentage of partner's entitlement);
- Discretionary income top-ups - usually means tested, available to some beneficiaries and/or bereaved spouses / partners;
- Discretionary one-off grants - usually means tested, available to some beneficiaries and/or bereaved spouses / partners;
- Psychological Support - mixture of referrals, discretionary grants (for support via non-NHS services) or direct Health Service psychological support;
- Cost of Living / Winter Fuel Payments - either via supplementary application or already automatically added within other support payments.

**5.5** A table showing the current (2020) payment levels for each of the above types of support is included at Appendix 4.

## Scope of Compensation

### Term of Reference:

To consider the scope of eligibility for such compensation (including the appropriateness or otherwise of any conditions such as ‘cut-off’ dates), and whether it should be extended beyond infected individuals and their partners, to include for example affected parents and children, the wider affected family (e.g. siblings), and significant non-family carers and others affected, either because of the impact of caring responsibilities or the effects of bereavement or some other impact; to include consideration of former and new partnerships/marriages; and whether the estate of any individual who has died should be eligible for compensation.

### *Current eligibility*

**6.1** The following is a summary of the eligible beneficiary categories used by the current support schemes:

- Infected - those historically infected with Hepatitis C from NHS blood or blood products or tissue prior to September 1991;
- Infected - those historically infected with HIV from NHS blood or blood products or tissue prior to October 1985 (SIBSS & IBPSNI cut-off date is 17 February 1992; WIBSS is February 1992, but acknowledges unlikely after Autumn 1985);
- Infected - those secondarily infected with Hepatitis C and/or HIV by an infected person falling into the above categories (via sexual transmission, from mother to baby or accidental needlestick injury);
- Infected - the estates of those infected in the above categories who have died;
- Affected - spouses, civil partners and long-term partners of a deceased beneficiary (who were living together at the time the beneficiary died); and
- Affected - dependent children (usually as a component to payments for one of the other categories).

### *Views of the community on eligibility*

**6.2** Below are some of the views that the infected and affected community have expressed to me on what they think should be the criteria for eligibility for compensation. There was, on the whole, a consistent view across the infected and affected community on who they thought should be eligible to claim for compensation and the general principles that should inform any eligibility process. These views boiled down to four general themes:

- That eligibility should be as wide and inclusive as possible, allowing anyone who could show they had been adversely affected by the infected blood tragedy - either directly or indirectly - the opportunity to make a claim, while at the same time recognising that any process would need to show a degree of proportionality, as the moral entitlement to redress

would become more difficult to establish the further away from the core family group you got;

- That eligibility to claim should be individual rather than collective - while the infected themselves were clearly the primary claimants (along with the estates of deceased infected, or duly authorised attorneys of those infected lacking capacity to represent themselves, standing as proxy for the individual infected), other individual affected family members and carers should be able to make separate, individualised claims for the harm and loss they specifically had suffered;
- That any eligibility criteria should avoid being unduly onerous on those making a claim, with a process that was quick and easy to implement, and avoided where possible for the majority where proof of eligibility had already been established by having been accepted into an existing support scheme;
- That any eligibility criteria, and the processes that supported them, should be as flexible, responsive and sensitive as possible, to enable the inclusion of unique and outlier circumstances and as yet unforeseen future developments within their scope, and avoided arbitrarily excluding those who could show a moral entitlement to make a claim (where the default stance was inclusion and the onus was on the scheme to prove the balance of probabilities arguments for exclusion).

## Eligibility Criteria

### Overview

**6.3** The starting point for any compensation scheme has to be the criteria for eligibility. The criteria must define the scope of entitlement for the infected and affected, and regrettably for both the living and the dead. Each of these categories are likely to have different entitlements to compensation. The criteria must define the products from which infection might have been received and any relevant time period. The criteria also need to address any evidential or procedural requirements for eligibility. So far as is practical the criteria must be easy to understand and apply, and unless there is some strong indication for a different solution, align with eligibility for the support schemes. The boundaries of the eligibility criteria suggested here must naturally be subject to the findings of the Inquiry which on the basis of the evidence received may identify any important gaps.

**6.4** What follows are my recommendations for the categories of infected and affected persons who should be eligible for compensation under the scheme. They build on the categories of eligibility for the support schemes, but go beyond the categories of affected persons currently included in those schemes. The reasons for those extensions are suggested as we come to them.

### Eligibility for Directly Infected Persons

**6.5** *Condition 1:* The applicant has been diagnosed as being infected with either or both of:

- HCV

- HIV

[the relevant diseases]

**6.6** For the reasons set out in the Rationale section, I have concluded that none of HBV, HDV, or vCJD should be separate categories of eligibility. Where a person infected with HCV or HIV also has been infected with HBV or HDV, the cumulative impact of those infections can be taken together for the purpose of assessing compensation as, generally, it would be impossible and unfair to try to distinguish between the effects of each disease. vCJD is the subject of a separate scheme in any event.

**6.7 Condition 2:** the applicant received one or more blood transfusions or blood products known to be capable of transmitting one or more of the relevant diseases. [the relevant treatment]  
It may be advisable for clarity to list in more specific detail the products recognised for the purpose.

**6.8 Condition 3:** the patient received the relevant treatment between defined dates, namely during the period when no effective screening for infection/contamination of blood or blood products was applied to blood or blood products used for the relevant treatment, or alternatively after that period using blood or blood products likely to have been collected or produced during that period. [the relevant period]

- The eligibility criteria under the EIBSS are (the other devolved schemes use the same or very similar criteria):
  - Those infected with HCV before September 1991;
  - Those infected with HIV before October 1985.
- Cogent submissions have been made to the Study that the currently used end date for eligibility does not take sufficient account of the later use of stocks which were produced during the period and retained. The Inquiry may wish to consider the evidence concerning that issue to establish whether a later cut off date should be defined for that or some other reason.
- The defined period should be that during which the administration of infected blood or blood products was avoidable, whether in the light of the knowledge of the time or retrospectively, subject to the relevant technology or science being available at the time. It is difficult to identify such a strong moral case for compensation for treatments received before, for example, HCV or HIV were known to exist.
- Consideration should be given to extending eligibility to patients who received the relevant treatment before the defined period but at a time when it was known or knowable that the blood or blood products could be infected and there were other effective infection free treatments available for the patient's condition.

**6.9 Condition 4:** The applicant's infection was likely to have been caused by the administration of a relevant treatment.

## Eligibility for Indirectly Infected Persons

**6.10** The condition to be met is that the applicant was infected by transmission of the infection from an infected person who is or would have met the conditions for eligibility for a directly infected person.

### Proof of Eligibility

**6.11** It is clear that problems have been experienced in some cases in obtaining the evidence required to meet conditions 2, 3 and 4 (above). It appears that a fairly sympathetic attitude about such problems is taken by the current support schemes but, it will be important that this approach is reinforced in any compensation scheme by explicit statements as to standards of proof and evidential expectations.

**6.12** If a standard of proof is to be imposed on applicants it should be no higher than a balance of probability, but too rigid an adherence to the legal concepts of proof risks introducing an overly adversarial approach, as opposed to a proactive search by the scheme administration for information supporting eligibility, subject of course to the consent and cooperation of the applicant.

**6.13** Entry to the compensation scheme should be made as easy as possible for all those infected persons who have been accepted as eligible for support by one of the existing or past support schemes. Assuming evidence of this can be obtained, acceptance of such persons should be automatic. If there are applicants who have been accepted as eligible by the Alliance House Organisations<sup>70</sup>, they should be supported to access the relevant personal data from the holder of the records archive<sup>71</sup>, where this is relevant. Even better, steps - if necessary by way of regulatory changes - should be taken to require the holder to disclose those records to the compensation scheme, to enable the scheme to contact potentially eligible applicants.

**6.14** For new applicants, for whom the automatic route to eligibility is not available, an empathetic and proactive approach needs to be taken to the assessment of eligibility. The following suggested practice is built on the learning obtained from the administrations of existing schemes:

- The starting point has to be a medical diagnosis of infection. This should be easy to obtain.
- It may be less easy to establish the onset of the infection, given the common absence of symptoms. In the absence of firm clinically relevant evidence of when the infection started, it is suggested that where there is evidence of a potentially causative treatment with blood or a blood product, it should be presumed that the infection occurred at that time unless it is overwhelmingly probable (i.e. beyond reasonable doubt) that the infection had some other cause - supported by at least one independent consultant medical opinion to that effect. Where there is more than one such treatment event, or a course of such treatment, the presumption should apply to the earliest administration of the treatment.
- While the history of treatment may be apparent from medical records, experience has shown that in many cases records from a relevant time are missing. Where this is the case, the recollection of the applicant or other witnesses should be considered and in

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<sup>70</sup> The MacFarlane Trust; the Eileen Trust; the Skipton Fund Ltd; the MacFarlane and Eileen Trust Ltd; and the Caxton Foundation.

<sup>71</sup> Russell-Cooke LLP.

general accepted, unless there is overwhelming evidence to contradict their recollection. In some cases an applicant may simply not know or remember whether they were given blood or a blood product. In such a case, treatment may be inferred where there are surrounding circumstances from which a clinician could reasonably infer that blood or a blood product could have been administered, and there is no persuasive evidence supporting an alternative cause for the infection.

- While the applicant should be expected to cooperate in the obtaining of relevant evidence, this task should primarily - with the applicant's consent - be for the scheme administration to carry out in a proactive, compassionate and empathetic manner. The scheme should be resourced to develop the necessary expertise in seeking out relevant records and empowered with the authority to require their production. To the extent necessary, all NHS bodies should be required to cooperate with the scheme's performance of its functions.
- Rejection of eligibility by any existing or previous support scheme should not be relied on in assessing eligibility under the compensation scheme, which should consider and collect all the available evidence afresh.
- A person should not be disqualified from eligibility by reason of the absence of symptoms during any period since the onset of the infection, although the length and severity of symptoms will be relevant to the assessment of the amount of compensation due.

### **Eligibility for Estates of Deceased Infected Persons**

**6.15** Where a person, who would have been eligible in accordance with the conditions applicable to a directly or indirectly infected person, has died, the administrators, executor, or personal representatives of a deceased person's estate may apply for an award for the personal injury and financial losses caused by the infection during the deceased person's lifetime, during the years between the onset of the infection and their death.

### **Eligibility for Affected Persons**

**6.16** There has been some variation between schemes, past and present, with regard to the range of persons eligible to apply for an award, and the levels of such awards, for the indirect impact on them of the infection (for example, in the awards available for spouses and partners of deceased infected). In part, these variations have been due to awards for the indirectly affected mostly falling within the discretionary award areas of schemes. For the existing schemes, recent parity changes have mostly redressed any variations.

**6.17** In designing a compensation scheme which is proportionate and not unduly complex, it is advisable to place some limit on the relationships with an infected person that can be considered by applications to be an affected person. This is to ensure that there is a close practical, and not just theoretical, relationship between the infected person and the potential applicant, and that the relationship is not so remote that the causal connection with the infection is likely to be questionable and where alternative causes are more likely to be significant. Further, a line has to be drawn in order to keep the numbers of potentially eligible people within a range it is reasonable to expect a scheme to be capable of managing without significantly interfering with the expectation

of expeditious resolution of cases. The example of the experience of the vCJD Trust<sup>72</sup> of one case involving the need to trace 88 potential relations of an infected person illustrates the difficulties which could arise if the categories are too widely drawn.

**6.18** It is suggested that the following should be the categories of person eligible to claim as affected persons, who are likely to be able to show the strongest moral case for compensation:

*Spouses, civil partners and long term cohabittees*

**6.19** Persons who were or are married or in a civil partnership with an eligible infected person at any time after the onset of infection (whether or not the infection was diagnosed during the marriage or partnership):

- The support schemes appear to have proceeded on the basis of recognising the existing (or if deceased, the last) spouse or partner, where it can be shown that there was a cohabiting relationship (of at least one year's duration) at the time of death. The indirect effects of the infected status could equally affect former spouses and partners, and indeed in some cases the breakdown of the relationship may be attributable to the infection and its consequences; and
- Persons who cohabited with an eligible infected person as close partners for a continuous period of at least one year after the onset of the infection:
  - It is necessary to confine this category to a relationship which has the characteristics of a marriage or civil partnership, apart from the formalities, in order to exclude people who have no such relationship but merely share accommodation. The latter may still be eligible if they are infected themselves by transmission from another infected person.

*Children*

**6.20** Children (biological or adopted [formally or informally]), of an eligible infected person or, if deceased, would have been eligible as an infected person in accordance with the above conditions.

*Parents of infected children*

**6.21** A parent (biological or by adoption [formal or informal]) of, or other person who has accepted and after the onset of the infection has acted as a parent for an eligible infected person where the infection started when the person was under the age of 18.

*Siblings of infected persons*

**6.22** A brother or sister (biological or by adoption [formal or informal]) and step-brothers and sisters of an eligible infected person, where the infection started when the sibling was under the

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<sup>72</sup> See Appendix 6(c) for more on the vCJD Trust experience.

age of 18 and lived in the same household as the infected person for a period of at least 2 years after the onset of the infection:

- The categories of parents are limited to those who have acted as a parent for an infected child and to siblings who lived in the same household as an infected child sibling, because the personal and financial impact will be likely to have a special character in such circumstances. In many such cases, the parents will have been involved in, and therefore feel responsible for, the administration of blood products or other subsequent treatment. The impact on siblings is likely to be particularly burdensome due to the stress and distress caused by their sibling's infection and the resulting lack of attention and support offered to them. Where the infection has only struck during the infected person's adulthood, these effects are likely to be reduced and be difficult to distinguish from the impact caused by any serious injury to an adult for which the common law offers no compensation. Parents and siblings of adult infected persons may still be eligible by other routes, such as where they qualify as carers or because of indirect infection, or come within the discretionary category described below.

### *Carers*

**6.23** Many of those infected will have received care and support over and above that normally expected from family members or close friends, most often without any payment and at considerable inconvenience and stress to themselves. At common law such service is compensated for in the award of damages to the injured person. That part of the damages is then held on trust by the claimant who has to make a fair allocation of the award to their carers. That approach is as attractive for a compensation scheme, as much as for court proceedings, as it reduces the number of separate claims, and transfers the responsibility for apportioning the fund between carers to the injured person. However, it may not be attractive for claimants who may wish to avoid this administrative burden and potential for intra-family disputes. It is suggested that a better course is to allow for past gratuitous care claims to be made by the providers of that care, where a care claim which includes that carer's contribution to the infected person's care is not made by the infected person. Such claims must - subject to a discretion for justifiable exceptions - be made with the main claim on behalf of the infected person, who will, in any event, be likely to want to claim for the cost of other past and future paid care, and future expected gratuitous care.

**6.24** Eligibility can be defined as follows:

- A person who has provided personal care or support to an infected person;
- The care and support provided has been over and above that which they would have been reasonably expected to provide to the infected person but for the infection and its consequences;
- The care and support provided has been without remuneration (except for reimbursement of reasonable expenses incurred in the provision of the care or support); and
- The care and support provided was reasonably necessary to mitigate the effects or consequences of the infection on the infected person.

*Others seriously affected by the consequences of the infection on the infected person*

**6.25** Rather than add an almost endless list of possible relationships to the list of those eligible, the scheme should admit to eligibility a class of claimant who can show they have been injured by the effects of the infection on the infected person. This is a difficult category, not only because of the range of people who might theoretically qualify, but because it would be possible to include eligibility for compensation for adverse consequences which would not be recognized at common law. For example, damages will not be awarded for the 'mere' distress or anxiety caused by the worry arising out of an infected person's condition, or for the lack of support received as a child from a parent whose time is taken up coping with the infected sibling. It is suggested that while it might be permissible to allow for closely related individuals to claim for this sort of impact, as it is at least arguably reasonably foreseeable, the same cannot be said for the wider family, friends and neighbours unless it can be shown that they had a close relationship with the infected person and as such could reasonably be expected to suffer from recognizable psychological injury as a result. It is suggested that this category be drawn tightly because it will stray too far beyond the bounds of what the common law would recognise as coming within the proximity required to establish a duty of care.

**6.26** Therefore it is suggested the category could be defined as follows:

- A person who is member of the family of or long term friends with an infected person;
- Has since the onset of the infection maintained a close relationship of friendship and support with the infected person, for a continuous period of at least two years; and
- The person has in fact suffered a mental or physical injury as a result of the infection or its consequences.

*Deceased affected persons*

**6.27** Where an affected person has died, a claim should be allowed to be brought on their behalf by their estate and the estate should be entitled to claim such compensation as the deceased affected person would have been entitled to claim in respect of injury, loss and damage incurred during the years between the onset of infection and their death.

*Dependants of deceased infected persons*

**6.28** In addition to the claim on behalf of a deceased infected person's estate for the compensation to which they would have been entitled during life, a claim should be allowed for what in law is called loss of dependency, where the death was caused by the infection or its consequences. The claim must be brought by the duly authorised personal representatives of the estate for the loss of all eligible dependants. The definition of 'eligible dependants' can be aligned closely to the definitions in the Fatal Accidents Act 1976. What can be claimed is discussed below, but the category of eligibility can be described as follows:

- Where an infected person dies as a result of the infection or its consequences, their personal representatives should be entitled to bring a claim on behalf of the dependents of

the deceased. The persons accepted as dependants of the deceased are, in line with the Fatal Accidents Act 1976 as amended:

- The spouse or former spouse or civil partner of a deceased eligible infected person;
- Any person who was:
  - living with a deceased eligible infected person in the same household immediately before their death; and
  - had been living with the deceased in the same household for at least two years before that date; and
  - was living during the whole of that period as the spouse or civil partner of the deceased; any parent or other ascendant of the deceased;
- any person who was treated by the deceased as their parent;
- any child or other descendant of the deceased or was at any time treated as a child of the family; or
- any person who is or is the issue of a brother, sister, uncle or aunt of the deceased.

## Recommendation 2:

I recommend that the scheme should offer redress to those infected with HCV and/or HIV, and defined serious cases of HBV [relevant diseases], and defined categories of persons indirectly affected by such infections [relevant affected persons].

## Recommendation 3:

I recommend that the conditions of eligibility for admission of relevant infected persons to the scheme should be that:

- a) they have been diagnosed as being infected with one or more of HCV, HCV, or HBV of the defined level of severity;
- b) they received one or more blood transfusions or blood products known to be capable of transmitting one or more of the relevant diseases [the relevant treatment];
- c) the patient received the relevant treatment within - or from stocks created within - the periods of eligibility employed by the current support schemes **or** a period to be defined (subject to any findings of the Inquiry with regard to such dates) during which in retrospect and without necessary attribution of culpability or negligence, in the light of the knowledge at the time or subsequently, the relevant technology or science could have been available to avoid infection/contamination of blood or blood products

and/or of transmitting such infection to patients [the relevant period], alternatively, after the relevant period using blood or blood products likely to have been collected or made during it; and

d) their infection was likely to have been caused by administration of the relevant treatment **or** they fulfil condition a) above and their infection was likely to have been transmitted to them by a person who fulfils conditions a) to c) above.

#### **Recommendation 4:**

I recommend that the scheme should, so far as possible, avoid legalistic and adversarial concepts of the burden and standard of proof: establishing eligibility under the scheme should be either:

a) automatic in the case of infected persons already accepted for eligibility under the support schemes;

or

b) a collaborative process in which:

- the applicant is sympathetically supported by the scheme in obtaining any required information and documentation;
- in general a presumption is applied that statements of fact made by an applicant are correct;
- applicants are not required to repeat information already provided to the support schemes.
- eligibility is accepted if the information available points towards eligibility and there is no strongly persuasive evidence which contraindicates eligibility.

#### **Recommendation 5:**

I recommend that the following relevant indirectly affected persons should be admitted to the scheme:

a) spouses, civil partners and long term cohabitantes (for at least one year) of living or deceased eligible infected persons;

b) children of an eligible infected person;

c) parents of eligible infected persons whose eligibility started in childhood;

d) siblings living, while under the age of 18, as a family with an eligible infected person;

e) providers of care to an eligible infected person, as a result of the infection;

f) members of the family, or friends of an eligible infected person, whose relationship with them was so close that it could reasonably be expected that their mental or physical health would be seriously affected by the consequences of the disease, and who has in fact suffered a mental or physical injury as a result;

g) the estates of deceased affected persons who would, if alive, have been an eligible affected person for the compensation to which they would have been entitled during their lifetime; and

h) dependants (as defined by the Fatal Accidents Act) of deceased infected persons whose death was caused by the infection or its consequences.

## Categories of Injury and Loss

### Term of Reference:

To consider the injuries, loss and detriments that compensation should address, in relation to the past, present and future, including: (a) the physical impact and consequences of infection/s (including the effect of any treatment, and potential future adverse effects); (b) infections that cleared naturally; and the risk of any significant or long-term side effects of treatment (such as liver damage, increased risk of cancer) even if they are yet to materialise (c) the mental health, social and financial impacts (including access to financial services) - both actual and in terms of loss of opportunities - suffered by both the infected and affected; and (d) other types of loss if appropriate.

**7.1** In order to offer meaningful compensation which reflects the actual suffering and loss of each eligible individual, it is necessary to identify the categories of injury and loss which must be assessed. Some of these categories are likely to apply to all, some only to those who have incurred the relevant loss. Some categories are likely to apply more to the infected and some more to the affected.

### *Expectations of the infected and affected community*

**7.2** From our meetings with infected and affected groups, the legal representatives and the submissions we have received, the primary areas for which they expect any compensation award to cover are:

- Pain and suffering from the physical and mental injury and damage caused by the infections, and consequent treatment, including the effect on abilities and quality of life, in particular:
  - The physical damage and continuing symptoms;
  - Lifelong fear of the risks or expectation of deterioration and death;
  - Treatment side-effects from the gruelling drug regimes (often more painful and damaging than the infection itself), including the increased risk of other terminal conditions (such as cirrhosis and cancer);
  - Mental health and psychological damage from the constant and long-term stress and trauma of living with a debilitating illness (for example: financial insecurity, survivor's guilt);
  - The distress and suffering having to live without explanation, diagnosis, recognition or support, sometimes for decades.

- Stigma (both for the infected and those in close proximity to them), including the fear of cross infection, and consequent deprivation of a normal family and social life and the distress and inconvenience of behavioural change to avoid or mitigate it.
- Grief following the loss of loved ones due to the infections in circumstances unique to the tragedy that have aggravated 'normal' grief: unauthorised postmortems and tissue retention; lack of normal funerary practises due to risk of infection; losing multiple family members);
- Loss of earnings (including pensions) and job opportunity, for the infected;
- Cost of care in time and money for the infected and those who have cared for them without remuneration;
- Reduction in ability of the infected to obtain financial services including mortgages, travel and life insurance;
- Miscellaneous expenses associated with the infection;
- Interference in the autonomy of the infected through lack of informed consent (lack of informed choice and consent in the circumstances that led to infection, and for being tested upon and having blood taken without knowledge);
- Exemplary and aggravated damages, principally as a disincentive from this happening again, but also as a proxy for the amount of time they have been made to wait for recognition and justice and for punishment for alleged cover up and destruction of records; and
- Ease of access to counselling and other support services.

## Possible Models for Compensation

### Introduction

**7.3** A central part of any compensation for the infected must be for the non-financial physical and mental impact on them of the infection, i.e. the physical and psychiatric/psychological consequences, and the associated social effects. A choice has to be made, as with all other potential heads of awards, as to how these impacts can be valued in money, when as is often said, no money can compensate for the effects of a serious injury - particularly one which in so many cases has ruined the victim's life. With regard to financial losses, a decision has to be made as to what heads of such loss should be recoverable and which are to be regarded as not sufficiently closely connected with the infection (in lawyer's language, too remote from the infection to be regarded as having been caused by it).

*A bespoke model of individual assessment*

**7.4** It would be possible to devise a schema in which an assessment was made of the impact of the infection on each infected person, using similar heads of claim, taking into account their precise and detailed history and experience, as would happen in a court process of a claim for damages, or as occurs in the Republic of Ireland's Hepatitis C and HIV Compensation Tribunal. As the experience of that Tribunal shows, to do so would require a complex gathering of evidence including medical evidence as to history, condition and prognosis, as well as financial evidence in relation to financial losses - an assessment akin to that conducted by a judge in a personal injury action in court. It is an approach which would require detailed expert evidence in support of many aspects of the claim. A consideration of what would be involved suggests this would be complex, burdensome for applicants, uncertain in outcome, and productive of disputes about detail. Such a scheme would also fail to deliver the prompt relief so many infected people appear to want. That is not to say that the option of that type of detailed assessment could not be open to those who want it, either as an alternative to a simpler and more accessible methodology, or in addition to it.

*A more standardised tariff based model*

**7.5** It is, therefore, proposed that for compensation for non-financial injury and loss, the framework should offer categories representing each type of infection (including stages of the disease) and combination of infections, and for each category, defined degrees of severity. The assessor would be required to place the case of each applicant in the appropriate classification of infection and severity. The award for the non-financial impact of the infection would be determined within the range of awards prescribed for the category and severity of infection suffered by the applicant.

**7.6** I have concluded that it is not appropriate for me to recommend figures for the various heads of damages - this is a matter which will require consultation and if possible consensus, and greater expert input than would have been practical for this Study. Most importantly, I do not have the benefits of the findings of the Inquiry on the wealth of evidence it has collected. However, I can propose a framework by which figures of general application could be arrived at and an illustration of the matrix through which such figures could be applied to individual cases. In doing so, I will put forward some figures for illustrative purposes only, which should not be taken as being more than a very provisional view of what might be appropriate. Such figures will, however, be based on a consideration of awards made in such comparable cases as I have been able to identify.

**7.7** The matrix of permissible impact awards would need to be prepared on the basis of the conclusions of two independent expert panels:

- **Medical panel:** The definition of each disease, and any relevant stages and different degrees of severity, should be determined by an independent medical expert advisory panel similar to those which have given such helpful evidence and advice to the Inquiry. In order to allow the scheme's assessors to place an application in the correct award range, the panel would be tasked with producing a consensus description of the range of pathology and symptoms recognized in each relevant infection, and the stages through which it can progress. This needs to be expressed in terms allowing both assessors and applicants to understand where in the matrix the individual case best fits.
- **Legal panel:** For each category and degree of severity, a range of possible financial awards would need to be specified on the advice of a second independent panel of legal

experts, in accordance with terms of reference requiring them to identify a range of awards consistent with what would be awarded in personal injury litigation, where the head of damage was one recognised in a common law damages claim, and by applying comparable principles in any area which was not subject to a conventional personal injury award.

**7.8** From this material a matrix could be prepared of the type illustrated as an example, below. The assessor would then consider the information available about each case and determine where in the relevant range it would be appropriate to place them.

**7.9** Such a system should enable applicants and assessors to understand, and hopefully agree, from a relatively simple account of the case, the appropriate level of award for that case. It should have the attraction of making the application process simple by addressing the complexities in broad, general terms. It may be possible to separate out from the many consequences of an infection, items where the fair approach would be to make a formulaic award common to all cases, thus further simplifying the process. At the same time, the resulting award should bear comparison to what an applicant might have hoped to achieve in litigation, thus incentivising them to accept the scheme offer.

#### *No waiver of litigation rights required*

**7.10** It will be necessary to decide whether an applicant will be required to accept a scheme award as a full and final settlement of their claim if any against the State or a state agency. It is recommended that this is not the route taken. This group of victims has been subjected to multiple attempts to deter them from pursuing their rights, and it might be thought to be adding to their distress and suffering by taking choices away from them. They are likely to regard that as a further affront to their dignity and autonomy. Far better, would be to provide that any recipient of a scheme award should remain free to pursue a legal claim if so advised, but to be obliged to do so after considering certain risks. Firstly, it should be provided that the availability of an award under the scheme should be a factor the court could have regard to in relation to liability for costs in the court proceedings. Secondly, any award should be taken into account in the award of damages by the court, which may be reduced accordingly.

**7.11** I shall now turn to consider various models for compensation which could be adopted, or which may have features on which the scheme could draw.

### **Compensation for Impact of Being Infected**

#### *The Common Law approach*

**7.12** If no compensation scheme is created, the only redress - over and above the support schemes - available to either the infected or the affected would be by way of a legal action for damages. Therefore, as a starting point, consideration should be given to the approach that would be taken in such proceedings. What follows assumes that the claimant has been successful in establishing liability for a breach of duty in tort and that the injuries for which damages are claimed were caused by that breach. Unless liability in that sense is admitted by a defendant, the claimant would have to overcome the legal and evidential hurdles of proving liability, and doing so on a balance of probability. This Study cannot, and this report does not, purport to prejudge the

outcome of Sir Brian's Inquiry, but it is not doing so to observe that no findings of fact or conclusions of the Inquiry are binding on any party in litigation, although the evidence submitted to the Inquiry might well be admissible in the proceedings. Therefore, however supportive the Inquiry conclusions might be to a potential claimant, there is a risk of a claimant having to endure protracted and complex proceedings in order to get to the point of an assessment of damages. The experience gained from litigation in this area to date does not suggest that success is easy to obtain for litigants. However, that does not mean that the common law approach to damages is not a useful starting point to guide the formulation of a compensation scheme.

**7.13** The object of compensatory damages is, as far as is reasonable, to put the claimant in the position as if the wrong had not occurred.<sup>73</sup> The heads of recognised recoverable damage are usually divided into financial and non-financial loss. In a civil action, if liability and causation were established, an infected person would recover an award of damages for pain, suffering and loss of amenity, namely the non-financial deficits caused by the infection. While it is recognised that money can never perfectly restore the loss or cure the injury:

*“money has to compensate, as far as it can, for those injuries that cannot be cured.”<sup>74</sup>*

**7.14** Financial loss, once found to be reasonable, is a matter of calculation, albeit sometimes by way of estimation, depending on the detail of the evidence available. Damages awarded for non-financial loss, such as pain, suffering and loss of amenity are:

*“not as a replacement for other money, but as a substitute for that which is generally more important than money: it is the best a court can do.”<sup>75</sup>*

**7.15** It is difficult to know what awards would be made in the cases with which the scheme will be concerned, because very few have been to court. Little is known about the cases which have been settled, but even if the amounts of individual settlements were disclosed this would be of little assistance as benchmarks, because almost certainly the sums agreed were not calculated by reference to what it would be expected the claimant would be awarded in court, but rather an assessment of the risks of winning/losing, and an appreciation of the personal difference or significance the sum offered might have for the individual claimant, regardless of whether in theory more could have been claimed.

#### *Damages for the infected - non financial loss*

**7.16 Damages for pain, suffering and loss of amenity** in personal injury litigation are assessed in accordance with sums awarded in comparable cases. For many types of injury the precedent and experience of the courts is synthesised in the Guidelines, published by the Judicial College, formerly known as the Judicial Studies Board. These are revised and updated for inflation annually.<sup>76</sup> An illustrative table showing extracted categories from the Guidelines, which may be of some relevance for this scheme, is at Appendix 5. The table has been updated for inflation.

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<sup>73</sup> *Livingstone v Rawyards Coal Co* (1885) 5 App Cas 25, 39.

<sup>74</sup> *Whittington Hospitals NHS Trust v XX* [2020] UKSC 14 §1.

<sup>75</sup> *McGregor on Damages* 21<sup>st</sup> edition §2-002 (2021) Sweet & Maxwell.

<sup>76</sup> The current version is *Judicial College Guidelines*, (2022) 15<sup>th</sup> edition, Judicial College.

**7.17** A physical injury caused by an actionable wrong will give rise to an entitlement to damages whether or not the victim is aware of the injury, although the amount awarded will inevitably be less than if they are aware and suffer consequent pain and distress.<sup>77</sup>

**7.18 Mental distress, short of a mental illness**, is more problematic. It will be considered as part of the suffering for which damages can be recovered, when it is associated with a physical or psychological injury, but not otherwise. At common law, the anxiety understandably associated with the development of a physiological change not considered to amount to a physical injury, even if it is indicative of a risk of a disease developing in the future, does not give rise to liability or an entitlement to damages for that anxiety and distress.<sup>78</sup>

**7.19 The shock and distress arising from a failure to inform a patient** of a condition can give rise to damages when the condition comes to light.<sup>79</sup>

**7.20 Loss of a chance to have a spouse or partner in life:** an award for loss of amenities can include an element to recognise the loss of or reduction in the prospects of marriage and support from a spouse if caused by the injury<sup>80</sup>. It is difficult to work out in many cases what was awarded for this loss, as it is absorbed in the overall lump sum. The same applies to the non-financial consequences of an inability to have a child or indeed the loss of a child.

**7.21 Invasion of human rights, in particular right to family life:** since the advent of the Human Rights Act 1998, it is possible to claim damages for a breach. However, no award of damages can be made:

*“unless taking account of all the circumstances of the case, including:*

*(a) any other relief or remedy granted, or order made, in relation to the act in question (by that or any other court), and*

*(b) the consequences of any decision (of that or any other court in respect of that act,*

*the court is satisfied that the award is necessary to afford just satisfaction to the person in whose favour it is made.”<sup>81</sup>*

**7.22** Further, there is a limitation period within which the claim must be brought of one year of the breach of rights complained of, subject to such a longer period as the court thinks is equitable.<sup>82</sup>

**7.23** While in theory a claim could be made outside the ambit of the Human Rights Act, or the European Convention on Human Rights from which it derives, in respect of the alleged absence of informed consent, both in relation to the original administration of the infected blood or blood product, or any subsequent treatment, a claimant would not only have to overcome a limitation hurdle, but also establish that what occurred was a breach of a common law duty.

<sup>77</sup> *Wise v Kay* [1962] 1 QB 639 CA; *West v Shepherd* [1964] AC 326.

<sup>78</sup> *Rothwell v Chemical & Insulating Co Ltd* [2008] AC 281, an asbestosis case concerning the development of pleural plaques. Such plaques are now deemed by statute to be an injury in Northern Ireland and Scotland. However, a physiological change such as platinum salt sensitisation or pneumoconiosis, which damages lung tissue, but does not necessarily produce immediately detectable symptoms will be recognised as an injury: *Cartledge v E Jopling & Sons Ltd* [1963] AC 748; *Dryden v Johnson Matthey* [2018] UKSC 18.

<sup>79</sup> *Gallardo v Imperial College healthcare NHS Trust* [2017] EWHC 3147 (QB) where the claimant was awarded £27,500 for the “shock and distress” of learning that a tumour found at operation 4 years previously was malignant, the additional pain suffered during that time, and the need for more complex surgery because of the delay.

<sup>80</sup> See *McGregor on Damages* chapter 40 § 40-265 fn1237; *Assinder v Griffin* [2001] 5 WLUK 655.

<sup>81</sup> Human Rights Act 1998 section 8.

<sup>82</sup> *Ibid* section 7.

**7.24** Therefore, if it is thought appropriate to offer recognition by way of compensation for this type of invasion of rights, it would be preferable to do so through a compensation scheme, as it is very uncertain whether a legal remedy would be available.

*Common law approach to damages for financial loss of the infected*

**7.25** At common law, financial losses are divided into past losses, for which special damages are awarded, and future losses. Special damages are calculated by adding up the cost of the past losses. Generally, interest is added to represent the time the claimant has been kept out of the money to which the court has held they are entitled. Future losses can be compensated for by a lump sum arrived at by multiplying the number of years the loss is expected to last discounted by a statutory percentage for acceleration of receipt, alternatively by periodic payments representing the loss.

## Categories of Award for the Affected

*The common law approach*

**7.26** In the context of the victims of infected blood, those who have been unwittingly infected by disease transmitted to them by the recipient of infected blood would be treated as primary, directly injured, victims, assuming that liability in negligence was established. It would be reasonably foreseeable that if the primary victim was infected, that they might pass this infection on to others. Therefore, people so infected, whether sexual partners or children, should be treated by any scheme in the same way as primary victims, as they would be in a common law claim.

**7.27** In contrast, it is only in very limited circumstances that damages can be recovered by a person who has not been directly injured by an actionable wrong but has only been indirectly impacted. Such people are sometimes referred to as secondary victims.

**7.28** Where the infected person has died, a legal claim could be pursued on behalf of their estate to recover the damages for financial and non-financial losses suffered by the deceased. This is separate from any right to claim for loss of financial support from the deceased on the part of their dependents (see below). Fairness requires any claim the infected would have been able to make if alive, for compensation, should be capable of being made by the deceased infected person's executors or authorised personal representatives. Obviously, such claims are limited to the impact of the disease on the deceased during his or her lifetime.

**7.29** Bereaved dependents of a deceased infected person would be able to make a claim under the Fatal Accidents Act 1976:

- **Bereavement damages** - by statute<sup>83</sup> a claim for a bereavement award may be made on behalf only of spouses, civil partners, and partners who have cohabited for more than 2 years immediately before the death; both parents of a legitimate child who dies before the age of 18; and the mother of an illegitimate child, who was never married or had a civil

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<sup>83</sup> Fatal Accidents Act 1976 section 1A as amended by Civil Partnerships Act 2004 section 83(7) and Fatal Accidents Act 1976 (Remedial) Order 2020 SI 1023.

partner or a cohabitee of more than two years. The recent addition of an entitlement for cohabiting partners of two years standing comes after a court ruling that their omission was incompatible with Articles 9 and 14 of the European Convention on Human Rights<sup>84</sup>. The sum currently payable is £15,120<sup>85</sup>. It has to be shared between all those who are entitled to claim this item. This award has been criticised as being too little, in spite of the recent increase, and particularly inadequate if it has to be shared.

- **Loss of dependency:** a claim for the loss of a financial benefit which would have been enjoyed but for the death of the deceased can be made on behalf of:
  - The deceased's spouse or civil partner at the time of death;
  - Former spouses or civil partners;
  - Cohabitees living as partners with the deceased for at least two years immediately before the death;
  - Parents and ascendants of the deceased or persons treated as a parent;
  - Children or other descendants, and persons treated by the deceased as their children;
  - The deceased's siblings and uncles and aunts and their children.

**7.30** The assessment of the loss of dependency is complex but includes the financial benefit dependents would have obtained from the deceased's income, or his or her services and support<sup>86</sup>. Put perhaps over simply, the assessment is generally based on what the deceased would have spent, or by way of services performed, for the benefit of dependent members of their family, out of the income and resources the deceased would have had but for their death. The assessment is based on the actual resources and earning capacity possessed by the deceased, not what they might have had but for some preceding injury. That loss can only be recovered in a claim brought on behalf of the estate as described above. Frequently the annual dependency is arrived at by an almost conventional calculation of taking two thirds of the deceased's net annual earnings at the time of death and deducting the whole of any earnings of the spouse. This figure is then multiplied by a multiplicand representing the number of years the dependency would have lasted but for the death from the date of trial, discounted for acceleration of receipt. A comparable process is adopted to identify the past loss of dependency between the date of death and the date of trial.

### *Conclusion on the common law approach*

**7.31** Even from this cursory summary of what is involved in a common law claim for damages, but even more so if the detail of the practice in this area is examined, it will be seen that the evidence necessary, and the calculations required to arrive at an award can be burdensome and complex. It is a process which it would be very hard for a legally unqualified applicant to undertake without legal support. As was made clear by the Archer Inquiry, the needs of this community are not appropriately catered for by the legal framework for compensation in any event.

<sup>84</sup> *Smith v Lancashire Teaching Hospitals NHS Foundation Trust* [2017 EWCA Civ 1916.

<sup>85</sup> For deaths occurring after 1 May 2020; the sum is £12,980 for deaths before that date: The Damages for Bereavement (Variation of Sum) (England and Wales) Order 2020 (S.I. 2020/316), arts. 1(1), 2. Note that in Scotland the amount that can be awarded for bereavement is at large and sums far in excess of the English statutory figure can be awarded, and the range of people entitled to claim it is wider: see article by Michelle Victor 7 May 2021:

<https://www.leighday.co.uk/latest-updates/blog/2021-blogs/the-right-to-bereavement-damages-moral-or-legal-responsibility/>.

<sup>86</sup> For a more detailed account of how loss of dependency claims are assessed see *McGregor on Damages*, 15<sup>th</sup> edition, chapter 41 §§41-028 onwards.

## Exemplary and Aggravated Damages

**7.32** Many of those who have contacted the Study argue that compensation should include exemplary or aggravated damages. The scope of exemplary or aggravated damages is the subject of a great deal of academic writing and case law for which there is no place here. It is also possible that the law of the devolved nations differs from that of England and Wales. What follows is an extremely broad brush summary of how the term is understood in England and Wales.

**7.33** Aggravated damages are awarded as compensation for the non-financial loss of the additional shock and distress caused by the wrongdoer's conduct:

*“Non-pecuniary loss includes mental distress arising from the circumstances in which the tort was committed, such as justified feelings of outrage at the defendant's conduct. Damages awarded for this type of loss are sometimes called aggravated damages, as the defendant's conduct aggravates the injury done.”<sup>87</sup>*

**7.34** Exemplary damages are a non-compensatory award of damages designed to mark the court's disapproval of outrageous conduct and to deter the repetition of such conduct. They may be awarded in three circumstances:<sup>88</sup>

- Where there has been oppressive, arbitrary or unconstitutional action on the part of a servant of the State;
- Where the defendant's conduct has been calculated to make a profit for themselves which may exceed the compensation payable to the claimant; or
- Where exemplary damages are expressly authorised by statute.

**7.35** There is no limit on the nature of the cause of action in which the court is entitled to make such an award, so long as the case comes within one of the above categories.<sup>89</sup> However, it is not at all clear in what circumstances in a negligence action any of the required conditions for exemplary damages might be met. In the case quoted above, one judge expressed doubts as to the merit of allowing such claims in negligence actions. The leading textbook on damages observes:

*“It would not usually be expected that actions in negligence would lead to exemplary damages, ... since the necessary mental element is not usually present.”<sup>90</sup>*

**7.36** However the book goes on to describe a case in which negligence combined with other conduct might attract an award:

*“In addition to compensatory damages, exemplary, and also aggravated, damages were sought on the grounds that for some time after the contamination the authority, in its capacity as a statutory body and a public servant, had acted in a high-handed and arrogant manner by ignoring customers' complaints, had wilfully and deliberately misrepresented the situation in a circular letter asserting that the water was safe to*

<sup>87</sup> See Kuddus [below] §§50.

<sup>88</sup> See Kuddus v Chief Constable of Leicestershire Constabulary [2002] 2 AC 122 §6, 32.

<sup>89</sup> Ibid §26-27, 38, 45.

<sup>90</sup> McGregor on Damages 15th edition §13-015.

*drink, and had failed to give out proper information or to take precautionary measures so that the contaminated water had been consumed for a longer period and in greater quantities than would otherwise have happened.”*

**7.37** This is not dissimilar to some of the complaints I have heard made by the infected and affected community.

**7.38** While I note that the Republic of Ireland’s scheme allows for claims for exemplary damages, that has been following an extended inquiry process. In my view, it is premature to propose that such awards should be included in this scheme. It is hard to envisage such awards, which are intended to be punitive, being capable of being assessed by scheme assessors in any event. It would require lawyers, preferably judges, to consider the disputed legal principles involved as well as their application to each case. This is a task much better suited to the court process than it is to a scheme, a principal purpose of which is to provide accessible and fair compensation to this group, as simply and as quickly as possible. In the absence of an ability to claim exemplary damages in the scheme, anyone seeking them would have to resort to court proceedings to establish their case in this regard. This position could and should be reviewed in the light of the findings of the Inquiry.

**7.39** Aggravated damages are a different matter. If it is accepted that victims of this scandal, or some of them, were deprived of their autonomy and right to make informed decisions, to be made aware of the real risks of treatment, their diagnosis and of tests being carried out on their blood, a case could be made for aggravated damages in the sense of increasing the awards for pain, suffering and loss of amenity. It is clear, even from the limited conversations I have had with members of the infected and affected community, that they believe their distress has been exacerbated by exactly these features.

**7.40** Therefore, I recommend that the scheme allows for the possibility of an additional award for the distress caused by matters such as a lack of informed consent, information about risks of treatment, diagnosis, treatment and testing. These are matters which are inevitably case specific and would require an individualised assessment based on the account given by the applicant. The damages matrix should contain a maximum figure which could be awarded under this head.

## **Recommendation 6:**

I recommend that infections eligible for compensation should be classified in the following manner:

- a) there should be defined categories for each type of eligible infection, and the stages through which it progresses, and for each category defined degrees of severity to which a range of possible awards for the impact of the disease can be applied;
- 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.
- c) the range of potential awards for the impact should be determined by an

independent legal expert advisory panel, to be consistent with what would be awarded in common law personal injury litigation.

### **Recommendation 7:**

I recommend that, with reference to aggravated and exemplary damages:

- a) the scheme should allow, as part of the autonomy award, for eligible infected persons an award equivalent to aggravated damages for the aggravated distress caused by interferences in their autonomy and private life such as lack of informed consent, information about the risks of treatment, and about diagnosis, treatment and testing; and
- b) the issue of exemplary damages be reviewed in the light of the findings of the Inquiry.

## Measures for Compensation

### Term of Reference:

To consider the measures for compensation, looking at other national schemes (for example, the compensation tribunal established in the Republic of Ireland) to examine their merits or otherwise, and experiences, both as to form (i.e. administration/process) and the substance of compensation.

**8.1** Having briefly reviewed the common law approach to damages, I shall now turn to consider other schemes, some of which are for the benefit of victims of infected blood and blood products in other countries, and some of which relate to other tragedies in this country and elsewhere.

**8.2** I have looked at a number of roughly comparable compensation schemes, both within the UK and wider afield<sup>91</sup>, in order to understand how they work (or do not), to draw some comparisons with the circumstances of the infected blood tragedy, and to draw what conclusions a cursory inspection of those schemes allows in order to determine what might be worthy for inclusion in my recommendations for how an infected blood compensation scheme might operate.

**8.3** I have chosen a number of the schemes that I have reviewed to outline in more detail in this report, by way of example of the salient issues I have considered as I assessed their relevance to the design of a framework for a scheme for the benefit of the infected and affected, that I have proposed elsewhere in this report. My detailed review of these schemes can be found within Appendix 6 at the end of this report. There are many other schemes that might be thought relevant, but the ones I have selected are in my opinion sufficient to illustrate the learning to be obtained from them.

### Other UK Based Compensation Schemes

**8.4** I looked at a number of existing UK compensation schemes. The advantages of studying these schemes is that they will already take account of the particular set of social, political and legal circumstances that set the UK apart from other countries. The schemes I have reviewed in this report are:

- the [Criminal Injuries Compensation Scheme](#);
- the [Windrush Scheme](#); and
- the [vCJD Compensation Trust](#).

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<sup>91</sup> I am indebted, for some of this analysis, to the detailed and very well researched work by Dr Sonia Macleod and Professor Christopher Hodges, of the Centre for Socio-Legal Studies at the University of Oxford, “*Redress Schemes for Personal Injuries*” (2017); and also for the personal assistance of Dr Macleod in speaking directly with me on this issue and for her very helpful presentation to the discussion forum I held with the Recognised Legal Representatives (RLRs).

### *Criminal Injuries Compensation*

**8.5** This scheme is not directly comparable because it does not arise from injuries for which the State is accused of being responsible, and it is a scheme of last resort for where there is no or insufficient recompense available from other sources. However, as pointed out in the Archer inquiry report and by Lord Ackner (see above), it is an illustration of circumstances in which without legal liability the State offers compensation in accordance with principles comparable to common law damages to victims of harm through no fault of their own. The scheme also shows the benefits of simplicity that can be offered by a prescribed matrix of awards which can be applied to an individual case, but also the difficulties that can arise with a tariff scheme that is too complex for applicants - and assessors - to navigate easily. It also demonstrates how compensation can be assessed for loss of earnings either by reference to a statistical source or the actual evidence of earning loss or capacity. Where complexity is unavoidable, even with a tariff it remains essential that legal or other appropriate support is made available to applicants. Finally, the model for scheme administration it offers has features which may be helpful here.

### *Windrush Scheme*

**8.6** Again, this scheme is not directly comparable in that it was not intended principally to provide compensation for physical or mental injury, as opposed to the gross interference with the private lives of victims through the State's failure to recognise their true status. However, there are elements of that type of interference from which the victims, infected and affected, have suffered and continue to suffer. The range of awards eventually permitted (£10,000 - £100,000, and in exceptional cases more) is a potentially useful comparator given the similar issues that have been experienced. Further, the ability to make an early payment is recognised as a means of mitigating the hurt and distress caused by the original wrong, by getting money to people quickly, although in the Windrush scheme benefit appears to have been reduced by an inability to offer adequate amounts for urgent and exceptional need. This mirrors the demands I have heard for swift interim payments. There are also lessons to be taken from the considerable dissatisfaction that has been expressed at the administration of the scheme, in particular the time taken to process claims, and the bureaucratic burden on applicants to produce supporting evidence.

### *vCJD Compensation Trust*

**8.7** This scheme has a degree of direct relevance as a limited number of the victims of infected blood and blood products have contracted vCJD and many others have been warned of the risk of doing so. It is relevant to note that this scheme also made interim payments in the year the Trust was set up, with an associated disregard for social security purposes. The initial basic sum proposed was accepted to be inadequate and has been increased to £125,000. At first impression, this seems to be a relatively small sum for a disease described by one of the Trustees, a highly experienced practitioner in personal injury claims, as "the most horrific imaginable" disease,<sup>92</sup> but there are a number of heads of loss for which claims can be made including care, the impact on family and difficulty in accessing financial and insurance services. The lessons suggested by the same Trustee are worthy of attention when designing our scheme. Again, he emphasises the advantages of simplicity, avoidance of delay in payment, and of distressing procedures for applicants.

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<sup>92</sup> [www.vcjdtrust.co.uk](http://www.vcjdtrust.co.uk): the article by Melville Williams QC *Setting up the vCJD Trust*.

## Foreign Compensation Schemes

**8.8** It has also been helpful to look at some overseas compensation schemes. The subject-matter and methodologies vary widely, and much depends on the social, political and legal context in which they were set up and administered. It is unlikely that many, if any, comparators with regard to the amounts awarded can be found. Each country is likely to have its own value system for compensation set against an economic background that may be very different from the UK. However, the way in which schemes operate may be of assistance. The foreign schemes I have reviewed in this report are:

- the [September 11 Victim Compensation Fund](#), USA; and
- the [Hepatitis C & HIV Compensation Tribunal](#), Republic of Ireland.

### *September 11 Victim Compensation Fund*

**8.9** This remarkable fund shows what can be done with sufficient generosity in terms of avoiding any need for litigation, swiftness and flexibility of remedy, and retaining options for applicants as to the detail of assessment they require, recognising the necessary tradeoff between the degree of personalisation of assessment and the speed of the process. The particular features which deserve attention for our purposes are:

- The proactive approach to supporting applicants to produce the required information;
- The facility to offer informal meetings and hearings to allow applicants to be heard and their suffering personally recognised;
- The importance attached to the development of a personal relationship between the applicant and their case manager;
- The approach to assessment of awards which erred on the side of generosity with the avowed aim of avoiding litigation.

**8.10** However, the limitations of the comparison must be accepted: there was a compelling economic and political motivation behind the extraordinary funding of this scheme, and the remarkably low administrative costs were attributable to a willingness of lawyers to act without charge, which may be difficult to replicate here.

### *The Hepatitis C and HIV Compensation Tribunal, Republic of Ireland*

**8.11** As is clear from the many submissions received referring to this scheme, it is not only of direct relevance as it provides compensation for the very same injuries as this scheme needs to address, but it does so in an entirely bespoke manner resulting in an award more or less aligned to the damages which would be awarded in a successful court action. For this reason, the review of its operation and background legislation and rules are reviewed in detail<sup>93</sup>. If it were decided that

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<sup>93</sup> See Appendix 6(e).

the attractions of a bespoke scheme outweighed its disadvantages, then this is undoubtedly a model which could be followed in this country with a virtually identical structure.

**8.12** It has been argued that the Irish scheme is not a model which should be followed here, because the Irish scheme was founded on a governmental and legislative acceptance of state responsibility or liability, but this has been rejected by the High Court.<sup>94</sup> It is difficult to see that this point has much if any relevance, given the availability of exemplary damages in the Irish scheme. Currently, there is no such acceptance on the part of the Government or Parliament in this country.

**8.13** Given the sophistication of the model, I suggest that it is an option the government should consider as an alternative to the structure I shall propose and also recommend for consideration.

**8.14** However, before this solution is accepted, it is important that its disadvantages be taken into account. There are significant:

- It is not a swift process: the table in the appendix shows the number of cases dealt with each year. The time taken may have been acceptable when this Tribunal was set up, because the Irish government took this step at a much earlier stage in the discovery of the scandal than will be the case here. It would not appear to be a scheme which could meet the demands of those families whose infected loved ones fear they face an imminent death or who otherwise desire a rapid resolution of their claims so they can put their affairs in order before they die.
- It is as complex as a personal injury claim in court. A reading of a sample of High Court judgments on appeal will confirm that.
- It is not clear that the process could be adequately navigated by many without the assistance of lawyers.

## Conclusions

**8.15** With the possible exception of the Irish Tribunal scheme, none of the schemes examined offer a system which could be applied directly in a compensation scheme for the infected and affected, but they each offer learning points as identified above. They do show that where there is no easily accessible legal solution to the obvious needs of victims, a tailor-made scheme fitting the particular tragedy in question needs to be and can be devised.

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<sup>94</sup> See the conclusion of the judgment in *R (March) v Secretary of State for Health* [2010] EWHC 765 (Admin) §§46-54 to the effect that the Irish scheme was set up at a time when the government had not accepted responsibility.

## Types of Award and Method of Assessment

### Term of Reference:

To consider: (a) the extent to which any framework should offer compensation on the basis of an individualised assessment and/or fixed sums or a combination of these (including consideration of the position of an individual who was both infected, and affected by another individual's infection); (b) whether awards should be by way of final lump sums, periodical payments or both; (c) whether an individual should be required to prove matters (if so what types of matters, by what means, and to what standard); (d) whether there should be any limitation by way of time or other bar on entitlement or claim, and whether any existing time bars should be maintained; (e) the extent to which compensation should be limited to matters currently recognised by the law (taking into account any differences in the law across the UK) on damages and evidence as recoverable for the purposes of compensation, or, if not, the basis on which broader matters should be taken into account.

### A Suggested Framework

**9.1** Taking into account the particular circumstances and expressed needs of the infected and affected, the alternative offered by way of litigation, and the experience gained from other compensation schemes, a framework on the following lines is suggested. Any suggestion must naturally be subject to the findings and recommendations of Sir Brian's Inquiry which this report does not try to prejudge. As is shown in the section of rationale for compensation, given the special circumstances in which the infected and affected have suffered, there is a strong moral case at least for recognising what has happened to them as avoidable harm for which compensation should be offered.

**9.2** Findings by the Inquiry of fault or responsibility should not require major alterations to the framework, as the amounts proposed will be based on principles derived from personal injury claims, but simplified to ease the challenges of proof and assessment.

**9.3** The objectives of a compensation scheme for the victims of infected blood should be to offer fair and proportionate redress for the suffering and losses of the infected and affected. The compensatory needs can be addressed in the scheme under the following heads of potential claim:

- Compensation for the infected person or, if deceased, their estate:
  - **Injury Impact Award:** Redress for the past and future physical and mental injury caused by the infection and its consequences to the infected person.
  - **Social Impact Award:** Redress for the past and future social consequences of being infected for the infected person including in particular the stigma and social isolation attached to these infections.
  - **Care Award:** redress for the past and future cost of paid for (private) treatment, care, and the value of gratuitous care received by infected person in the past and/or

likely to be required in the future, subject to an equivalent Family Care Award not having been made (see below).

- **Autonomy Award:** Additional redress for the aggravation of the distress and suffering caused by the impact, as recognised in the impact award (above), caused by interference with the right to family life, the right to personal autonomy, absence of informed consent to the administration of blood or blood products, failure in candour with regard to infections and their cause, testing and screening, and any other instance of wrongful interference with the right of the individual to control over their own life.
- **Financial Loss Award:** Redress for the past and future financial losses incurred by the infected person caused by the infection.
- Compensation for eligible affected persons (as defined by categories):
  - **Injury Impact Award:** payable to eligible affected persons for physical or mental injury caused by their experience of the relevant conditions or death of the relevant infected person, where such injury was a clinically or psychologically recognised consequence of close and established association with the infected person.
  - **Social Impact Award:** an award for eligible affected persons for the stigma and adverse social consequences of being associated with the infected person.
  - **Family Care Award:** where a Care Award has not been made to the infected person, redress payable to defined family members or their equivalent, for care provided free of charge to the infected person in the past and likely to be provided in the future.
  - **Bereavement Award:** payable to defined family members or their equivalent when the death of the deceased has been caused by the infection or its consequences.
  - **Bereaved Family Financial Loss Award:** for defined family members or their equivalent, to reflect the financial benefits payable only in respect of losses of financial benefits they would have enjoyed but for the death of the deceased infected person.

**9.4** The claim for a family bereavement award and a bereaved family financial loss award, would have to be brought by the personal representatives of the deceased for all relevant eligible affected persons, and would have the responsibility of allocating appropriate shares of the award between them.

## Flexibility

### *Options of lump sums or periodical payments*

**9.5** A common complaint among infected and affected has been their loss of autonomy and freedom of choice. Many want a settlement which will allow them to put behind them their worries about the future. It is possible to address both of these needs by offering living applicants a

combination of lump sum and periodical payments. Impact awards are likely to be more suited to lump sum payments, but awards for continuing financial losses and care costs could be awarded either as lump sums or as periodical payments. In damages claims periodical payments are increasingly used particularly in cases where a state body is the paying party.

*Past waiver of litigation rights relevant not a bar to a claim for compensation*

**9.6** Some have had adverse experiences of believing they were pressured into accepting inadequate settlements purporting to be in full and final settlement of their claims. It may be a matter the Inquiry will comment on, but for the purposes of this scheme it is recommended that no such settlement will be a bar to an application for compensation under the scheme. However, assuming that to be the case, any sum received in the settlement should be taken into account as a deduction from any lump sum award for past financial losses or provision of care, in so far as it can be identified what part of any settlement was attributable to such losses or provision.

*No waiver of litigation rights required to claim compensation*

**9.7** The purpose of this scheme should be to provide a fair alternative to litigation in which the potential precision of a court based award is replaced by a broader and less detailed assessment based on standard figures. The success of the scheme should be judged on the extent to which it satisfies the infected and affected and incentivises them to choose not to litigate. It is more likely to do that if it is seen to be sufficiently generous to be a fair settlement and an acceptable way to avoid the ordeal of litigation and all its risks. It is suggested that to make a waiver of litigation rights a condition of a scheme award could be counterproductive. In any event, there may be aspects of a damages claim for which it would be challenging to fit into a compensation scheme, such as the suggestion of liability for exemplary damages. However, it would be fair to provide that any award of compensation under the scheme could be taken into account in any assessment of damages awarded for the same subject-matter in court proceedings and in the exercise of the court's discretion as to liability for costs. For example, if the recipient of an award went on to take legal proceedings but failed to obtain a damages award in excess of the compensation award, they might be awarded no damages and be liable for the costs of the proceedings.

## **A Tariff Approach**

*A matrix*

**9.8** In order to offer victims as simple as possible a means of access to compensation, and as clear as possible an understanding of their entitlements, as well as ease - and therefore speed - of assessment by the scheme administrators, it would be helpful to devise a matrix which recognised in respect of each relevant infection the usual stages of progress and the range of severity likely to be experienced. For each stage and severity level a range could be identified within which an award could be made or a method by which a presumptive award could be calculated. This would have the advantage of providing broad recognition of the individual circumstances of the applicant while avoiding the complexities of a bespoke assessment for each applicant.

**9.9** A matrix of this nature could provide the basis on which interim payments could be made, possibly consisting of the realistic minimum likely to be determined on a final assessment.

### *Understanding the impact of relevant diseases*

**9.10** The nature of the diseases and their stages should be identified and defined by, or with the assistance of, an expert medical panel of the type employed by the Inquiry to advise it. The description should include a description of the range of conditions and symptoms that can be suffered. The medical panel should be asked to consider each disease separately, and also the combined effect of both diseases on those who are co-infected. It would be helpful for sufficient detail to be supplied to enable an assessment as to whether overall one disease is more or less serious than the other in terms of its impact on the lives of sufferers.

**9.11** Such a panel or process would be clearly enhanced by the involvement in this work of the infected communities who can contribute the benefit of their lived experience.

### *Standardised ranges of compensation for impact by reference to comparables*

**9.12** In order for the scheme to gain the confidence of the infected and affected communities, while at the same time providing the necessary justification for the proportionate and fair spending of public money, it is important that the levels of compensation are broadly consistent with other forms of compensation and have regard to the levels of awards for personal injury in tort based litigation. The figures should reflect the advantages to applicants of obtaining a financial remedy without the complexities, stress and expense of litigation, while also recognizing the exceptional nature of the injuries suffered in these cases, in addition to any special features identified by the Inquiry. That balance may require offering compensation for impacts which would not necessarily be recognized in a personal injury action.

## **Compensation for the Infected Person or Their Estate**

**9.13** Implicit in the acceptance of the obligation to offer such a scheme is that all infected individuals who fulfil the criteria for eligibility are granted the right to be compensated retrospectively. It follows that the estate of infected individuals who have died should not be deprived of the financial resource represented by such compensation by the death of the infected person before they were able to claim compensation. Therefore, the estate of deceased infected persons who would have been eligible to claim if alive should be able to claim the compensation that would have been due to the deceased up to the time of their death, whatever the cause of their demise.

### **Award for Impact on Life - The Injury Impact Award**

#### *An award for all eligible infected persons*

**9.14** This award would be the scheme's equivalent of an award for pain, suffering and loss of amenity: but for the purposes of the compensation scheme would be intended as an award for the physical and psychological impact of the infection on the life of the claimant. Such an award should be made to all infected persons, regardless of any other consequences which follow. Excluded from consideration would be the distress and suffering caused by any stigma or social

isolation caused by the infection (to be covered by the social impact award), or issues of partnership or family prospects (to be covered by the autonomy award).

**9.15** While no amount of money can truly compensate for physical and mental injury, the sum awarded should be a fair reflection and acknowledgment of the past, present, and likely future pain and suffering caused by the relevant avoidable harm, taken as a whole, but not the social consequences more closely associated with the responses of others to the infection, which are dealt with below.

**9.16** This award would offer a financial remedy for the non-financial consequences of the infection including:

- Physical and mental injury;
- Actual injury suffered to date;
- Predicted likely course of any illness or condition caused by the injury in future, including risk of deterioration or new illnesses or conditions occurring;
- Psychological damage and distress caused by the physical and mental injury including prospect of early death or increased illness or disability;

**9.17** To reflect the severity of the impact, account will have to be taken of the overall severity of the injury suffered, having regard to any changes in the past and the prognosis for the rest of the claimant's life. Account will also have to be taken of the length of time during which the claimant has and will have to endure the infection and its consequences.

**9.18** In respect of each disease and combination of disease and each degree of severity identified for them, the range within which the award should be identified. An illustration of the sort of figures that might be appropriate is offered below.

**9.19** Whichever diseases or combination of infections has been inflicted, the precise effects, duration and experience will be different for every victim. While it would be possible to take account of the detailed circumstances of each claimant by individual assessment supported by medical examinations and opinions, to require such an approach would prevent fulfilling the wish of many victims for a swift, simple and fair scheme allowing them to obtain a settled life. A tariff approach is of necessity less individually tailored, but fairness and proportionality is obtained through defining broad categories into which it is likely most victims can be assessed to fit.

#### *Tariff categories*

#### **9.20**

- The tariff should reflect in simple but comprehensive terms the categories of infection and the stages through which each typically progresses, and the range of conditions and symptoms which can be suffered by the infected in each stage.

- As suggested above, these need to be identified (or confirmed) by a panel of independent medical experts, including if practicable, preferably the experts who formed the advisory Expert Groups for the Inquiry.<sup>95</sup>
- Victims and their representative groups should be consulted on the categories proposed.
- For the purposes of this report as an illustration categories broadly similar to those used in the support schemes will be used.

### *Assessing a range for awards in each category*

**9.21** If a tariff or guidance system is to be adopted, either as a determinative or presumptive basis of assessment, the tariffs should reflect in respect of each category of injury identified a level of award that might be expected in a civil action.

**9.22** The range of awards for each category should be determined on the basis of recommendations by an independent legal expert panel of judges and lawyers experienced in personal injury. They should be tasked with considering categories, degrees of severity and descriptions of the associated conditions and symptoms described by the expert medical panel, and then attaching a range of values to each category (by an approach in accordance with that suggested below). Their proposals should be the subject of consultation with victims and their advisers, and between the expert panels.

**9.23** The resulting tariff table should then be used as the basis of assessment by the scheme's assessors.

### *How should the value of an award be defined for the impact on life?*

**9.24 Overview:** It is clear from the meetings we have had, the Expert Groups' evidence to the Inquiry, and the statements of infected and affected, that there is a wide variety of life experiences following an infection. It seems unfair to ignore that variety by prescribing a single figure for all cases in a particular category. The infected we have spoken to require recognition of their individual circumstances and that is more difficult to achieve if the award does not offer at least some reflection of their personal experience. The framework should define a figure or a range within which an award can be made for the impact on life.

**9.25 Award for impact of physical and mental injury:** it is recommended that for each category of infected person there is a range between which an impact award for the physical and mental injury suffered should be made. That range should be identified for the purposes of the framework by reference to such guidance as is thought is given by the Judicial College guidelines, the CICA tariffs (to the extent that they are considered useful as comparables) and a general assessment of the likely range of awards in a civil action for this range of injury. It is important that the figures are comparable to those potentially recoverable in court proceedings. They should not exceed that standard, except where the scheme is compensating a detriment which is not strictly a matter of personal injury as recognised in tort claims. The reliance on comparables is to ensure equity between people injured across different circumstances, consistency and proportionality. The

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<sup>95</sup> See the section on options for administering the scheme for further detail on how the recommended expert groups might work.

award must take into account the length of time lived after onset of the infection (not the diagnosis which may be later), the effects of any treatment, the severity of the symptoms suffered, and the prognosis. It is likely to be appropriate to make this award as a lump sum rather than a periodical payment.

### 9.26 Severity of disease:

- In order to simplify the assessment of where in the range a particular award should be placed, a limited number of levels of severity should be defined.
- The definitions of severity should be made by reference to a clinical consensus as to the progress of each disease, taking account of the lived experience of the infected. Such stages should be defined for the progress of each disease, when a person is infected only with that disease, and also for each common combination. For the sake of ease of assessment it is suggested that three levels of severity be defined for each infection or combination of infection:
  - 1. Mild
  - 2. Moderate
  - 3. Severe
- The legal panel would have to consider, based on the description of the impact of each disease on sufferers provided by the medical panel, to what extent any difference in severity between each disease should be recognised by different ranges of award. It seems likely that there is such a difference but it would be wrong for me to prejudge that.
- It would be theoretically possible to distinguish in such a matrix between those with no prior blood disorder who received blood or blood products as part of medical or surgical treatment and those with a prior blood disorder, such as haemophilia, for which the infected person received blood or blood product as part of their treatment. In at least in some cases it is possible that a pre-existing blood disorder would have had impacts of a similar nature to those caused by the infection, if less serious. If medical advice is that there is no overlap between the impact of a pre-existing blood disorder and one or more of the relevant infections, then there will be no difference in the award for that particular combination and this point need not be considered further. In any event, it is likely to be very difficult to establish the hypothetical effect of a pre-existing condition that led to the administration of a blood transfusion, for example, and the infection. Likewise, there is likely to be room for considerable dispute as to what the effects of the various relevant blood disorders might have been in any event. It will be far simpler and equally fair in every case to assess the severity without regard to the hypothetical effect of the pre-existing condition. At common law, damages are payable for injuries to which the wrongdoing has made a material contribution - a similar approach should be taken here.
- There will be those who contend, as they have done to the Study, that those who have been infected without having had the background of a blood disorder have suffered an additional trauma, and therefore need to be treated separately. In my view there is no need to develop a separate category to recognise this. Any additional trauma can be taken into account in assessing the severity of the impact of the infection. This is an area where the advantages of a relatively simple assessment framework producing broadly consistent outcomes outweigh the advantages of a more bespoke approach.

- The definition of each severity level should take account of the expected or normal progress of the infection from onset to termination, either by natural recovery, medical cure, or death. It should focus on the physical and mental injury, and loss of capacity caused by the infection. The definition should leave out of consideration social aspects surrounding these diseases (such as stigma) which, it is recommended, should be addressed by a separate head of award as described below. As the award is a lifetime award, the severity must be judged over the expected lifetime of the eligible person, not merely by their current condition. It would be artificial, and probably increase the distance between the award and the reality of any case, to prescribe an annual figure and multiply that by the number of years during which the infection has or will be suffered. That is not the approach taken in personal injury litigation. An overall lump sum is better able to account for the inevitable, non-linear, ups and downs in a person's condition and, for example, the fact that some people may go without evidence of problems for periods of time, but still have to endure the threat of deterioration or even death hanging over them throughout. Even those whose HIV/AIDS symptoms have been suppressed by modern medication know of and fear the possibility of all existing drugs becoming less effective, allowing the full force of the disease to return. Therefore, in assessing where in any particular range an award should fall must have regard to the likely length of the effects of the infection lasting without seeking mathematical precision. The principal focus should be on where within the category and level of severity identified the claimant falls compared with the cohort as a whole.
- A person co-infected with both HCV and HIV should receive an impact award larger than that awarded to a person with just one of those infections, but - because there is inevitably an overlap in the stigma, illnesses and disabilities caused by each - the award for the impact of co-infection should be less than the total which would be awarded for each infection separately. It must be recognised that people may suffer pain and distress from multiple causes simultaneously. An impact award should look at the effect on each individual as a whole and awards should not be made up by simply adding together the sums indicated in the tariff for each applicable category.
- As recommended elsewhere, those who actually contract vCJD should look to the vCJD Compensation Scheme for redress for that disease.

## Calculating a Range for an injury Impact Award

*An illustration of how a grid could show a range of possible awards*

**9.27** As discussed above, an impact award would be the scheme's equivalent of an award for pain, suffering and loss of amenity. It is, therefore, a logical starting point to refer to the guideline figures used for personal injury actions. Unfortunately, there is very little material from which comparables can be found.

### *Judicial College guidance*

**9.28** Extracts from the current Judicial College's guidelines are included at Appendix 5. Some of the extracts are chosen because of their direct relevance, but many are included to demonstrate

the overall range of awards which are acceptable for either relatively minor injuries or for the most serious. A number of points can be observed:

- The maximum award for the most catastrophic injury is currently £344,640. This is not a statutory maximum or 'cap', but it is highly unlikely that any award for pain, injury, and loss of amenity will exceed a figure in that area. Clearly, this would be thought inadequate recompense for the most serious cases that reach the courts, but this sum would be but one component of the overall award which will, in a catastrophic case, include large sums for the cost of care, adapted accommodation, equipment, and loss of earnings - it is those heads of damage which result in some cases of awards running into many millions of pounds.
- Serious and tragic though cases of the infected may be, it seems unlikely that any will be at the maximum level of severity which the court would reflect by an award at the maximum level.
- If we consider the most serious level of injury, disability and illness suffered by infected persons as described in the expert group reports, the type of features experienced are potentially more comparable to those described in the Judicial College guideline categories for:
  - 'moderate' brain damage (category 3Ac (ii): £77,410 - £128,060);
  - moderately severe psychiatric damages (category 4Aab: £16,270 - £46,780);
  - moderately severe post-traumatic stress disorder (category 4Bb: £19,750 - £51,180);
  - mesothelioma (category Ca: £59,730 - £106,410);
  - Severe toxicosis (category 6Gb(i): £32,780 - £44,790);
  - Kidney damage risking total loss of kidney function (Category 6Hb: £54,600);
  - Severe chronic pain including serious persisting fibromyalgia (category 8Ai: £17,970 - £32,840).
- It must be stressed that in considering a personal injury case with some of these elements, a court would not simply add up and award the amounts that have been awarded for each condition or injury separately, but would take an overall view having regard to these figures.

### *Judicial awards*

**9.29** There appear to have been very few awards in court cases in England and Wales in which damages have been judicially assessed for directly comparable cases. In *AA v National Blood Authority*<sup>96</sup>, Mr. Justice Burton did give awards in six test cases involving claimants who had been infected with HCV from blood or blood products through transfusion in March 1988. The awards

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<sup>96</sup> For a summary of the judgment see the Rationale section, above. The part of the judgment dealing with the award of damages (as set out in Appendix 8) is from paragraphs 69 onwards.

appear to be very modest. Even updated for inflation, the largest award for pain suffering and loss of amenity was just under £19,000. However, it should be noted that all but one of the cases were provisional awards, i.e. awards assuming no deterioration from the claimant's current expected prognosis. Most of the cases appear to have concerned infections towards the minor end of the spectrum and, of course, were assessed before quite so long a period had elapsed as would now be the case.

### *Settled cases*

**9.30** NHS Resolution kindly provided me with some limited information about cases which had been settled by their predecessor following on from this judgment. 113 claims were settled with damages paid, but 162 were withdrawn with no payment. I was informed of a further 123 cases, not associated with product liability or the AA case, which had been brought in negligence actions, all relating to HCV infection; in only 21 of which had a payment been made in settlement. The highest figure award was over £500,000 and the lowest £1,000. As these figures would not have been restricted to pain, suffering and loss of amenity damages, they are of very limited assistance. What is clear, however, is that the vast majority of claims have been withdrawn without payment, a factor which in itself suggests that settlement resulting in payments are likely to have been at a level significantly less than what could have been expected to be recovered if legal liability had been established in court.

### *Criminal Injuries Compensation*

**9.31** We have identified two potentially relevant reports of Criminal Injuries Compensation Board awards. The first, in 1998, was for a claimant who contracted HIV from a sexual assault.<sup>97</sup> The award was made 9 years after the infection and the claimant had suffered serious side effects from treatment to which they were responding. It was assumed a patient could live for 15 to 20 years with the infection. The Board awarded £50,000 general damages (based on RPI of 164.5 in October 1998 and 317.7 in January 2022, that is worth about £96,500 today). The second<sup>98</sup>, in 2018, was for a 26-year old man deliberately infected with HIV by an ex-partner. A settlement of £22,000 (about £24,500 today, based on RPI of 284.6 in November 2018 and 317.7 in January 2022) was achieved; unfortunately no detail is available as to the severity suffered.

### *Republic of Ireland's Hepatitis C and HIV Compensation Tribunal*

**9.32** The Republic of Ireland's Hepatitis C and HIV Compensation Tribunal publishes overall figures for its awards, and for completeness a table of these is included in this report<sup>99</sup>. This discloses that between 1996 and 2019 a total of 3,652 claims received awards from the Tribunal totalling €751.6 million, an average of €205,805 per case. There are also a number of High Court awards on appeal, and separate payments from the Reparation fund for the equivalent of exemplary damages. Again, this information is of limited assistance as the pain, suffering and loss of amenity element is not separated out, and we are informed that the level of damages awarded in

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<sup>97</sup> *Re H CICB 1998* [1998] 10 WLUK 170.

<sup>98</sup>

<https://www.hudgellsolicitors.co.uk/news/criminal-injuries/man-deliberately-infected-with-hiv-by-partner-secured-damages-through-the-criminal-injuries-compensation-authority-cica/>.

<sup>99</sup> *Annual Report of the Hepatitis C Compensation Tribunal 2019*; see Appendix 7.

the Republic tends to be more generous than in this jurisdiction. The published judgments of appeal cases demonstrate how the Tribunal is expected to assess awards and it is possible to identify breakdowns of the awards. Three cases are summarised in Appendix 6(e). The awards have to be seen against a background in which there is a 'cap' on general damages awards of between €500,000 and €550,000.

*Discussion and conclusion*

**9.33** Given the dearth of helpful comparables, it is clear that a range of awards can only be arrived at on an impressionistic basis. The figures suggested in the grid below are, in my view, potentially generous, but at the same time fit within the generally accepted range of awards for significant injuries. I must emphasise that these figures are included for illustrative purposes only to demonstrate a method of arriving at standardised figures. I have assumed that one of the diseases is considered by the medical and/or legal panels to have a greater impact than the other, and accordingly a higher range than the other. Were it to be decided that was not the case, obviously the grid would be simpler. Where in the range a particular case comes, has to be assessed on the basis of the actual history of the claimant's experience, the time over which they have suffered it and can be expected to endure it in future, and the particular circumstances of the case.

**9.34** I have arrived at ranges for persons co-infected with both diseases by adding one half of the range for the 'less serious' disease to that suggested for the value of the 'more serious' disease. An expert panel might come to the conclusion that a different proportion was justified, depending on the view taken about the degree of overlap of symptoms between the two infections.

**9.35** I must emphasise once again, that I have produced this grid as an illustration of how an expert independent legal panel might proceed to determine appropriate figures. It would be quite wrong for me, as a single, now retired practitioner, to seek in advance of that process to prescribe something of such significance to the victims of this tragedy.

**ILLUSTRATIVE GRID FOR AN IMPACT AWARD BY CATEGORIES OF SEVERITY**

Infection Type	Mild	Moderate	Severe
Disease A	50,000 - 75,000	75,000 - 125,000	125,000 - 190,000
Disease B [if decided to be more serious]	70,000 - 90,000	90,000 - 140,000	140,000 - 220,000
Disease A/B co-infection	95,000 - 127,500	127,500 - 202,500	202,500 - 315,000

**9.36** Given the conventional restrictions on the upper limits of awards, it would be the very rare case indeed which approached the maximum figure illustrated here, particularly given the additional awards which might be made for stigma and social effects.

## Social Impact Award

### *Stigma and Social Effects of Infection*

**9.37** The purpose of this award would be to compensate the infected for the stigma and adverse social effects of these infections. While it is right to recognise differences in the severity of physical and mental injury by an assessment of where an individual case falls within the prescribed range, there are certain aspects of the distress and loss of amenity where a monetary award is almost arbitrary and distinctions between cases are likely to be unfair or inappropriate. For example, the stigma attached to a diagnosis of either HIV or HCV is well known and described and affects everyone with these infections. The Scottish Clinical Review Group advised that:

*“Hepatitis C, particularly in the context of the source of infection being an NHS one, changed lives because of its negative effects on family, relationships in general, ambition, employment, self-esteem and general mental wellbeing; these effects stem from a number of factors including the stigma associated with hepatitis C and the recalibrating effects of being diagnosed with an infection that, according to their healthcare attendants, would likely reduce the quality and quantity of one’s life.*

*Most individuals with chronic HCV who are registered with SIBSS were aware of their infection for many years, most lived with the uncertainty surrounding its consequences and most attributed, fully or in part, any ill health to it.*

*For those diagnosed more recently, there has been less uncertainty due to improved knowledge and better treatment; however, the failure to have been offered a test decades before (and the disadvantages of a later diagnosis) has caused resentment.*

*While the majority have been treated successfully, the legacy of their infection manifests, commonly, in the reflection - “... if I hadn’t been infected with hepatitis C what would my life have been like...”*

*While some infected people welcome action in the form of Inquiries, Reviews and Reports, most are stressed by them and yearn for closure - a time when they are free from hepatitis C in their bodies, but also free from hepatitis C in their minds.*

*In the context of the life changing impacts of hepatitis C on infected individuals, the burden on many of their partners and the widows/widowers/partners of those deceased - a burden which was particularly evident in conversations with SIBSS beneficiaries - must be recognised.”<sup>100</sup>*

**9.38** Later in the report it was observed:

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<sup>100</sup> *Clinical Review of the Impacts of Hepatitis C: Short Life Working Group Report for the Scottish Government*, (May 2018) Scottish Government page 7.

*“Just as critical are the notable losses sustained by most infected individuals. Such losses relate to relationships with family and friends, employment and financial security, and stem from many factors; these include i) the stigma of hepatitis C because of its association with injecting drug use and the fear of transmission to others, ii) the loss of ambition and self-esteem from knowing one has a life-threatening, generally untreatable, condition, iii) the debilitating effects of antiviral treatment and iv) the constant, long standing, reminder through news bulletins that one is the victim of an NHS “scandal and disaster”, the scale and intensity of which is unprecedented.”<sup>101</sup>*

**9.39** They pointed out that the effects of stigma could be suffered even when clinically relevant symptoms were not present<sup>102</sup>.

**9.40** The stigma attached to HIV and AIDS is so well known it hardly needs evidence to confirm its existence, but I have seen many examples of how sufferers report their experience of this. For example, an anonymous HIV infected witness to the Inquiry stated:

*“At the beginning, I experienced a lot of rejection as no one would touch you and if you had a cup of tea at someone else's house, they would put the cup in the [bin] when you left. My dentist refused to treat me when he was told that I was infected with HIV as he did not understand the infection...”*

*When I found a job and my company discovered that I was infected with HIV when I fell ill, I was dismissed. I got compensation ... I have been out of work for the last 10 years now ... I think that there is definitely a stigma around HIV and people still don't understand.”*

**9.41** One HIV sufferer told me<sup>103</sup>:

*“I wish to be more open about my condition, and have started to be in terms of speaking to close friends. A couple of months ago I told ... friends who've never known before. It was the dirty secret in the family. I've got [relations] with young children. I fear that the stigma may come back to bite them. For that reason I'm not more open - it's not a concern for me but for others within my family. It is something all of us had to live with for so long. It was partly by government actions - the tombstone adverts. The consequences of that campaign for our community have been devastating. We've had parents of children going into school demanding to know about HIV status. It's been horrendous and horrific and it continues to be so. It would not be straightforward to be public about it.”*

**9.42** Needless to say, those coinfecting with HCV and HIV tell similar stories of social isolation and stigma. One such sufferer told the Inquiry:

*“My infections had always been something that we had kept private, due to the stigma associated with it. When I was younger there was a great deal of media attention surrounding HIV and AIDS. People were having their houses spray painted and they were receiving abuse due to their infected status. We kept my infections a secret, to*

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<sup>101</sup> See above §2.5.1.

<sup>102</sup> See above §10.2.2.3.

<sup>103</sup> A note of an oral contribution at one of the Study's forums.

*protect the family. The societal shame has been the biggest obstacle for me to work through over the past fifteen years. I have since learnt that shame does not belong to me, it belongs to the society and I do not need to carry it. However, when I was younger it nearly killed me and it felt like it would have been better if I died than for anyone to have found out.”*

**9.43** The compensation here is not for the suffering caused by physical or mental illness or injury, but for the psychosocial impact of having one or both of the relevant infections.

**9.44** The social effects of these diseases will show up in completely different ways depending on individual social circumstances. To ascribe differential values to different circumstances is potentially offensive and unacceptably artificial. For example, one person may react to the stigma by isolating themselves entirely from others, another may hide the facts and try to lead a life as if there were no infection. Someone else might share the information and receive reassuring loving support. One person may be unable to find a lifetime partner or spouse, or suffer the breakdown of an existing relationship, whereas others may have no such impact but overcome the same challenges. The Scottish Clinical Review concluded that the distinction that had been drawn between chronic and advanced HCV in the Scottish Scheme was too sharp because the differences in impact were not so great<sup>104</sup>. There is no justification for trying to identify a different monetary value to those different circumstances. The only measurable difference is the length of time over which the stigma is suffered, from the date of diagnosis. In conclusion, I recommend that a single figure is specified as an award for stigma which is expressed on an periodic basis for the period from diagnosis for life.

**9.45** The stigma may be reduced by a ‘cure’ produced by modern treatment, but no one can avoid the burden of their history of infection. Therefore, the entitlement to compensation under this head should not be limited by any positive effects of treatment. Again, it is likely to be appropriate to award this as a lump sum, taking into account the assessed life expectancy of the claimant. However, it is right to impose a maximum sum. This may be artificial but some limit is necessary to reflect the fact that while the stigma may continue, firstly, its effects will be constantly changing, sometimes for the better and sometimes for the worse. Secondly, the sufferer is likely to become accustomed to it and find means of mitigating its effect. The figure awarded should be a lump sum reflecting both the past and future suffering of this type.

**9.46** The actual level of the standard sums to be awarded should be considered by the expert legal panel in consultation with the infected and affected communities. What follows is the author’s own impressionistic recommendation. An assumption is made that the worse the severity of the disease and its impact, the worse the stigma is likely to be. Firstly, the experiences reported in relation to seeking medical treatment will be more frequent the more severe the symptoms. Secondly, the nature of disease is more likely to be apparent to others. Thirdly, severe illness is likely to cause more concern and embarrassment within the family circle. Similar effects with regard to social isolation might well follow a similar track.

**9.47** It is suggested that consideration is given to an award of a tariff figure which is for periods of 5 years up to 15 years. The figure for those who have suffered, or will suffer, the stigma for longer than 15 years should be entitled to a prescribed maximum. It should be borne in mind when considering the adequacy of what is in any event a somewhat arbitrary figure, that recipients will also be receiving awards under other heads, in particular the injury impact award.

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<sup>104</sup> See above page 12.

**9.48** It should be for the expert panels to decide whether or not the stigma and social isolation experienced by those infected differs in quality and severity depending on which of the relevant diseases is contracted. It would be wrong for me to make that judgement. However, for illustrative purposes, I have suggested below the sort of figures that might be appropriate should a differential range be considered appropriate.

**ILLUSTRATIVE PERIODIC FIGURE FOR THE IMPACT OF STIGMA AND SOCIAL ISOLATION**

Infection Type	Mild	Moderate	Severe
Disease A			
0-4 years	10,000	15,000	20,000
5-9 years	15,000	20,000	25,000
10-14 years	20,000	25,000	30,000
15+	25,000	30,000	35,000
Disease B [if stigma thought to be more serious]			
0-4 years	15,000	20,000	25,000
5-9 years	20,000	25,000	30,000
10-14 years	25,000	30,000	35,000
15+	30,000	35,000	40,000
Disease A/B co-infected			
0-4 years	18,500	25,000	31,500
5-9 years	25,000	31,500	38,250
10-14 years	31,500	38,250	45,000
15+ years	38,250	45,000	51,500

**9.49** Where applicants are co-infected, they should receive the appropriate level of award for the more serious disease, plus a standard uplift of the appropriate tariff for the less serious, which for the illustrative purposes of the table I have set at one third. This uplift is lower than for the impact award for the co-infected applicants, because while the symptoms may be cumulative, the stigma

may be to be less so. Again, the appropriate figures for this table should be a matter for the legal panel to recommend.

*Interference with ability to form marriage, partnerships or equivalent long term relationships*

**9.50** One specific aspect of social isolation might be the resulting interference with the ability to form marriage, partnerships or equivalent long term relationships. A claim for such a loss is **not** for the consequences of the breakdown of a marriage, which are not recoverable in a negligence claim on the grounds, firstly, that any redistribution of assets resulting from the divorce were not a loss as such. Secondly, it would irremediably complicate the process of allocating assets after a divorce by adding an award to them. Thirdly, and, for our purposes, most relevantly, it is not in the public interest for a court to be required to investigate the complexities of a relationship and the reasons for a breakdown<sup>105</sup>. For these same reasons, I do not recommend that there be any additional award reflecting the actual breakdown of a relationship.

**9.51** However, awards are made for the loss of prospects for marriage, although usually as part of the award for general damages for pain, suffering and loss of amenity. It is, therefore, difficult to find guidance as to the appropriate amount for this item on its own. However, where there is a specific history of an infected person having been deprived of the chance of developing a long term relationship whether through stigma, illness, psychological trauma or personality change due to the experience of the infection, I suggest it would only be fair for this to result in a supplement to the social impact award.

**9.52** It is recommended that the more general emotional and social challenges thrown up by these infections are reflected in the recommended lump sum for the social impact award, for interference in family and private life. There is no doubt that many of the infected will have suffered serious adverse consequences to relationships with partners, spouses, family members and their wider social circle, but it would be disproportionately distressing for claimants and highly challenging for assessors to seek to put a separate value on these issues, as opposed to having regard to them as background to a determination of where in the range of possible impact awards a particular case should be located.

**9.53** The Judicial College Guidelines for psychiatric injury may be of some assistance in valuing an award for the loss or marriage or partnership prospects, as they include the effect of such injury on family life:

Moderately severe cases:	£16,270 - £46,780
Moderate cases (good prognosis):	£5,000 - £16,270

**9.54** It is suggested that a range of £10,000 - £20,000 may be an appropriate addition to the social impact award where there is evidence of a loss of prospects of forming a partnership. The top end of the range would be where there is evidence of an identifiable relationship, whereas the lower figure might be more appropriate where the inability to form relationships was for a shorter period, or the victim was older at the onset of the problem. These figures are less than would be awarded for a diagnosable psychiatric illness and seek to separate out the social effect of being infected, or associated with an infected person.

<sup>105</sup> *Pritchard v Cobden* [1988] Fam 22; *Damages for Personal Injury: Medical, Nursing and other expenses: Collateral Benefits* (Report) Law Commission, (1999) Law Com 262 §§2.55 - 2.62, 6.2 - 6.34 which reviewed the law and decided not to recommend any change.

### *Loss of Chance to Have Children*

**9.55** Likewise, any award for such a loss should be part of the social impact award, and should be available to all infected persons and affected persons, who because of their condition - or their relationship with an infected person - have been deprived of the chance of having children. The award should be simply for the inability or loss of the chance to have children; any psychological damage should be included in the award for the impact on life.

**9.56** The Judicial College Guidelines indicate higher figures for females than males. Whatever may be the merits of that, in the context of civil actions, it is suggested that parity is an important factor and that no presumptions based on gender are likely to be fair. The illustrative figures proposed are lower than the guidelines, firstly because of the suggested exclusion of certain psychological injuries, and also because in many cases both spouse or long-term partners may be eligible for an award.

**9.57** Where the claimant has no children and would have wanted to have them:

£30,000 - £90,000

**9.58** Where the claimant has one or more children but would have wanted to have more:

£15,000 - £30,000

**9.59** Where the claimant has been rendered infertile but would not have had children in any event (either through life choices or age):

£5,500 - £15,000

**9.60** It is not recommended that there should be an award for the cost of fertility treatment: it is assumed that such treatment, where a viable option, will be available via the NHS. The Scheme's support services should include assistance on obtaining the appropriate referral, where required.

## **Care Award**

### *Needs of the infected for care and support*

**9.61** In this section, the need for care by the infected is considered. The impact on the carer of having to provide it is addressed elsewhere. The general social and psychological impact of living with, being close to or related to an infected person is also addressed elsewhere, as possible direct claims by carers for compensation. Any reference to 'care' in this section is a reference to care and support, whether nursing or social, needed by the infected to support or replace their own participation in normal activities such as self care, housework, shopping, gardening, and DIY from which the infected has been disabled because of the relevant disease or consequent condition or treatment.

*The need of the infected for care and support*

**9.62** Many of those to whom we have spoken have described the care they have received, often from members of their families. While there has not been the time or the need to delve into the details, it seems likely that the need and incidence of the care required is very variable. Those whose infection has 'cleared' or who are symptom-free, are unlikely to have required any care at all, whereas those who have been very ill and debilitated - either because of their infection or because of treatment - are likely to have required many hours a week.

*The common law approach to damages for care*

**9.63** In a negligence based personal injury action it is possible to claim for care of this nature. The judgment in *AA v National Blood Authority*<sup>106</sup> gives illustrations of the way in which such claims are assessed in court proceedings<sup>107</sup>. Essentially, where care required by reason of the injury is obtained and paid for, the actual cost will be awarded, provided it is reasonable. Where, as will commonly be the case for the infected, such help will be provided by a partner or close relative without charge, the practice in personal injury cases - as demonstrated by the *AA* case - is to establish the number of hours which have been required in the past and will be required in the future, and then to identify a contemporary commercial rate of pay for comparable care. The award will be that hourly rate multiplied by the number of hours, from which will be deducted a percentage, often 25%<sup>108</sup>, to reflect the tax, national insurance and other costs which would have had to be paid by a professional carer but not by the gratuitous carer. It should be noted that the award for care in a personal injury case is paid to the injured claimant, who holds this sum on trust for the benefit of those who have provided the care, who are then entitled to be paid an amount which reflects their contribution to the gratuitous care. There is no legal right under which the carer can make a direct personal claim against the tortfeasor. In general, courts will not award more than the net commercial rate, even where the carer has given up more profitable employment. The reason is that the right to recompense is that of the injured person of what is reasonable to pay for their care, not a right on the part of the carer to reclaim their losses.

**9.64** In the most serious cases, such as that of a quadriplegic requiring 24-hour a day nursing care, the costs and the awards for this can amount to hundreds of thousands of pounds a year. It is highly unlikely, although not impossible, that care of this intensity would be required by the infected with which this study is concerned. More typically, there will be periods during which no care has been required, followed by periods of illness or treatment when some help of a few hours a day will be required.

**9.65** In deciding how to approach the issue of compensation for care given, it is relevant to note the complexity involved in calculating such an award in court proceedings. As an examination of the *AA* case will show, it is common practice for care experts, often qualified nurses or occupational therapists who run care agencies, to be instructed to interview the injured person and their family and to obtain highly detailed accounts of the history of their needs over time. They will then analyse that evidence, which can be extraordinarily detailed, to identify separate periods of differing need. Sometimes they will go into minute detail, for example considering the month

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<sup>106</sup> The issues of damages are considered in the judgment from page 84 §24 onwards.

<sup>107</sup> For a summary of the law and practice in relation to awards for gratuitous care, which has not significantly changed since the *AA* case, see §§63-66.

<sup>108</sup> There are frequent arguments put forward by defendants and their insurers in favour of a 33% discount, which in the writer's experience are usually rejected, if resisted. In any event Mr Justice Burton accepted that in these cases 25% was the appropriate deduction - see the judgment §66iv.

following a spell in hospital, or a period when the injured was away at school. Then, in respect of each such period, the expert will calculate the type of care required (e.g. nursing, gardening, DIY), the number of hours, and the appropriate commercial rate. The rate may differ according to whether the care is daytime or night care, itself divided into 'sleeping' or 'non-sleeping' care, or for 'unsocial' hours such as when care is required at weekends or public holidays. The exercise is then repeated for the predicted future needs of the injured person.

**9.66** It is suggested that to conduct such an exercise in the case of each applicant infected under a compensation scheme would defeat the ambition of most to have a scheme which is simple to understand, and prompt in its determinations. It is necessary to devise a method of offering a fair, if broad brush, reflection in any award of the need for care generally experienced by the infected both in the past and present. An option could be made available enabling an applicant to choose between accepting the broad brush sum, or undertaking a more detailed application as would take place in a civil action. Alternatively, it may be felt that setting a maximum applying to all within the scheme - except for the truly exceptionally severe cases - would promote equity/parity among the infected in the scheme.

**9.67** Whatever approach is taken, this is an area where the advantages of avoiding a demanding process involving detailed evidence and expert support suggest that a high degree of self assessment should be encouraged, but limited by reference to expert based standardised presumptions with regard to care needs and costs.

#### *A suggested approach to awards for care by the scheme*

**9.68** There are two categories to be considered:

- Cost of paid for care; and
- Care provided by family members without charge.

#### **Cost of Paid Care**

**9.69** It is possible that some of the infected will have actually paid for care or will be likely to do so in future. If this need can be shown to be attributable to the infection, then they should be compensated for what they have had to pay.

#### *Past paid care*

**9.70** In order to establish a claim for the cost of paid care the applicant would have to show:

- That they had a reasonable need for such care or assistance in order to undertake activities which would normally be undertaken personally: in most cases this need could be established by the applicant describing the activities for which such care and assistance were required. To make the process of application easier, there could be a presumption of such need in any case in which the applicant received attendance allowance.
- That the need was due to the infection or its consequences: in many cases this association will speak for itself, but there may be cases where care is required for unrelated reasons.

For example, the victim of a road accident may need help because of their injuries. A person with haemophilia may need care because of that condition or its natural consequences. In such a case, the applicant and the assessor will need to apportion any care provided, if it is not entirely clear into which category the care falls.

- That there is evidence of the amount of care provided which is related to the need: it would be unreasonable to expect applicants to provide a detailed breakdown of unpaid care provided, as opposed to a general description, and disproportionate to engage experts in the type of reconstruction described as occurring in personal injury actions. The general description should be used by the scheme assessors to identify where in a prescribed range of care costs lie. That range could be prescribed by the legal panel in consultation with appropriate nursing care experts.
- The cost of paid for care: supporting evidence would preferably be by way of invoices, but any confirmatory evidence could be considered. Any evidence showing an excess beyond the maximum prescribed for the relevant condition and its severity category (see below) would be irrelevant unless the applicant was claiming theirs was an exceptional case.
- That the cost charged was reasonable by reference to the prescribed hourly rate (see below): if this requirement were fulfilled, the claimant should be awarded the resulting amount in respect of care received in the past.

#### *Future paid care*

**9.71** If it were contended that care will be required in the future, an award could be made at the prescribed rate, and either awarded as a periodical payment for the periods when the care was likely to be required, or as a lump sum, documented for acceleration of receipt as would be a lump sum of damages in a comparable case.

#### **Value of Unpaid Care**

**9.72** Where an infected person has received care without charge, for example from a family member, or close friend, they should be able to claim a sum to reflect the value of that care. The criteria for assessing such an award would be similar to those required for paid care. The applicant would have to show:

- That they had a reasonable need for such care or assistance in order to undertake activities which would normally be undertaken personally: in most cases this need could be established by the applicant describing the activities for which such care and assistance were required. There could be a presumption of such need in any case in which the applicant received attendance allowance.
- That the need was due to the infection or its consequences.
- That there was evidence, for example in the form of a description by the applicant, supported by confirmation from the person who had provided the care, of the amount of time spent on care. It should not be a requirement that the applicant provide precise details of hours provided, as this would be very demanding, and generally encourage artificially

precise estimates. Where this is difficult, the assessor and the applicant should seek to agree between them an estimate based on the scheme's general experience, or standard advice obtained from the medical panel about care needs of the infected. For this purpose, the panel would need to be supplemented by care experts.

**9.73** The award would be for a number of hours of need for care in the past and anticipated to be needed in the future. This would be assessed by the scheme assessor on the basis of the applicant's evidence and the available information about the applicant's history and condition, against the expert based prescribed scales discussed below. The hours assessed should not exceed the prescribed number of hours of the applicant's condition and severity categories, and not exceed the prescribed commercial hourly rate (see below), from which would be deducted 25% to account for the fact that the award will be free of tax and national insurance.

#### *Lump sum and periodical payment alternatives*

**9.74** A lump sum should be awarded for past commercial or gratuitous care. In respect of future care, a lump sum could be awarded to reflect future needs discounted for accelerated payment, or a periodical payment could be made for the assessed future needs of the applicant for life.

#### *Prescribed scale of care hours required and commercial costs*

**9.75** In respect of each category of condition and severity level (which will have been described by the panel of medical experts) the medical and legal panels supplemented by independent care experts should be tasked with identifying:

- the median and maximum number of care hours, if any, that might reasonably be expected to be required; and
- an hourly rate determined by the average commercial rate for the region<sup>109</sup> in which the applicant lives. They should avoid differentiation of rates between different periods, such as between weekdays and weekends, public holidays and unsocial hours, and recommend a standard hourly rate for each year. To require further detail is impractical in a scheme of this type if simplicity and speed of process is to be prioritised.

**9.76** The maximum prescribed award would be the annual figure produced by multiplying the care hours by the relevant commercial rate (discounted by 25% and any attendance allowance received).

**9.77** The experts should not be required to assess cases individually, but to provide a matrix by which scheme assessors can identify the appropriate level of compensation within the scheme for each applicant.

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<sup>109</sup> At a minimum, the current average commercial rate for care in each nation should be identified preferably by reference to an agreed source of such statistics. To the extent possible, any differential between the commercial rates in different regions should also be identified. Awards for past care will require access to such figures for each year. Future awards should be made on the basis of the current applicable figures. The experts should be required to arrive at an overall hourly figure on an annualised basis, which does to require either applicants or assessors to break down the provision of care into different categories (such as day/night, weekday/weekend, etc.).

### *Exceptional cases*

**9.78** There may be exceptional cases in which the particular needs of the applicant required payments higher than this, for example where specialised nursing care is required, following serious complications from major treatment, such as a liver transplant.

## **Financial Losses**

### *Status of support payments*

**9.79** The overwhelming number of victims who have shared their views on this topic to the Study, consider that past support payments of whatever nature should not be taken into account when assessing or awarding compensation under the scheme. I agree that to do so would be highly complicated, particularly with reference to grants offered by the Alliance House Organisations, for which the records are likely to be incomplete, and the process for obtaining what records there are would be laborious. The complexity is added to by the variety of payments made by the more recent Infected Blood Schemes. In some cases, tracking down relatively small payments would be disproportionate. The strongest argument for this course is that all such payments have either been charitable or discretionary without any acceptance of obligation to make such payments. They have generally been paid for ‘support’, or to ‘lift out of poverty’, or simply to have been an expression of solidarity towards the victims of a terrible tragedy.

**9.80** The normal rule is that the value of ‘benefits’ (this word is used generally here and is wider than state benefits) accruing to the claimant are taken into account in assessing damages, but only if the ‘like-for-like’ principle applies. The effect of this principle is that before the value of benefits accruing to the claimant is deductible, it must be referable in its subject-matter to a head of loss which forms part of the claimant’s damages claim.<sup>110</sup>

**9.81** Even where the like-for-like principle does apply, there are two exceptions to the normal rule that benefits are taken into account: (1) proceeds of insurance where the claimant has paid or contributed to the insurance premium directly or indirectly (so not relevant here)<sup>111</sup> and (2) charitable receipts.

**9.82** In relation to charitable receipts, in one leading case<sup>112</sup>, Lord Reid said:

*“It would be revolting to the ordinary man's sense of justice, and therefore contrary to public policy, that the sufferer should have his damages reduced so that he would gain nothing from the benevolence of his friends or relations or of the public at large, and that the only gainer would be the wrong-doer. We do not have to decide in this case whether these considerations also apply to public benevolence in the shape of various uncovenanted benefits from the welfare state, but it may be thought that Parliament did not intend them to be for the benefit of the wrongdoer.”*

**9.83** The justification for the so-called ‘benevolence exception’ was explained in another case:<sup>113</sup>

<sup>110</sup> *Kemp & Kemp: Quantum of Damages*, accessed 11th March 2022 via Westlaw Books, paragraph 5-117.

<sup>111</sup> *Kemp & Kemp: Quantum of Damages*, accessed 11th March 2022 via Westlaw Books, paragraph 5-118.

<sup>112</sup> *Parry v Cleaver* [1970] AC 1.

<sup>113</sup> *Hussain v New Taplow Mills East* [1988] A.C. 514 at 527E-528.

*“Why should the tortfeasor derive any benefit, in the one case, from the premiums which the plaintiff has paid to insure himself against some contingency, however caused, in the other case, from the money provided by the third party with the sole intention of benefiting the injured plaintiff?”*

**9.84** The courts have held that ‘different considerations apply where the defendant, rather than a third party, is the benevolent provider of benefits.’<sup>114</sup>

**9.85** In Scotland, but not apparently the other devolved nations, “any benefit payable from public funds, ... designed to secure to the injured person or any relative of his a minimum level of subsistence” is taken into account in respect of any period prior to the date of the award of damages, but not in respect of any period after the date of the award of damages<sup>115</sup>.

**9.86** It is challenging to apply these principles to a UK-wide scheme, and against a background in which it is by no means clear whether the potential ‘wrongdoer’ is the same entity as the source of support payments. It is also difficult to identify the heads of compensation against which the support payments could be set off fairly. Therefore I consider that support payments made to date by any of the support schemes should not be set off against any part of a compensation award. They are an expression of the ‘benevolence’ of the State and were not intended to be relevant to any claim for compensation. It would be unfair to make payments already made relevant now to compensation. Finally, in order to preserve parity, the same principle should be applied to support payments and compensation throughout the UK.

**9.87** However, in my view support payments, if they are to continue, cannot be completely ignored when it comes to the future. The case for continuing them in a form which is guaranteed for life is very strong and is supported by all the beneficiaries of the current schemes to whom we have spoken. A regular annual payment of that nature is vital to enable victims who have lacked security for so much of their lives because of these infections. They need stability, as well as a guarantee of sufficient income to enable them to maintain themselves without resort to benefits designed to lift all members of society out of poverty. It is not entirely clear what the current regular payments are designed to achieve or provide ‘support’ for. However, since the largely welcomed attempts to bring payments up to the same level in all nations to achieve parity, they are now at a level which exceeds the national living wage and even the national average or median earnings. The annual payments offered by the various support schemes as of 2022 (following parity adjustments), for example, are shown in the table at Appendix 4. There are, of course, a wide variety of more specific figures available and which could be used as reference points, and this is a matter which should be considered by the expert legal panel. Generally, an overall figure applicable to all is likely to require less detailed assessment of individual cases and, therefore, a swifter resolution and less demands on applicants for evidence. However, for illustrative purposes, the national median earnings are used here.

**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:

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<sup>114</sup> *Kemp & Kemp: Quantum of Damages*, accessed 11th March 2022 via Westlaw Books, paragraph 5-119, citing *Gaca v Pirelli General plc* [2004] 1 W.L.R. 2683.

<sup>115</sup> s10(c) and (iii), *Administration of Justice Act 1982*.

- 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).<sup>116</sup> If that were taken as the base figure the 5% enhancement would make a total of £33,361.<sup>117</sup>
- 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.

**9.90** I recommend that in exchange for the lifetime guarantee of this increased annual sum, uprated annually for inflation, by reference to the annual increase in median earnings equivalent to ASHE 80%<sup>118</sup>, such payments should be taken into account in the assessment of entitlement to any means tested state benefits. The payments should still be disregarded against any entitlement to non-means tested benefits such as disability living allowance.

**9.91** Therefore, I recommend that this sum (including, as is currently the case, the winter heating allowance) should be awarded within a continued support scheme, which is underpinned by a statutory authority and obligation to continue such payments for the life of the beneficiary. Alternatively, the support schemes annual payments could be merged into the compensation scheme as a minimum sum for financial loss payable to all eligible infected persons annually for life, under the same strength of guarantee as applies to court ordered periodical payments payable by a government department or State body.

**9.92** This sum, and the entitlement to it, should be substituted for the annual payments currently made under the support scheme and should be credited against any additional claim, whether under the compensation scheme, or in any civil action based on injury caused by the infection, for future financial losses, including loss of earnings, loss of earning capacity or other costs.

**9.93** 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.

#### *Additional claims for loss of earnings*

**9.94** It should be open to an infected person to claim for past and future loss of earnings, over and above the tariff sums described above, if they can prove an actual loss of earnings, net of tax, caused by an inability to work due to the infection, or an illness or disability caused by the infection. If the evidence is available, the actual loss could be calculated and awarded. In respect of past

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<sup>116</sup> <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/bulletins/annualsurveyofhoursandearnings/2021>. Details of these figures will require re-visiting as at the time of the setting up of the scheme in the light of up to date statistics.

<sup>117</sup> ASHE Table 14a 2021 provisional figures:

<https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/datasets/occupation4digitsoc2010ashtable14>.

<sup>118</sup> The ASHE 80% index is conventionally used to uprate periodical payments in legal actions for personal injury damages.

loss of earnings calculated on this basis, a lump sum should be awarded assessed on the actual loss incurred.

**9.95** In the absence of an employment record sufficient to make an assessment of the past loss of earnings, where an infected applicant can show persuasively that they have been unable to work, or have had a reduced earning capacity because of infection, reference should be made to relevant statistics, for example the national average earnings for that class of employment.<sup>119</sup> Where the relevant category of employment for that applicant cannot be shown, or working out a probable career path is speculative or disproportionately complex, to assess there should be a presumption that the applicant has lost income equivalent to the national median earnings. These figures are available from the Office of National Statistics in ASHE Table 14.1a. Ready reckoners to calculate the tax notionally payable are also available.

**9.96** The period for which loss of earnings compensation could be claimed is that during which the claimant was an adult following the onset of the infection as the presumptive loss. The claimant would be entitled to an award of this figure for each year during which they were incapacitated from work, unless the State proved on convincing evidence that for reasons not associated with the infection, the claimant would have been incapacitated from work in any event.

**9.97** In some cases, such as young children for whom inevitably no pre-injury history of ability or achievement would exist, it would be necessary, as in personal injury claims, to defer to the overall general median earnings figures. As these will already have been taken into account in the presumptive starting point, no further award would generally be available.

**9.98** From the figures arrived at, a deduction needs to be made for the tax and national insurance which will not have to be paid on the award. Tables are available giving broad calculations of the deductions to be made from the gross earnings figure.<sup>120</sup> Finally, any earnings actually received should be deducted.

**9.99** For past loss of earnings the resulting total would be payable as a lump sum. The assessed future loss of earnings would be calculated by multiplying the predicted annual loss by the number of years the loss is expected to last discounted for acceleration of receipt.

#### *Loss of earning capacity*

**9.100** Where the claimant has worked in spite of the infection, but has lost the prospects of better remunerated employments, or of a career likely to result in better remuneration, a sum could be awarded for the likely or possible loss calculated as a percentage of the probable earnings in that employment or career, the percentage to reflect the assessed chances of the claimant achieving that level of earnings, less their actual earnings. Such an award can be made in addition to earnings lost from an actual employment because of illness or disability.

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<sup>119</sup> I suggest the median earnings from the ONS Annual Survey of Hours and Earnings Table 14a are used for this purpose:  
<https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/datasets/occupation4digitsoc2010ashtable14/2015>.

<sup>120</sup> For example see Facts and Figures, (2021) PNBA, Sweet & Maxwell TableBLE G1.

*Taking account of past court awards or legal settlements of damages claims*

**9.101** In the few cases where the applicant has already received a settlement or award in court proceedings for damages arising out of the consequences of receiving infected blood, the amount received should be deducted from the award under the scheme, on a like for like basis. Thus awards for pain suffering and loss of amenity would be taken into account in the assessment of an impact award and awards or settlements in respect of financial losses should be taken into account in assessments of financial losses under the scheme. Where it is not possible to separate the sum paid into these component parts, the settlement should be deducted from any lump sum awarded under the scheme.

*Other possible heads of financial loss*

**9.102** In conventional litigation, claims can be made for any additional costs incurred as a result of the injury. Examples of these, which have been mentioned by the victims who have made submissions to the Study, include:

- Equipment
- Transport
- Holidays
- Insurance
- Medical treatment (not available on NHS)
- Counselling (if not provided by a support service)
- Accommodation
- Special dietary requirements
- Other specified costs caused by the injury or the needs associated with the injury.

**9.103** It would be possible for the scheme to allow for claims under these, and indeed any head of claim where the applicant can show they have incurred a loss. I have already proposed that there would be a standard annual sum added to the support payment to cover this type of expense. It would be preferable to adopt a broad approach like that wherever possible. I suggest that the scheme allows for discretionary awards to be made for additional expenses where the applicant can show they are significantly in excess of the standard annual payment. The discretion should not generally be used in respect of goods and services available free of charge, either through the scheme or a state agency.

*Assessment of future losses*

**9.104** Financial losses can be divided into past losses and future losses. Past losses may be calculated from evidence of actual or estimated costs, or in the case of care provided free of charge by reference to a discounted appropriate commercial rate (discounted for the fact that payments will be tax free, and there will usually have been no costs incurred in providing the care other than potentially the loss of time which could have been used in remunerative employment).

**9.105** Future losses can be calculated by identifying an annual probable cost multiplied by a multiplier representing the appropriate discount for accelerated receipt for future losses, or by way of periodical annual payments representing the assessed annual loss, uprated each year for inflation by reference to a specified index, commonly now the CPI.

## Compensation for the Eligible Affected

### Injury Impact Award

**9.106** This will be assessed in accordance with the same principles as I have suggested should be applied to the impact awards for the infected, but with necessary differences. Clearly injury and distress have a different origin and depend more on a relationship with the infected person rather than the effects of the disease itself. While I have mentioned physical injuries the much more likely injury is a mental one, and indeed a psychological one which may not result from a recognised psychiatric illness.

**9.107** However, it is not unreasonable when setting a general range of award to relate them to the severity of the suffering of the relevant infected person. I suggest that the approach taken should be for the assessors to consider the nature of the injury, if any, and the distress, anxiety and impact caused by the applicant's experience of witnessing the effects of the infection by reference to the guidelines and comparables already referred to and identify by that process an appropriate figure. However, the maximum payable should be the sum the infected person either has been awarded, or would have been awarded if they had made a claim.

### Social Impact Award

**9.108** This will be an award for eligible affected persons for the stigma and adverse social consequences of being associated with the infected person. The same considerations apply to them as would to the infected person, but almost certainly to a lesser extent. It is suggested that the social impact award for the affected should be no more than one half of that award appropriate for the infected person.

**9.109** The only affected persons who should be eligible for consideration for a supplement to this award for loss of partnership prospects or chance to have children, should be the spouses or partners of the infected person.

### Family Care Award

**9.110** Where a Care Award has not been made to the infected person, Eligible affected persons as defined should be able to claim directly for care they have provided free of charge to the infected person in the past. They should not be entitled to an award for future care, as the arrangements for this have to be in the hands of the infected person.

### Bereavement Award

**9.111** This should be a sum equivalent to the statutory sum payable under the Fatal Accidents Act 1976. It should be one payment to the personal representatives of the estate to share between dependants as defined under that Act. It would be payable in respect of deaths which have been caused by the infection or its consequences.

## **Bereaved Family Financial Loss Award**

**9.112** This should be calculated as would a loss of dependency claim under the Fatal Accidents Act as described above. The claim would have to be brought by the personal representatives of the deceased infected person.

## **Options as to the Form of the Award**

**9.113** A decision will have to be made as to the structure of awards.

**9.114 Final or provisional awards:** A provisional award is one which compensates the applicant on the basis of various defined assumptions with regard to their future condition; if within a defined period after the award the applicant's condition deteriorates seriously from that defined in the assumptions, they have the option of applying for a supplementary award to reflect that deterioration. Such awards are allowed for in the Irish Tribunal scheme.

**9.115** A final award is a one off award which compensates the applicant for all past injury and loss, but also all future injury and loss, as predicted on the available evidence at the time of the award.

**9.116** The choice between a final and a provisional award, if available, should be for the applicant to make. There are advantages and disadvantages to both types of award for both the applicant and the paying party. Some applicants would prefer the certainty of a final award, the avoidance of continued engagement with a scheme, and the ability to plan the rest of their lives in the knowledge of a defined fund. Others would prefer the assurance of being able to claim compensation more truly reflecting their condition, should there be a serious deterioration. Availability of provisional awards would mean that the scheme administration would be required to be maintained for a longer period, as cases in which provisional awards were chosen could not be closed.

**9.117** On balance, it is my view that the length of time which has passed since most of the relevant infections occurred is so long that it will be possible to make reasonably confident predictions with regard to the future progress of the disease. Further, the overwhelming message of the infected is that they want certainty to enable them to put the affairs of themselves and their families in order. For those reasons I recommend that provisional awards be not made part of this scheme. The advantages of finality outweigh the theoretical benefits of flexibility.

**9.118 Lump sums/periodical payments:** Awards which relate to past injury or of losses would inevitably be awarded as a lump sum. Generally speaking, in personal injury claims awards for the future injury loss and damage are also awarded as lump sums. This is because the past and future physical and mental impact of an injury are usually assessed holistically. To do otherwise would introduce an unduly artificial degree of precision into what is a broad overview of what is an appropriate sum to recognise the impact of an injury.

**9.119** Periodical payments are payments based on an assessment of a probable future financial loss which is measurable on an annual basis. An award is made for the life of the applicant - or the predicted length of the period of loss, if shorter - for a sum to be paid annually equivalent to that loss, uprated annually for inflation as measured by an agreed index, such as the Consumer Prices

index, or an earnings index.. The payments are guaranteed by a government undertaking or legislation having the same effect.

**9.120** There is an increased tendency in serious personal injury claims for future financial losses which can be assessed with a degree of probability on an annual basis to be compensated by a periodical payment. For example, where an injury results in an identifiable and regular need for care, its annualised cost can readily be compensated by an award of a periodical payment in that amount. The advantage is that the award then precisely reflects a known and relatively certain future need, and ends - usually on the death of the applicant in the case of care costs - at precisely the time the need ends. A similar approach could be taken to compensation loss of earnings, where an annual loss can be calculated with relative ease and probability, with the end point of compensation being the date on which it could be predicted the applicant would have retired but for the injury suffered.

**9.121** Again, the choice of whether the award should include periodical payments of this nature should be for the applicant to make.

**9.122** For these reasons I recommend that periodical payments for identified categories of regular future financial losses, in particular loss of earnings and care costs, be made available as part of an award, at the option of the applicant.

**9.123 Interest:** In litigation, interest at prescribed rates is usually awarded on general damages awarded for pain suffering and loss of amenity at 2%,<sup>121</sup> and on past losses (special damages) at a discretionary rate from the date the action was commenced, and the date of the injury, respectively. The general damages rate is 2% and the discretionary rate is in practice based on the rate offered on a prescribed court account. In the case of many of the claims that might be made under this scheme for past losses, these could go back many years leading to a large sum of interest. For example, the cumulative interest rate from January 1991 to June 2021 would have been 141.41%. In other words for £1 awarded for a loss in January 1991 interest of £1.41 would have been added in June 2021. A rough and ready approach to past continuing losses is to award half the cumulative interest on the total amount of the award.<sup>122</sup>

**9.124** The theory justifying an award of interest is that the claimant has been kept out of money which was due to them at the time of the loss, and thus they have been deprived of the potential investment income on that money ever since. The view could be taken that a compensation scheme such as is being proposed here is different from a court action, in that the 'liability' can only arise when the scheme is set up. However, the loss which the scheme is designed to compensate, if financial, occurred in some cases a long time ago: merely to award the then going rate, say for earnings, fails to take account of the fact that the applicant has been without that money for the intervening period of time and, therefore, arguably they have not been fully compensated for their loss. Apart from anything else, an award of £1 for a loss in 1991 without interest takes no account of the intervening inflation. The pound awarded now is worth considerably less than it would have been if paid then.

**9.125** There is a risk that an award of interest might be out of proportion to the actual loss originally suffered. The money has not been 'owed' over that period of time and, if the premise of this scheme is one of compensation in recognition of a moral obligation for avoidable harm, rather

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<sup>121</sup> *Lawrence v Chief Constable of Staffordshire iCA*, transcript 29 June 2000.

<sup>122</sup> *Dexter v Courtauld* [1984] 1 All E.R. 70.; cf *Prokop v Courtauld v DHSS* [1985] C.L.Y. 1037.

than for a wrong giving rise to a right of court action, this newly created entitlement is not completely comparable to the rights arising out of a court action.

**9.126** Nonetheless, I consider that the effect of inflation must be recognised, either by an award of interest, or by an uplift by reference to an inflation index. This does not, however, apply to lump sums awarded for non-financial losses (apart from the past value of care), where the award is made at the value applicable at the date of the award.

**9.127** Therefore, I recommend that either interest is payable on awards for past financial losses and the value of care, in accordance with the practice in personal injury damages claims; alternatively, that such awards are uplifted for inflation between the date of the loss and the date of the award.

### **Interim payments**

**9.128** Sadly, many of the infected community fear that they have not got long to live. It can only be hoped that this is not the case, given the improved availability of life prolonging treatments. Nonetheless, the fear is real, and indeed is a major factor behind submissions that the compensation scheme needs to be simple and rapid in process. There is a strong desire to be able to obtain the satisfaction that families will be secured after the infected person has died. Put bluntly, many have witnessed the death of their friends alongside whom they have fought for recognition of the wrong they believe they have suffered. Many seek compensation in reality not for themselves but for their loved ones. They want a compensation payment, and a substantial one at that, now.

**9.129** This fear, and the need for early resolution as a result, is perfectly understandable and indeed realistic. It is generally understood that the full detail of a compensation scheme cannot in practice be finalised until the conclusion of the inquiry. No criticism of the Inquiry is intended by noting that the anxiety in this regard has notably increased since an understanding spread that the Inquiry report may not now be delivered until 2023, whereas there had previously been an expectation this would have happened this year (2022).

**9.130** In any event, it seems unlikely that the scheme could become operational until after the publication of the Inquiry report and a process of discussion and consultation, although some elements of the scheme could possibly be set up in advance. This Study has been set up in part to mitigate the risk of delays for these reasons, but as will be clear from the text of this report, the time necessary to set up a complex scheme such as this cannot be eliminated entirely. In the meantime, the risk increases that infected persons will die without the reassurance of knowing of the financial benefits available to pass on to their families, and what may be many cases of hardship will continue without certain remedy.

**9.131** Unfortunately, it is not possible to eliminate this problem for all potential beneficiaries of the scheme. There will be potential beneficiaries in categories which have yet to be accepted as eligible for compensation. Others may qualify for existing categories in the support schemes, but they have yet to apply or be accepted. It is difficult to see how they can be offered any immediate compensation payment before the scheme is fully operational.

**9.132** There is, however, one category where not only is the need for immediate assistance the most clear, but who are the most easily identifiable, namely the infected persons who have already

been accepted as eligible for regular payments under the existing support schemes. Further, the support schemes provide an organisation through which a paid payment could be made if the funds to do so were made available.

**9.133** In personal injury litigation a similar problem arises frequently. Claimants have immediate needs to pay for care and other costs before their case can be finally resolved. There is a procedure by which they can apply for an interim payment, effectively on account of the damages they can expect to receive in their final award. Usually, the amount ordered to be paid by way of an interim payment will be a proportion of the sum the court is confident will be awarded in due course.

**9.134** I suggest a comparable course could be taken here if, and only if, the government is able to commit itself to the setting up of a compensation scheme. It could then offer an immediate payment to those infected known to be eligible because of their membership of a current support scheme. To take this step would generate confidence that a scheme would be set up, and potentially help to promote trust in the process.

**9.135** If it is decided to offer interim payments along these lines, the question remains what sum should be offered. This is clearly a matter for discussion, but one approach would be to look at the likely levels of the impact and social care impact awards. I have tentatively, and by way of illustration only, suggested figures for these awards. However, if it were accepted that the eventual scheme would be highly unlikely to specify a range of awards at significantly lower levels, then it could be considered appropriate to offer a figure broadly representing the lower part of the range for both awards. While clearly the amounts that might be payable eventually will vary considerably, depending on the severity of each individual's condition, it may be considered that very few if any of the eligible infected person could expect to receive an award of less than £100,000.

**9.136** Therefore, I recommend that arrangements should be made immediately through the existing support schemes for an interim lump sum payment of compensation to be made to every living infected person accepted by a support scheme as eligible for annual support payments. The payment should be a standard figure which reflects broadly the Government's assessment of the lowest amount of compensation likely to be awarded to such persons for the impact of the physical and mental injuries caused by the infection, and the social stigma and isolation caused thereby.

**9.137** The interim payment should be on account of any compensation awarded under the compensation scheme in due course, and should be free of tax and disregarded for benefit purposes on the same basis as support payments. While the payment is interim, there will be no obligation to return the payment, or any part of it, if the eventual award of compensation is less than the interim payment.

## **Recommendation 8:**

I recommend that the following available heads of award should be available to eligible infected persons, recognising that while guided by them, compensation will need in some instances to be of broader scope than permitted by the principles of common law, to recognise the particular social and psychosocial impacts relevant to the relevant infections:

- a) an **injury impact award** for past and future physical and mental injury caused by the infection and its consequences injury;
- b) a **social impact award** for past and future social consequence of the infection including stigma and social isolation;
- c) a **care award** for the past and future care needs of the eligible infected person;
- d) an **autonomy award** as additional redress for the distress and suffering caused by the impact of the disease, including interference with family and private life, including where relevant: loss of marriage/partnership prospects, loss of chance to have children, personal autonomy, the right to informed consent and candour from healthcare professionals and providers; and
- e) a **financial loss award** for past and future financial losses incurred by the eligible infected person because of the infection.

### Recommendation 9:

I recommend that the following heads of award should be available for eligible affected persons, recognising that while guided by them, compensation will need in some instances to be of broader scope than permitted by the principles of common law, to recognise the particular social and psychosocial impacts relevant to the relevant infections:

- a) an **injury impact award** for past and future physical and mental injury caused by their experience of the effect of the infection on the relevant eligible infected person;
- b) a **social impact award** for the adverse social consequences of being associated with the eligible infected person;
- c) a **family care award**, available where a Care Award is not made to the eligible infected person directly, for care provided free of charge to the infected person or likely to be provided by them in the future;
- d) an **autonomy award** for interference with family and private life;
- e) a **bereavement award** to the eligible affected persons in categories a) to c) above (recommendation 5, above) in the event of the death of the relevant eligible infected person by reason of the disease; and
- e) a **bereavement financial loss award** to the eligible affected persons in categories a) to c) above (recommendation 5, above) in the event of the death of the relevant eligible infected person by reason of the disease, for the loss of financial benefits they would have enjoyed but for the death.

### **Recommendation 10:**

I recommend that the Government should set out a framework of tariff based compensation for eligible infected and affected persons, at rates which broadly reflect comparable rates of common law damages and other UK compensation schemes, and in addition allowing an assessed basis for defined financial losses. The factors described in this report should inform the matters for which compensation is awarded. The rates of compensation should be based on the advice of the independent clinical and legal panels.

### **Recommendation 11:**

I recommend that, with reference to the status of awards:

- a) eligible infected and affected persons should not be required to accept the offer of an award in full and final settlement of any right to pursue legal actions related to the infection;
- b) any accepted scheme award should be set off against any entitlement to damages for the same subject matter;
- c) the availability of an award under the scheme should be a factor to which the court could have regard when determining liability for costs in any court proceedings related to the infection.

### **Recommendation 12:**

I recommend that, with regard to the type of award made:

- a) all awards should be final;
- b) at the option of the eligible person, awards be made in a lump sum, or, in respect of awards for continuing future losses, by way of guaranteed periodical payments uplifted annually for inflation for life, or the predicted period of the loss, if earlier.

### **Recommendation 13:**

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.

**Recommendation 14:**

I recommend that the Government should immediately consider offering a standard figure by way of substantial interim payments, on account of awards likely to be made under the scheme, to infected persons currently in receipt of support under any support scheme. The figure offered should represent broadly the minimum amount an infected person could be expected to receive by way of a final award.

## Relationship with Current Schemes

### Term of Reference:

To consider the relationship between a compensation framework and other receipts and payments by individuals, including: (a) the pre-existing financial support schemes; (b) legal claims; (c) welfare benefits and tax.

**10.1** The official explanation which may be most helpful in explaining the reason for the present relationship between support and benefit payments is the following:

*“All payments made to individuals via the schemes mentioned above are currently fully disregarded for the purposes of calculating eligibility for income-related benefits as they do not supplement income in the way that those benefits do but **are intended to compensate ‘infected persons’ and their relatives in recognition that the physical, mental and other health impacts for those infected can lead to additional costs which cannot be met through the benefits system.** Entitlement to contributory benefits is not affected by such payments. Such payments are also exempt from the DWP compensation recovery scheme.”*

Paragraph 7.2 of the Explanatory Memorandum to the *Social Security (Infected Blood and Thalidomide) Regulations 2017*

### Relationship of a Compensation Scheme to the Support Schemes

**10.2** With almost one voice, the beneficiaries of the support schemes wish their regular payments to continue, and for the security of them to be strengthened into a binding government commitment that they do so. None wish to lose their support entitlement in order to obtain compensation. I have, therefore, recommended that the annual payments offered by the support schemes should continue; alternatively, that they should be merged into the compensation scheme under which an irrevocable guarantee of continued payment could be made. The continued payment of the annual payments currently made by the support schemes provides a minimum base for compensation in the future. Given the availability of compensation for loss of earnings and other expenses, the rationale for the support payments will have changed from one of mitigating hardship, to one of giving beneficiaries back the standard of living which they would have enjoyed but for the injury. No existing beneficiary of a support scheme should be made worse off by any changes or by the introduction of the compensation scheme.

**10.3** I have further recommended that no account be taken when calculating compensation of any past payment from a support scheme or one of the preceding trusts and charities. Put simply, all such payments were *ex gratia*, were without any admission of liability, and were never intended to be compensation. In any event, the inquiry required to establish the full detail of support payments would be burdensome to all, and in some cases impossible because of lost or inaccessible records.

**10.4** A different approach is recommended for future support payments. Firstly, the anxiety about the security of such payments should be addressed. A formal undertaking on behalf of Her Majesty's Government should be given to each recipient of an annual support payment, that it will be paid for life. Alternatively, the same security could be provided by amendment of the law. Given that level of security, it is recommended that it would be fair and proportionate to have regard to future support payments in the assessment of awards for future financial losses, and compensation for future care. In the case of periodical payments for such losses, this would be a simple matter of deducting the support payment from the assessed annual award of compensation.

#### *Deduction of benefits*

**10.5** No deduction should be made for past support payments, for the reasons set out in the section considering the status of such payments<sup>123</sup>.

**10.6** A deduction, however, should be made from any award for care, past or future, of any attendance allowance received or receivable in future, unless it was shown that the disability for which it was awarded was unrelated to the injury forming the basis of the claim.

**10.7** Where an applicant has received income support in the past, the same approach should be made with regard to deductions from the award as would apply in a personal injury action pursuant to the Social Security (Recovery of Benefits) Act 1997.<sup>124</sup>

#### *Taxation*

**10.8** An award of damages is not chargeable to tax, and the same should apply to an award under a compensation scheme. The same principle already applies to the support schemes in relation to income tax<sup>125</sup> and council tax.<sup>126</sup>

**10.9** Submissions were also received with regard to inheritance tax. So far as I am aware, a conventional court award of damages is not exempt from inheritance tax, but, given the adverse effects these infections have inevitably had on family life, it seems appropriate that the amount of

<sup>123</sup> See the *Financial Losses* section in the *Types of Award and Method of Assessment* chapter.

<sup>124</sup> This is a complex subject, but essentially the DWP issues a certificate listing the deductible benefits received in the 'relevant period'. The defendant has to repay this amount to DWP and "may offset its expenditure against the claimant's damages award, but only to the extent that the claimant is being compensated for the same sort of losses which the benefits in question are supposed to alleviate". (*Kemp & Kemp: Quantum of Damages*, accessed 11th March 2022 via Westlaw Books, paragraph 5-073). In cases involving a disease, the 'relevant period' is five years running from the date on which the claimant first claims a listed benefit. In cases involving accident or injury the 'relevant period' is five years from the date of the accident/injury. (*Kemp* paragraph 5-074.) The legal panel would need to decide whether the relevant infections would appropriately be regarded as 'disease' for this purpose. For further information, see: <https://www.gov.uk/government/publications/recovery-of-benefits-and-or-lump-sum-payments-and-nhs-charges-technical-guidance/recovery-of-benefits-and-lump-sum-payments-and-nhs-charges-technical-guidance#the-law>.

<sup>125</sup> Under the Infected Blood Schemes (Application of Sections 731, 733 and 734 of the Income Tax (Trading and Other Income) Act 2005) Order 2017, any periodic payments made by EIBSS, WIBSS and IBPSNI attract no liability to income tax (lump sum awards were already income tax exempt), meaning that beneficiaries do not need to declare any of the payments in any income tax return submitted to Her Majesty's Revenue and Customs (HMRC), nor do the schemes need to deduct income tax from any of the payments. The Scottish Infected Blood Support Scheme (Application of Sections 731, 733 and 734 of the Income Tax (Trading and Other Income) Act 2005) Order 2017 conveys the same benefit for SIBSS.

<sup>126</sup> Any Council Tax payments received from the schemes can be ignored when calculating income for Council Tax Reduction, under the Council Tax Reduction Schemes (Amendment) (England) Regulations 2017 and the Council Tax Reduction (Scotland) Amendment Regulations 2017.

any lump sum award should be added to the inheritance tax allowance for a deceased infected recipient.

*Entitlement to benefits*

**10.10** Under the *Social Security (Infected Blood and Thalidomide) Regulations 2017* and the *Social Security (Scottish Infected Blood Support Scheme) Regulations 2017*, a range of means-tested benefits administered by the Department for Work and Pensions (DWP) discount infected blood scheme payments for the purposes of calculating a beneficiary's income or capital (such as savings). Beneficiaries are still required to declare receipt of scheme payments, in order to ensure that benefit assessors can determine what money to disregard in benefit calculations and avoid any effect upon entitlement. The DWP benefits this exemption relates to are: Income support; Jobseeker's Allowance (JSA); State Pension Credit; Housing Benefit; Employment and Support Allowance (ESA); and Universal Credit. I recommend that this exemption continues to apply to the annual payments that continue to be made under the support schemes, or their equivalent under the compensation scheme.

**Recommendation 15:**

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;
- d) such deductions as would be made from damages under the Social Security (Recovery of Benefits) Act 1997, but no other, should be made in respect of equivalent awards under the scheme;
- e) awards of financial loss should be made net of tax, but the awards themselves should not be liable to taxation, and should be regarded for tax purposes as if they were support payments;
- f) any lump sum award under the scheme should be made exempt from inheritance tax by an equivalent addition to the inheritance tax free allowance of the recipient.

## Options for Administering the Scheme

### Term of Reference:

To consider options for administering the scheme (including but not limited to what bodies, organisations or tribunals might need to be established to facilitate such administration); what principles, aims or criteria, etc. might underpin the development of an appropriate scheme; and any ancillary matters which should be considered such as interim payments, publicity of the scheme, outreach to potential claimants, and support.

### Independence

**11.1** There is little evidence that the infected and affected have any confidence in Government bodies because of their experiences and the commonly held belief that they have been treated without their knowledge, not informed of infections, been the subject of experiments, and above all provided with avoidably defective treatment. The extent to which any of these beliefs is established is a matter for the Inquiry, but the lack of trust in Governments of any political persuasion is likely to persist whatever its conclusions.

**11.2** However, the enthusiasm of both infected and affected for the payments made by the existing schemes to continue make it advisable to continue the administration which makes them.

**11.3** I note that one of the issues with the Windrush Compensation Scheme has been the challenge of regaining the trust of claimants when the Scheme is being administered by the government department they hold responsible for the failings giving rise to an entitlement to compensation. For this reason, both Justice and the Home Affairs Committee have recommended that the scheme should be administered independently of the Home Office:

*“The Windrush Compensation Scheme is intended to compensate victims of Home Office failings. There is therefore an inherent lack of independence in the Home Office having responsibility for administering the Scheme and for determining whether they themselves should pay compensation. In circumstances where fear and mistrust of the Home Office continues to run deep among victims and spans multiple generations, the inherent lack of independence in this approach has seriously undermined the aims of the Scheme and is a major factor in the lower-than-expected number of applications. The Working Group recommends that the Scheme is moved from the Home Office.”<sup>127</sup>*

**11.4** For these reasons, I recommend that an Arms Length Body be set up to administer the Scheme. This should be guaranteed independence of judgement with regard to the assessment of awards, but accountable to Parliament directly for the expenditure of public funds and the fulfilment of its terms of reference/governing rules.

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<sup>127</sup> *Reforming the Windrush Compensation Scheme – A Report by JUSTICE*, (2021) Page 2 §1.3: <https://files.justice.org.uk/wp-content/uploads/2021/11/12142211/JUSTICE-Report-Reforming-the-Windrush-Compensation-Scheme-Press-Copy.pdf>.

## Scheme Administration

**11.5** The precise detail of how a compensation scheme will be administered can only be worked out once it is clear what will be the requirements for eligibility, and how compensation awards will be determined, but I can point to some of the features it is clear any administration is likely to require, should a scheme of the type I have recommended be adopted.

**11.6** The alternative of a completely bespoke scheme, similar to the Irish Tribunal Scheme, would best be set up by modelling it on the legislative framework which has been summarised elsewhere in this report. The legislation and other material is so detailed that it requires no repetition here.

### *Structure of scheme administration*

**11.7** The administration of the scheme will have to support a number of functions:

- **Promotion of the scheme** to potentially eligible infected and affected people.
- **Processing of applications.**
- **A tiered system of assessment.** I have recommended a tiered system of compensation consisting of:
  - firstly, an interim payment, intended to represent the minimum amount any infected applicant could expect to receive, in so far as these have not been made before the scheme starts, through the support schemes;
  - secondly, a basic award, based on fixed tariffs or ranges of possible award under defined heads; and
  - thirdly, a more complex, bespoke assessment - for those seeking one - allowing for a more detailed determination of entitlements exceeding or in addition to the assumptions underpinning the standardised awards.
- **Payment mechanisms.** Both the second and third tier applications (above) may be for a lump sum and/or periodical award, and will require a means of delivering the payments and any other services or support included in the scheme.
- **Review/appeal.** A process of review and/or appeal will be required.
- **Advice and advocacy service.** Either by direct or commissioned provision, potential applicants for and recipients of awards will require advice and advocacy. While this could be provided by legal professionals and potentially funded by the scheme, it may be more supportive for those who need such help to receive it from a bespoke service. In some more complex cases, legal representation may be justified and then the scheme should be in a position to arrange this, but many of the challenges that will be faced are likely to be administrative rather than strictly legal issues, which might be better handled by an advice and support service dedicated to this scheme.

- **Coordination/delivery of support services.** If, as recommended, support is offered by way of advice on, signposting to or coordination of support services, administrative support will be required for this.

## Applications

**11.8** Inevitably, the process involved in determining an award involves administrative complexity, but this does not mean that the burden of this should fall on the applicant. It is important that for them the application process is as simple, sensitive, ‘trauma-informed’<sup>128</sup> and undemanding as possible. It is clear that many of those who will be entitled to compensation have experienced what they perceive to be re-traumatisation through obstructive or insensitive responses, which they have found profoundly distressing and even humiliating. Many people resent having to repeat histories they have given many times before. The experience of some, of applications to Alliance House Schemes, has led them to compare it to “begging”. Recognising these concerns, it will remain the case that some applications for compensation will inevitably be complicated, either because they fall into a new eligibility category, the applicants have not previously been admitted to a scheme, or the losses or injuries are for issues which no support has been available to date. Any process for lodging an application will require two parts:

- **Provision of information in support of eligibility:**
  - In cases where the applicant has already been accepted by one or more support schemes in the past, that fact alone should be all that is necessary to trigger acceptance of an applicant’s general eligibility.
  - In cases of applicants without such a background, either because they have not applied before, or because they are applying on grounds of eligibility that have not previously existed, more information is likely to be required. It should not be left to the applicant alone to locate and provide the evidence required: the scheme must be supportive and proactive. For example, it should be part of the routine of the scheme to obtain relevant medical and other records for applicants and to advise them where other information may be found.
  - Wherever possible, the scheme should be enabled to rely on presumptions, for example with regard to causation, if a defined minimum amount of information is available. The experience of the Scottish support scheme suggests that generally applicants do their honest best to provide accurate information.
  - Therefore, the approach of the scheme to the assessment of eligibility, starting with the demands made on applicants for information, should be to offer all the best chance possible of establishing an entitlement, rather than to be searching energetically for reasons to exclude them. The requisite information should be obtained through a supportive dialogue with the applicant, rather than a one off

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<sup>128</sup> See, for example, website of the National Association for People Abused in Childhood: <https://napac.org.uk/trauma-informed-practice-what-it-is-and-why-napac-supports-it/>; and *Trauma-Informed Practice: A Toolkit for Scotland*, Scottish Government / NHS Scotland, 2021: <https://www.gov.scot/publications/trauma-informed-practice-toolkit-scotland/documents/>.

submission of a form. In this way, the relevant information required to establish eligibility should be obtained *with* the applicant rather than *from* them.

- **Assessment of eligibility:**

- Determination of whether an applicant is eligible in principle for compensation, should generally be capable of being addressed administratively on the basis of the information collected, particularly if constructive resort can be had to helpful presumptions. For example, if it is established that an applicant has received a blood product which might have been unscreened for infection and has developed a relevant disease within a time frame consistent with the product being its source, the causal link should be accepted without requiring a clinical opinion. On the other hand, a clinical report which as a matter of professional opinion accepts all the elements required for eligibility, should also be accepted as conclusive unless there is overwhelming evidence to the contrary.
- Therefore, it should only rarely be necessary for medical opinion to be obtained, but the facility to do so should be made available, paid for by the scheme.

- **Assessment of disease stage and severity:**

- The information obtained with an infected applicant will need to be sufficient to establish the stage and severity of the infection. This will require either relevantly qualified and experienced medical practitioners or administrators who have been trained for the purpose.
- Either form of assessor will need to be guided by a comprehensive definition of the signs, symptoms and experiences which are present at each stage and degree of severity. The process might be administrative, if the process allowed for an outside medical opinion classifying these matters to be taken into account. Otherwise, the alternatives are for applicants to produce their own medical assessments, aligned to the scheme's definitions of stage and severity, or for a medical assessment to be performed by a scheme medical assessor.

### *Expert panels*

**11.9 Medical panel:** I have recommended that the definitions of the disease conditions, and the stages through which they progress, should be defined by an expert panel consisting of independent clinical experts, including psychologists, in consultation with the infected communities.

**11.10 Legal panel:** A second panel of legal experts will be required to define appropriate ranges of award for the impact of those conditions, in terms of physical and mental injury, by reference to the range of awards that would be made in a tort based personal injury claim.

**11.11** In a UK-wide scheme, in which the UK Government is accepting responsibility for funding, these issues will have to be determined at UK-wide level and, therefore, I recommend that the expert panels are set up and appointed at that level for the whole country. While having regard to the context of each devolved nation, for which purpose the membership should include lawyers

qualified in each jurisdiction, the objective should be to achieve parity of compensation levels across the UK.

### *Assessment of awards*

**11.12** Recommendations as to the structure of awards can be found elsewhere. I suggest that the most effective model for assessing awards in each case, would be that adopted by the 9/11 compensation scheme, of a relatively small team of lawyers with experience in personal injury cases,<sup>129</sup> or at the very least, well trained claims officers will be required. Whichever route is taken, it is important that assessment decisions are effectively quality assured so as to ensure consistency. It would also promote trust in the scheme and its work for case handlers to maintain a personal contact with the applicants whose claims they are assessing. That requires, so far as possible, that one case handler or a small team of identifiable handlers is assigned to each case. This is a process which needs to be conducted as close to the applicants as possible, and therefore, should be located in each of the devolved nations, as are the support schemes.

### *Appeal process*

**11.13** In addition to quality assurance, dissatisfied applicants should have the opportunity to seek an internal review of any determination, and after that an appeal to an independent panel. This should be:

- Demonstrably independent;
- Single stage, with an easy to understand procedure;
- Preferably a panel, consisting of a judge (or a person who has held judicial office), a person with lived experience of infection and/or being affected (or a nominee of a representative organisation), and a medical practitioner or psychologist with relevant clinical experience.

**11.14** This could be provided either by a panel set up for the purpose or, by legislation, a judicial tribunal or a direct appeal to the High Court on matters of law. The Irish scheme allows the court to review cases by way of reconsideration of the evidence and the admission of new evidence, where required. It is recommended that a similar but not identical approach is taken here. As the potential numbers are greater, if the review/appeal is to be performed by a judicial tribunal or the High Court, it is recommended that the tribunal or court's permission be required before an application is admitted for consideration. Either the tribunal/court would need to have UK-wide jurisdiction, or each devolved nation would require one to exercise the jurisdiction locally. Given these complexities, it is preferable for appeals to be conducted by a review panel within the structure of the Arms Length Body, with recourse to the courts for judicial review of their decisions.

### *Support services*

**11.15 Advice and advocacy:** As indicated above, it is desirable that the scheme and its applicants are supported by an advice and advocacy service. This should be a commissioned

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<sup>129</sup> See my descriptions of this scheme in the *Measures for Compensation* chapter and Appendix 6(d).

service acting independently of the scheme management, to assist all applicants navigate the process and ensure that their needs and claims were fully and effectively articulated and understood.

**11.16** In cases of particular complexity or sensitivity, the scheme should have the discretion to fund legal representation to address the particular needs of the case.

**11.17** In the case of award recipients who lack the capacity to manage their property and affairs, it may be necessary on a discretionary basis to fund the costs of guardians, attorneys and Court of Protection proceedings.

**11.18 Financial and associated advice:** Such advice may be required to mitigate losses such as difficulties in obtaining finance or insurance services, or simply advice on the management of the award. The management of the sums involved will be outside the experience of many applicants, and they will be disadvantaged if independent and impartial advice is not available to them. One example, from the experience of the support schemes, is the facility to write on behalf of an infected or affected person to a prospective financial lender to confirm the nature, extent and security of funding arrangements under a support or compensation scheme.

**11.19 Access to health and care services:** Some of the schemes described have a facility to expedite or facilitate access to the health and care services, and also financial services relevant to the infected or affected person. The management of support schemes in the UK have often made efforts to do that here, which has been welcomed by the beneficiaries of the schemes.

**11.20** In a country where healthcare is free to all at the point of need, the issue may not be the theoretical availability of - and entitlement to - a service, but the ease of access to it. Insofar as it is an issue for the infected and affected, the scheme should be resourced to offer advice and referral to appropriate services. For example, if an applicant has experienced difficulties in accessing appropriate counselling, the scheme should be equipped to offer them a referral to such a service, or where there is a common unmet need, to take steps with the NHS to ensure that specialised counselling is available.

**11.21** Likewise, if - as must be hoped - the support schemes' efforts to engage the financial and insurance sectors are continued and improved on, either by the support schemes or the compensation scheme, the compensation scheme may have a role to play in signalling or certifying entitlement to access any special arrangements made for this cohort.

**11.22** In addition to this body, the scheme should seek and report on the views and feedback on their experience of all applicants whether they are successful or not in their application.

### *Reports and accountability*

**11.23** The accounting officer for the scheme should be obliged to present an annual report on the performance of the scheme to Parliament.

*Should the compensation scheme be delivered locally or nationally?*

**11.24** The current support schemes are all separately administered by the governments of the devolved administrations. Each has its own characteristics deemed to suit the local beneficiaries of each scheme. In the past, this has led to a lack of consistency across the United Kingdom with regard to eligibility criteria, amounts payable, and methods of assessment. In recognition of this, in recent times there has been a drive towards parity.

**11.25** We have received a clear message from the infected and affected who are served by the schemes in the devolved nations that they have a strong preference for retaining them in the future. This view is informed by their experience of having been able to develop a personal relationship with case handlers. By contrast, the English scheme has, of necessity because of the larger numbers involved, been less personal. There is no doubt that a personal relationship of the type Scottish, Welsh and Northern Irish beneficiaries have enjoyed is of value. It builds trust and confidence among beneficiaries that their own circumstances are understood without continually having to repeat themselves. This impression was confirmed by our discussions with scheme managers in that it was obvious that they recalled individual cases, in which they took a personal interest, for instance when they were familiar with the family circumstances.

**11.26** To the extent that a compensation scheme depends on a non-discretionary allocation of a claim to a fixed tariff, it may be that the closeness of the administration to the applicants is of less significance, but the local connection has many advantages:

- Where awards depend on any level of discretion, assessors need to be familiar with the individuals involved in order to assess the factors relevant to that discretion.
- A personal connection allows applicants to feel that their individual needs and experiences are being recognised and addressed with much more confidence than in a system entirely dependent on forms and algorithms.
- If the scheme is to provide non-financial support, it will be easier to coordinate this at a local level. Some at least of the relevant services are provided by devolved administrations and in accordance with devolved legislation and budgets.
- Indeed, a scheme which must be proactive and supportive to facilitate access to the appropriate entitlements, needs to be physically accessible to applicants.
- If, as I recommend, the support schemes are to be continued broadly in their present form, local administration will be required in any event. While additional infrastructure will be required for compensation, there are likely to be cost and administrative advantages for both functions to be performed in the same organisational structure.

**11.27** These advantages remain even if, as should be the case if parity is to be maintained, the levels and categories of compensation are fixed by the UK government. Therefore, I recommend that consideration be given to merging the administration of the compensation scheme with the devolved administration local support schemes, either by legislation or under a memorandum of understanding between the UK and devolved governments, defining the areas in which each has primacy of direction. With regard to the delivery of the compensation scheme by the recommended Arms Length Body, the oversight of its responsibilities could be overseen by a UK

appointed board in which nominees of each of the devolved governments and victim representatives were involved.

## Confidentiality

**11.28** Applications, decisions and awards should be strictly confidential, and any reporting of decisions should retain anonymity for applicants.

**11.29** Applicants, however, should be free to identify themselves should they wish to do so, and the scheme should be free to respond publicly to comments made by applicants, but preserving anonymity where that had not been waived by the applicant.

**11.30** The assurance of confidentiality and privacy, where it is required, is very important and there needs to be transparency and consultation with regard to the measures adopted.

## User Involvement in the Scheme

**11.31** Whatever form the scheme takes, it will be novel, and there will inevitably be opportunities to learn from claims experience. It is important that victims' groups are consistently involved in offering feedback to the scheme on applicants' experience. Therefore, there should be an advisory forum or committee with a membership representative of those infected with all the relevant conditions and also of all nations. The scheme should be obliged to have regard to the views of this body in the management of the scheme and any changes proposed to be made to it.

## Non-Financial Support

### 11.32

- The scheme should have a support unit which is available to provide or arrange the provision of medical, psychological and social support to infected and affected persons appropriate to the needs caused by the consequences of the infection. The Archer Inquiry recommended<sup>130</sup> that the infected should be issued with a card entitling them to benefits not freely available under the NHS, including free prescriptions, counselling, physiotherapy and support services. This recommendation should be revisited and consideration given to whether such a scheme or comparable facility should be provided via the administration of the compensation scheme or otherwise.
- The standard of such provision should be in accordance with recognised contemporary standards.
- Where such support is available, compensation should not be awarded for the cost of providing the equivalent on a privately funded basis.

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<sup>130</sup> Archer Inquiry Report (cited above), page 108 §4.

### **Recommendation 16:**

I recommend that an Arms Length Body (ALB) should be set up to administer the compensation scheme, with guaranteed independence of judgement and accountable directly to Parliament for the expenditure of public funds and the fulfilment of its terms of reference, and with a procedure in accordance with the principles set out in this report and in particular which:

- a) have regard to the need of applicants for simplicity of process, accessibility, involvement, proactive support, fairness and efficiency;
- b) create a review and independent, preferably judicially led, appeal process;
- c) involve potentially eligible persons and their representatives in the review and improvement of the scheme, for example, by way of an advisory forum;
- d) has access to the records held by or on behalf of any previous publicly funded support scheme.

### **Recommendation 17:**

I recommend that the scheme should include provision of the following support services:

- a) an advice and advocacy service, supplemented where necessary by discretionary access to independent legal advice and representation, to assist and advise applicants;
- b) a financial advice and support service to assist recipient in the management of awards and in accessing financial services; and
- c) facilitation of access to appropriate health, care and counselling services.

### **Recommendation 18:**

I recommend that the compensation scheme should be delivered locally within each devolved nation. Consideration should be given by the UK and devolved governments to entering an agreement under which either a partnership board is created to oversee the compensation scheme's ALB, into which the administration of the local support schemes be merged, or the ALB commissions or delegates the local administration of the compensation scheme to the devolved support schemes.

## Other Issues

### Term of Reference:

To consider other issues that, in the course of his investigations, Sir Robert considers relevant.

## Legal Support

**12.1** It is inevitable that the scheme will be complex for many applicants to understand, to prepare their case for compensation and to respond to an offer or assessment of compensation. If, as they did, the Home Affairs Committee considered the Windrush scandal victims required legal support, it is difficult to see how the same conclusion cannot be reached for the victims of the infected blood scandal. While no doubt there were cases of complexity among the Windrush victims, the period of time during which the impact of the deficiencies in administration were operative are likely to have been considerably shorter than will apply in most cases in an infected blood scheme, and the issues - medical, psychological and social - cover a much wider range of circumstances. Potential claimants will have to understand into which, if any, of the categories of eligibility their case falls, and except in the simplest of cases they will have to articulate and explain the impact of the infection on them. To consider and describe the losses they have incurred within the categories of loss recognised by the scheme, and to prepare their best case. Even if potentially willing to be satisfied by a tariff payment, they will require advice enabling them to compare that with their prospects of large sums by undergoing the more complex process.

**12.2** This support could be provided in one, or both, of two ways:

- The scheme could contain a support unit staffed by lawyers and paralegals, working independently of the general scheme administration, to offer support to all claimants requesting it, including proactive assistance in gathering any necessary evidence, the preparation of appropriate statements, and advice as to entitlement and expectations. Where relevant, the support would extend to the pursuit of reviews or appeals.
- Independent lawyers could be offered a fee to provide this support. It should be possible to establish a standard fixed fee applicable to particular categories of work, and ideally for simplicity there should be a panel of firms eligible to receive such funding, chosen from the firms with demonstrable experience of this scandal. I would recommend that consideration be given to including all the RLRs at the Inquiry on the panel, but there may be other firms who can demonstrate appropriate competence.
- A combination of the two.

**12.3** It is vital that the funding is sufficient to enable adequate support to be provided. Less than that will lead to a swift breakdown of trust, but also a failure of the scheme to obtain the information it needs to make fair and appropriate assessments of compensation in accordance with the scheme rules.

**Recommendation 19:**

I recommend that the proposals for the design and administration of the Scheme, contained within this report, should be reviewed by the Government in the light of the findings and recommendations of the Inquiry, and thereafter, on a periodic basis and reported on to Parliament.

## Infected Blood Compensation Study Terms of Reference

### RATIONALE FOR COMPENSATION

- To consider the rationale for compensation as a matter of general principle and in relation to any particular classes of compensation, recognising that it is not for the Study to pre-empt the determination by the Infected Blood Inquiry as to what, if any, rationale is supported by the evidence it has received;

### INDEPENDENT ADVICE TO GOVERNMENT

- Give independent advice to the Government regarding the design of a workable and fair framework for compensation for individuals infected and affected across the UK to achieve parity between those eligible for compensation regardless of where in the UK the relevant treatment occurred or place of residence. While the Study is to take into account differences in current practice and/or law in the devolved nations, it is not asked to consider whether delivery of that framework should be managed centrally or individually by the devolved administrations;

### SCOPE OF COMPENSATION

- To consider the scope of eligibility for such compensation (including the appropriateness or otherwise of any conditions such as 'cut-off' dates), and whether it should be extended beyond infected individuals and their partners, to include for example affected parents and children, the wider affected family (e.g. siblings), and significant non-family carers and others affected, either because of the impact of caring responsibilities or the effects of bereavement or some other impact; to include consideration of former and new partnerships/marriages; and whether the estate of any individual who has died should be eligible for compensation;

### CATEGORIES OF INJURY AND LOSS

- To consider the injuries, loss and detriments that compensation should address, in relation to the past, present and future, including:
  - (a) the physical impact and consequences of infection/s (including the effect of any treatment, and potential future adverse effects);
  - (b) infections that cleared naturally; and the risk of any significant or long-term side effects of treatment (such as liver damage, increased risk of cancer) even if they are yet to materialise;
  - (c) the mental health, social and financial impacts (including access to financial services) - both actual and in terms of loss of opportunities - suffered by both the infected and affected; and

(d) other types of loss if appropriate;

## TYPES OF AWARD AND METHOD OF ASSESSMENT

- To consider:

(a) the extent to which any framework should offer compensation on the basis of an individualised assessment and/or fixed sums or a combination of these (including consideration of the position of an individual who was both infected, and affected by another individual's infection);

(b) whether awards should be by way of final lump sums, periodical payments or both;

(c) whether an individual should be required to prove matters (if so what types of matters, by what means, and to what standard);

(d) whether there should be any limitation by way of time or other bar on entitlement or claim, and whether any existing time bars should be maintained;

(e) the extent to which compensation should be limited to matters currently recognised by the law (taking into account any differences in the law across the UK) on damages and evidence as recoverable for the purposes of compensation, or, if not, the basis on which broader matters should be taken into account;

## MEASURES FOR COMPENSATION

- To consider the measures for compensation, looking at other national schemes (for example, the compensation tribunal established in the Republic of Ireland) to examine their merits or otherwise, and experiences, both as to form (i.e. administration/process) and the substance of compensation;

## RELATIONSHIP WITH CURRENT SCHEMES

- To consider the relationship between a compensation framework and other receipts and payments by individuals, including: (a) the pre-existing financial support schemes; (b) legal claims; (c) welfare benefits and tax;

## OPTIONS FOR ADMINISTERING THE SCHEME

- To consider options for administering the scheme (including but not limited to what bodies, organisations or tribunals might need to be established to facilitate such administration); what principles, aims or criteria etc might underpin the development of an appropriate scheme; and any ancillary matters which should be considered such as interim payments, publicity of the scheme, outreach to potential claimants, and support;

OTHER ISSUES

- To consider other issues that, in the course of his investigations, Sir Robert considers relevant; and

REPORTING TO GOVERNMENT BY FEBRUARY 2022 [AMENDED TO 14 MARCH 2022]

- To Submit to the Government its report and recommendations as quickly as possible and no later than the end of February 2022 [amended to 14 March 2022], to provide the Government with advice on potential options for compensation framework design.

## **Example Principles Suggested For A Compensation Framework**

A selection of the principles that have been suggested for the creation of a compensation scheme by a number of the solicitors and associations representing many of the infected and affected communities.

### **Collins Solicitors**

- 1: The present financial position of all individual participants must not be adversely affected by engaging with the process.
- 2: The process must be Claimant friendly, avoid complexity and in addition avoid unnecessary evidential requirements.
- 3: On no account should the existence of the framework prejudice or in any way affect the rights of individuals to refer to normal judicial process, including in particular continued prosecution of the group legal action.
- 4: The extent to which any defence mechanisms can be submitted to any tribunal in due course must be taken into account. There is little point in embarking on the exercise if claims are regularly and persistently excluded because of e.g. limitation/remoteness/causation.
- 5: Any process should so far as possible be non-adversarial or otherwise have the effect of re-victimising those who are already vulnerable.

### **Milners Solicitors**

- 1: No person should be disadvantaged by any change arising from the recommendations of the Study.
- 2: The compensation framework born out of the Study must offer the infected and affected community a final resolution to their dispute with Government.
- 3: Each infected and affected person should have the right to an individual assessment of their own losses.
- 4: Each infected and affected person should have the eligibility to bring a claim through the compensation scheme.
- 5: There should recognition for the following categories of extraordinary suffering within the scheme: reinfection increasing viral load; recognition of the most damaging genotypes; repeated treatments; loss of intimacy; treatment issues over co-infection; impact of HIV medication;

older/poorliest claimants have a more urgent need for resolution; campaigning took up time and cost.

6: There should be recognition that separate claims may be brought by one individual in different capacities.

7: There should be recognition that damages are to be paid going forward and that they have not been paid thus far.

8: No regard should be had to limitation.

9: All claimants should have the right to legal representation.

## **Scottish Infected Blood Forum**

1: Flexibility - The variety of circumstances faced by infected and affected people will require there to be choices, including hybrid scheme solutions.

2: Fairness - What happened was unfair, so for justice to prevail, peoples' real choices when it comes to compensation are to be commensurate and enabling, recognising relevant tariffs but avoiding competing categories like "stages".

3: Inclusion - Every individual opinion and experience is valid and must be heard with assumed good faith, particularly from those previously or currently excluded from financial entitlements.

4: Trust - When people are believed, albeit belatedly, then there is minimal need (or no need) for assessment.

5: Simplicity - The resulting scheme should be straightforward to operate and easy to access at the point of delivery; with the aim of avoiding, as far as possible, an adversarial, assessment driven, courtroom-type procedure to determine harms.

6: Respect - People must be treated with dignity, having their rights and confidentiality preserved.

7: Devolution - Each national group must be encouraged and empowered to retain the unique aspects of their current support schemes as operating under the devolved administrations.

8: Normal - For all to attain at least an "average" quality of life without having to justify themselves further, then a collectively pragmatic, generous-spirited, and selfless approach may be needed so that ultimately everyone gets a decent settlement.

9: Community - The resulting model should be viewed as a whole community response as far as possible, not one to be derived by a plethora of time-consuming, separately argued, legal cases.

## **Terrence Higgins Trust**

1: Compensation must reflect the extremely poor treatment of the infected blood community. It must take account of the damage done not just to those infected with HIV as a result of infected

blood products but also to their families. Compensation must reflect 40 years of justice delayed, the trauma of an HIV diagnosis when so little was known about the virus, the impact this had on life chances of those infected and their families, and the stigma of living with the virus still after four decades.

2: The compensation framework must give people the freedom to choose the structure they would like compensation to take. This should include the option of a choice between a lump sum plus monthly payments guaranteed by primary legislation and an individual tribunal outcome with one-off lump sum payment. Regardless of the option chosen, no one should be financially worse off at any stage in their life. There should be provision to increase a compensation decision as medical knowledge around the impact of infected blood products develops, for example when additional tests become available to detect conditions, such as vCJD, or if new comorbidities as a result of the infection or past treatments come to light.

3: Where people choose a tribunal-based outcome, compensation must be assessed on an individual basis. The tribunals must be completed within one year of the legislation enacting this process. While this should be based on common law principles, that consider losses and the impact on the survivor's life, it needs to go much further in line with Principle 1.

4: Everyone must have legal costs funded during the process of awarding them compensation. Everyone must have a right of appeal against the final decision, with legal costs funded.

5: Compensation payments should be tax exempt and there should be a tax exemption ladder on interest that is paid on the compensation once it has been received. The government must supplement compensation payments to those domiciled overseas, so they are not disadvantaged as a result of taxes being imposed when they transfer their compensation to their home country.

6: No one should be left behind. Compensation must be inclusive of those who were directly infected because of blood products used by the National Health Service to treat people with haemophilia, bleeding disorders or other conditions; any individuals who were infected with HIV or hepatitis by those directly infected because of those blood products; plus their partners, parents, carers, children and dependents. This must be inclusive of the estates of those who have died before being awarded fair compensation.

7: The postcode lottery for those haemophiliacs with HIV, hepatitis and vCJD as well as the comorbidities associated with these conditions must end. Considering the mistreatment at the hands of the National Health Service, compensation must include a free 'gold standard' of health and social care provision guaranteed under law.

8: For decades there has been discrimination against those who are living with HIV as a result of infected blood products when accessing loans, insurance and mortgages. The government must either produce government-backed financial services or underwrite financial services in the market so that those affected are free from surcharges or penalties.

9: Previous awards from support schemes, ex gratia payments or money gained through court action should not be taken into consideration when calculating a compensation settlement.

10: There should be a UK-wide compensation system.

## List of Meetings Held by the Study

The following is a list of formal meetings with interested organisations<sup>131</sup> and representatives of the infected and affected community held by the Study during the course of its consultations and information gathering (edited, where necessary, to maintain the confidentiality of personal information).

26/7/2021	Haemophilia and Contaminated Blood APPG (hosted by The Haemophilia Society)
23/8/2021	Department of Health and Social Care (DHSC)
2/11/2021	Discussion Forum on Issues Affecting the Bereaved
8/11/2021	Discussion Forum on Issues Affecting the Hepatitis Infected
15/11/2021	Discussion Forum on Issues Affecting the HIV Infected
22/11/2021	Discussion Forum on Issues Affecting the Affected
29/11/2021	NHS Resolution
29/11/2021	Discussion Forum on Issues Affecting the Multiple Infected
30/11/2021	The Haemophilia Society
30/11/2021	[infected and affected individuals]
01/12/2021	Haemophilia Scotland
01/12/2021	[infected and affected individuals]
09/12/2021	[infected and affected individuals]
10/12/2021	[infected and affected individuals]
10/12/2021	[infected and affected individuals]
14/12/2021	Recognised Legal Representatives Discussion Forum on Legal Issues
14/12/2021	Additional Discussion Forum for the Infected and Affected

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<sup>131</sup> This list does not include regular liaison meetings with the Study's sponsor department, the Cabinet Office (principally the Inquiries Sponsor Team), nor directly with representatives of Sir Brian's Infected Blood Inquiry; it does include meetings with other governmental bodies.

## Infected Blood Compensation Study

10/01/2022	Hepatitis C Trust
10/01/2022	Terrence Higgins Trust
24/01/2022	DHSC & EIBSS
26/01/2022	Welsh Government & WIBSS
02/02/2022	Scottish Government & SIBSS
03/02/2022	Northern Ireland Executive & IBPSNI
15/02/2022	Malcomson Law

**Existing Support Scheme Payment Levels (2022)**

Payment Type	One-off Payments	Annual Payments
Hepatitis C (stage 1)	£50,000	£18,912
Hepatitis C (stage 1) with SCM	-	£28,680
Hepatitis C (stage 2)	£20,000	£28,680
HIV	£80,500	£28,680
Co-infected with HIV and Hepatitis C (stage 1)	-	£38,928
Co-infected with HIV and Hepatitis C (stage 1) with SCM	-	£45,072
Co-infected with HIV and Hepatitis C (stage 2)	-	£45,072
Bereaved Partner	£10,000	100% / 75%
Winter Fuel Payment (December)	-	£544
Discretionary Payments:		
Income Top-Up	[varies]	-
Child Payments	-	£3,000 + £1,200 per subsequent child
Employment Training	-	[varies]
Accommodation Adaptations	-	< £2,500 every 10 years
Accommodation Repairs	-	< £2,500 per year

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Car Repairs	-	< £500 per year
Counselling	-	< £900 per year
Dental Costs	-	< band three cost per year (£282.80)
Funeral Payment Plan	< £4,500	-
Respite Break	-	< £750 per year (+ same for carer)
Hospital Travel Costs	-	< £150 per month (£1,800 per year)
Hospital Travel Costs for Family During a Period of Hospitalisation	-	< £250 per month (£3,000 per year)
Mobility Aids	-	< £2,500 per year
Motability Deposits	-	< £500 every 3 years
Specialist Bed/Mattress	-	< £1,500 every 10 years

**Judicial College Guidelines: 15<sup>th</sup> Edition, 2021<sup>132</sup>**

For many years the civil courts of England and Wales have been guided in awarding damages for personal injury by the Guidelines issued by the Judicial College. As the Guidelines themselves explain:

*“The Guidelines have, now, long been an essential part of the personal injury practitioner’s toolkit, providing at the very least the starting point for the evaluation of awards of general damages and often the end point too with any remaining argument being reserved for where, within the bracket, the level of damages should fall...”*

Unsurprisingly, there are few categories within the guidance which would cover either in full or even in part the issues suffered by those infected with blood and blood products. In particular, there are no sections dealing with infection by hepatitis or HIV and none for injury to the liver generally. However, the guidance may be helpful in indicating the maximum awarded for the most serious injuries as it is tolerably certain that a court would not make an award in a claim by an infected person for more than the sums that might be awarded to the worst case of brain injury or tetraplegia - indeed the awards are likely to be significantly less. However, certain categories may be thought in their description to contain at least some of the elements described in the guidance in identifying awards for somewhat different injuries. I have selected some of those for illustration purposes.

The text and the figures in the following table are direct quotes from the current edition of the Guidelines. The figures are proposed by the editorial team of judges and lawyers after studying relevant judicial decisions and awards. The ranges they identify are uprated for inflation in each edition by reference to the RPI, which accounts for the superficially precise figures. Emphasis has been supplied to parts of the description which seem particularly relevant to the cases a compensation scheme for the infected and affected would have to deal with.

Guideline ref	Injury type	Description	Range
1A	Injuries resulting in death - full awareness	Severe burns and lung damage followed by full awareness for a short period and then fluctuating levels of consciousness for between four and five weeks, coupled with intrusive treatment or significant orthopaedic/physical injuries followed by death within a couple of weeks up to 3 months.	£10,700 - £20,320

<sup>132</sup> The figures given in the table are those without the 10% uplift required in court based litigation to reflect the costs incurred by litigants in entering conditional fee agreements, which are no longer recoverable as part of the costs of successful litigation. I suggest it is not appropriate in a scheme which is not intended to rely on unfunded legal representation to add such an uplift. If, on the other hand, it is accepted that in general legal representation comparable to that used in court proceedings will be required, then an uplift might have to be considered.

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Guideline ref	Injury type	Description	Range
1B	Injuries resulting in death - followed by unconsciousness	Severe burns and lung damage causing excruciating pain but followed by unconsciousness after 3 hours and death two weeks later.	£8,970 - £9,100
1C	Injuries resulting in death - immediate unconsciousness/ death after six weeks	Immediate unconsciousness after injury, and death occurring after six weeks.	£3,530 - £4,120
1D	Injuries resulting in death - immediate unconsciousness/ death within one week	Immediate unconsciousness, or unconsciousness following very shortly after injury, and death occurring within a week. Where the victim is conscious initially, but dies from their injuries the same day, an award towards the bottom of the range will be appropriate.	£1,170 - £2,390
1E	Injuries resulting in death - mental anguish	<b>Fear of impending death / reduction in expectation of life.</b> For the parents of young children suffering such mental anguish for a period of around 3 months.	£3,980
2A	Injuries involving paralysis - tetraplegia	The typical case of tetraplegia attracting <b>an award in the mid-range of this bracket is appropriate for cases in which the injured person is not in physical pain, has full awareness of their disability, has an expectation of life of 25 years or more, has retained powers of speech, sight, and hearing but needs help with bodily functions. At the top end of the bracket will be cases where physical pain is present or where there is a significant effect on senses or ability to communicate.</b> Such cases often involve significant brain damage where degree of insight is a relevant factor: see 3(A)(a). Lack of awareness/significantly reduced life expectancy will justify a below average award. Other factors bearing on the award include age, the extent of any residual movement, the degree of independence or pain relief (if any) whether through the provision of aids/equipment, treatment, or otherwise, the presence of respiratory issues, and depression.	£276,940 - £344,640

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Guideline ref	Injury type	Description	Range
3Aa	Brain and head injury - brain damage  Very severe brain damage	In cases at the top of this bracket there may be some ability to follow basic commands, recovery of eye opening and return of sleep and waking patterns and postural reflex movement. There will be little, if any, evidence of meaningful response to their environment, little or no language function, double incontinence, and the need for full-time nursing care.	£240,590 - £344,640
3Ab	Moderately severe brain damage	The injured person will be very seriously disabled. There will be substantial dependence on others and a need for constant professional and other care. Disabilities may be physical, for example, limb paralysis, or cognitive, with marked impairment of intellect and personality. Cases otherwise within (a) above may fall into this bracket if life expectancy has been greatly reduced.  Where there is a risk of associated future development of other severe medical problems such as blindness an award in excess of the bracket would be justified.	£186,890 - £240,590
3Ac  (i)	Moderate brain damage	This category is distinguished from (b) by the fact that the degree of dependence is markedly lower.  <b>Cases in which there is moderate to severe intellectual deficit, a personality change, an effect on sight, speech, and senses with a significant risk of epilepsy, and no prospect of employment.</b>	£128,060 - £186,890
(ii)		<b>Cases in which there is a moderate to modest intellectual deficit, the ability to work is greatly reduced if not removed, and there is some risk of epilepsy (unless a provisional damages order provides for this risk).</b>	£77,410 - £128,060
(iii)		<b>Cases in which concentration and memory are affected, the ability to work is reduced, where there is a small risk of epilepsy, and any dependence on others is very limited.</b>	£36,740 - £77,410

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Guideline ref	Injury type	Description	Range
3Ad	Less severe brain damage	<p>In these cases the injured person will have made <b>a good recovery and will be able to take part in normal social life and to return to work. There may not have been a restoration of all normal functions so there may still be persisting problems such as poor concentration and memory or disinhibition of mood, which may interfere with lifestyle, leisure activities, and future work prospects.</b> At the top of this bracket there may be a small risk of epilepsy.</p> <p>The level of the award within the bracket will be affected by:</p> <ul style="list-style-type: none"> <li>(i) the extent and severity of the initial injury;</li> <li>(ii) the extent of any continuing, and possibly permanent, disability;</li> <li>(iii) the extent of any personality change;</li> <li>(iv) depression.</li> </ul>	£13,070 - £36,740
3Ae	Minor brain or head injury	<p>In these cases brain damage, if any, will have been minimal.</p> <p>The level of the award will be affected by the following considerations:</p> <ul style="list-style-type: none"> <li>(i) the severity of the initial injury;</li> <li>(ii) the period taken to recover from any symptoms;</li> <li>(iii) the extent of continuing symptoms;</li> <li>(iv) the presence or absence of headaches.</li> </ul> <p>The bottom of the bracket will reflect full recovery within a few weeks.</p>	£1,880 - £10,890

Guideline ref	Injury type	Description	Range
4	Psychiatric and psychological damage	<p>This chapter covers those cases where there is a recognizable psychiatric injury. In part (A) of this chapter <b>some of the brackets contain an element of compensation for post-traumatic stress disorder</b>. This is of course not a universal feature of cases of psychiatric injury and hence a number of the awards upon which the brackets are based did not reflect it. <b>Where it does figure any award will tend towards the upper end of the bracket. Cases where post-traumatic stress disorder is the sole psychiatric condition are dealt with in part (B) of this chapter. Where cases arise out of sexual and/or physical abuse in breach of parental, family, or other trust, involving victims who are young and/or vulnerable, awards will tend to be at the upper end of the relevant bracket...</b></p>	

<p>4A</p>	<p>Psychiatric damage generally</p>	<p>The factors to be taken into account in valuing claims of this nature are as follows:</p> <ul style="list-style-type: none"> <li>(i) the injured person’s ability to cope with life, education, and work;</li> <li>(ii) the effect on the injured person’s relationships with family, friends, and those with whom he or she comes into contact;</li> <li>(iii) the extent to which treatment would be successful;</li> <li>(iv) future vulnerability;</li> <li>(v) prognosis;</li> <li>(vi) whether medical help has been sought;</li> <li>(vii) claims relating to sexual and physical abuse usually include a significant aspect of psychiatric or psychological damage. The brackets discussed in this chapter provide a useful starting point in the assessment of general damages in such cases. It should not be forgotten, however, that this aspect of the injury is likely to form only part of the injury for which damages will be awarded. Many cases include physical or sexual abuse and injury. Others have an element of false imprisonment. <b>The fact of an abuse of trust is relevant to the award of damages. A further feature, which distinguishes these cases from most involving psychiatric damage, is that there may have been a long period during which the effects of the abuse were undiagnosed, untreated, unrecognised, or even denied.</b> Awards should take into account not only the psychiatric effects of the abuse on the injured party but also the immediate effects of the abuse at the time that it was perpetrated, including feelings of degradation. Aggravated damages may be appropriate. Cases of prolonged and frequent physical and sexual abuse of a child over many years by a person in a position of trust, involving penetrative violation, are likely to fall into (A)(a) or (B)(a) and reflect aggravated damages, leading to an award towards the top end of the bracket.</li> </ul>	
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Guideline ref	Injury type	Description	Range
4Aa	Severe	In these cases the injured person will have marked problems with respect to factors (i) to (iv) above and the prognosis will be very poor.	£46,780 - £98,750
4Ab	Moderately severe	In these cases there will be significant problems associated with factors (i) to (iv) above but the prognosis will be much more optimistic than in (a) above. While there are awards which support both extremes of this bracket, the majority are somewhere near the middle of the bracket. <b>Cases involving psychiatric injury following a negligent stillbirth or the traumatic birth of a child will often fall within this bracket. Cases of work-related stress resulting in a permanent or long-standing disability preventing a return to comparable employment would appear to come within this category.</b>	£16,270 - £46,780
4Ac	Moderate	While there may have been the sort of problems associated with factors (i) to (iv) above there will have been marked improvement by trial and the prognosis will be good.  Cases of work-related stress may fall within this category if symptoms are not prolonged.	£5,000 - £16,270
4Ad	Less severe	The level of the award will take into consideration the length of the period of disability and the extent to which daily activities and sleep were affected. <b>Cases falling short of a specific phobia or disorder such as travel anxiety when associated with minor physical symptoms may be found in the Minor Injuries chapter.</b>	£1,310 -£5,000

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Guideline ref	Injury type	Description	Range
4B	Post-Traumatic Stress Disorder	<b>Cases within this category are exclusively those where there is a specific diagnosis of a reactive psychiatric disorder following an event which creates psychological trauma in response to actual or threatened death, serious injury, or sexual violation.</b> The guidelines below have been compiled by reference to cases which variously reflect the criteria established in the 4th and then 5th editions of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR and DSM-5). <b>The symptoms may include nightmares, flashbacks, sleep disturbance, avoidance, mood disorders, suicidal ideation, and hyper-arousal. Symptoms of hyperarousal can affect basic functions such as breathing, pulse rate, and bowel and/or bladder control.</b>	
4Ba	Severe	Such cases will involve permanent effects which prevent the injured person from working at all or at least from functioning at anything approaching the pre-trauma level. All aspects of the life of the injured person will be badly affected.	£51,070 - £85,880
4Bb	Moderately severe	This category is distinct from (a) above because of the better prognosis which will be for some recovery with professional help.  However, the effects are still likely to cause significant disability for the foreseeable future. While there are awards which support both extremes of this bracket, the majority are between £24,540 and £31,660.	£19,750 - £51,180
4Bc	Moderate	In these cases the injured person will have largely recovered and any continuing effects will not be grossly disabling.	£6,980 - £19,750
4Bd	Less severe	In these cases a virtually full recovery will have been made within one to two years and only minor symptoms will persist over any longer period.	£3,370 - £6,980

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Guideline ref	Injury type	Description	Range
5A 5Aa	Injuries affecting sight  Total blindness and deafness	Such cases must be considered as ranking with the most devastating injuries.	£344,640
5Ab	Total blindness		£229,260
5Af		...serious but incomplete loss of vision in one eye without significant risk of loss or reduction of vision in the remaining eye, or where there is constant double vision. A case of constant blurred vision and sensitivity to light in both eyes requiring constant wearing of dark glasses would be at the top of the bracket.	£20,210 - £33,600
5Ag		Minor but permanent impairment of vision in one or both eyes, including cases where there is some double vision, which may not be constant, and cases of permanent sensitivity to bright light but not sufficient to require constant wearing of dark glasses.	£7,780 - £17,900
6C	Asbestos related disease	Mesothelioma, lung cancer, and asbestosis are the most serious of these. Mesothelioma is typically of shorter duration than either of the other two and often proves fatal within a matter of months from first diagnosis. Lung cancer and asbestosis are likely to have a fatal outcome, but the symptoms often endure for several years. Most of the recent reported cases concern mesothelioma. Cases of lung cancer and asbestosis may result in similar levels of symptoms to mesothelioma, which may justify awards in excess of the suggested upper brackets for those conditions.	

Infected Blood Compensation Study

Guideline ref	Injury type	Description	Range
Ca		Mesothelioma causing <b>severe pain and impairment of both function and quality of life</b> . This may be of the pleura (the lung lining) or <b>of the peritoneum (the lining of the abdominal cavity); the latter being typically more painful</b> . There are a large number of factors which will affect the level of award within the bracket. <b>These include but are not limited to duration of pain and suffering; extent and effects of invasive investigations; extent and effects of radical surgery, chemotherapy, and radiotherapy</b> ; whether the mesothelioma is peritoneal or pleural; <b>the extent to which the tumour has spread to encase the lungs and where other organs become involved causing additional pain and/or breathlessness; the level of the symptoms; domestic circumstances; age, level of activity, and previous state of health; extent of life loss; and concern for spouse and/or children following death. Most reported decisions other than those involving extremely short periods of symptoms or very elderly claimants fall within the middle and upper parts of the bracket.</b>	£59,730 - £107,410
6Da	Asthma	Severe and permanent disabling asthma, causing prolonged and regular coughing, disturbance of sleep, severe impairment of physical activity and enjoyment of life, and where employment prospects, if any, are grossly restricted.	£36,740 - £56,100
6E	Reproductive system - male		
Ec	Sterility	Cases of sterility usually fall into one of two categories: surgical, chemical, and disease cases (which involve no traumatic injury or scarring) and traumatic injuries (frequently caused by assaults) which are often aggravated by scarring.	
Ec i		Most serious cases - up to:	£120,040
Ec ii		Bottom of the range is the case of the much older man - about:	£16,040

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Guideline ref	Injury type	Description	Range
Ed		An uncomplicated case of sterility without impotence and without any aggravating features for a young man without children.	£47,830 - £60,880
Ee		A similar case but involving a family man who might have intended to have more children.	£20,210 - £26,710
6F	Reproductive system - female		
6Fa		Infertility whether by reason of injury or disease, with severe depression and anxiety, pain, and scarring.	£98,010 - £144,520
6Fb		Infertility resulting from failure to diagnose ectopic pregnancy not included in section (a) above but where there are resulting medical complications. The upper end of the bracket will be appropriate where those medical complications are significant.	£29,050 - £87,140
6Fc		Infertility without any medical complication and where the injured person already has children. The upper end of the bracket is appropriate in cases where there is significant psychological damage.	£15,320 - £31,350
6Fd		Infertility where the injured person would not have had children in any event (for example, because of age).	£5,630 - £10,750
6Gb	Digestive system - illness/damage resulting from non-traumatic injury, e.g. food poisoning	There will be a marked distinction between those, <b>comparatively rare, cases having a long-standing or even permanent effect on quality of life</b> and those in which the only continuing symptoms may be allergy to specific foods and the attendant risk of short-term illness.	
6Gb (i)		<b>Severe toxicosis causing serious acute pain, vomiting, diarrhoea, and fever, requiring hospital admission for some days or weeks and some continuing incontinence, haemorrhoids, and irritable bowel syndrome, having a significant impact on ability to work and enjoyment of life.</b>	£32,780 - £44,790

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Guideline ref	Injury type	Description	Range
6Gb (ii)		<p><b>Serious but short-lived food poisoning, diarrhoea, and vomiting diminishing over two to four weeks with some remaining discomfort and disturbance of bowel function and impact on sex life and enjoyment of food over a few years.</b></p> <p><b>Any such symptoms having these consequences and lasting for longer, even indefinitely, are likely to merit an award between the top of this bracket and the bottom of the bracket in (i) above.</b></p>	£8,140 - £16,380
6H a	Kidney	Serious and permanent damage to or loss of both kidneys.	£144,520 - £179,530
6H b		<p>Where there is a significant risk of future urinary tract infection or other total loss of natural kidney function.</p> <p>Such cases will invariably carry with them substantial future medical expenses, which in this field are particularly high - up to:</p>	£54,600

<p>8</p>	<p>Chronic pain</p>	<p>This chapter deals with a variety of what may loosely be described as 'pain disorders'. This includes Fibromyalgia, Chronic Pain Syndrome, Chronic Fatigue Syndrome (also known as ME), Conversion Disorders (also known as Dissociative Disorders), and Somatic Symptom Disorders. <b>Many such disorders are characterised by subjective pain without any, or any commensurate, organic basis.</b> The figures given here assume causation of relevant symptoms is established. ....</p> <p>With the exception of cases of Complex Regional Pain Syndrome (also known as CRPS)<sup>133</sup>, no attempt has been made to subdivide between different clinical conditions. Guidance instead reflects the impact, severity, and prognosis of the condition.</p> <p>Where the condition principally affects a single part of the anatomy, cross-reference to the relevant chapter within the Judicial College Guidelines may assist. The presence of an overlapping psychiatric injury is commonplace in such cases.</p> <p>The factors to be taken into account in valuing claims for pain disorders (including CRPS) include the following:</p> <ul style="list-style-type: none"> <li>(i) the degree of pain experienced;</li> <li>(ii) the overall impact of the symptoms (which may include fatigue, associated impairments of cognitive function, muscle weakness, headaches etc. and taking account of any fluctuation in symptoms) on mobility, ability to function in daily life, and the need for care/assistance;</li> <li>(iii) the effect of the condition on the injured person's ability to work;</li> <li>(iv) the need to take medication to control symptoms of pain and the effect of such medication on the person's ability to function in normal daily life;</li> </ul>	
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<sup>133</sup> Not included as the condition concerns an intense burning pain to an affected limb, which is not a condition we have heard complained of.

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Guideline ref	Injury type	Description	Range
		<p>(v) the extent to which treatment has been undertaken and its effect (or its predicted effect in respect of future treatment);</p> <p>(vi) whether the condition is limited to one anatomical site or is widespread;</p> <p>(vii) the presence of any separately identifiable psychiatric disorder and its impact on the perception of pain;</p> <p>(viii) the age of the claimant;</p> <p>(ix) prognosis.</p>	
<p>8A</p> <p>8Ai</p>	<p>Other pain disorders</p> <p>Severe:</p>	<p>In these cases significant symptoms will be ongoing despite treatment and will be expected to persist, resulting in adverse impact on ability to work and the need for some care/assistance. Most cases of Fibromyalgia with serious persisting symptoms will fall within this range.</p>	<p>£17,970 - £32,840</p>

## Appendix 6(a)

**Review of the Criminal Injuries Compensation Scheme**

The **Criminal Injuries Compensation Scheme**, which is administered by the Criminal Injuries Compensation Authority (CICA)<sup>134</sup>, is an example of a blameless victim compensation scheme. It is not a no-fault scheme in the normally understood sense, as behavioural ‘fault’ is part of its eligibility criteria, but an alternative form of non-adversarial compensation. The scheme is designed to compensate victims of violent crime in Great Britain (it does not cover Northern Ireland, which has its own scheme). The rules of the scheme and the value of awards are set out by Parliament and are calculated by reference to a tariff of injuries.

The scheme covers victims of violent crime, as well as the bereaved family of those who have died as a result of violent crime. The scheme considers claims for:

- mental or physical injury following a crime of violence;
- sexual or physical abuse;
- loss of earnings where capacity to work has been limited or lost as a result of criminal injury;
- special expenses that can cover certain costs incurred as a direct result of an incident (only available for incapacitation of more than 28 weeks);
- fatalities caused by a crime of violence, including funeral payments, bereavement payments, loss of parental services and financial dependency.

While there is no legal definition of the term “crime of violence”, the scheme as agreed by Parliament does contain a substantive list of what is and is not considered a violent crime for the purposes of the scheme. The scheme will also cover those injured while trying to apprehend an offender, prevent or remedy the consequences of a crime or were helping the police do so, but only where claimants were taking an exceptional risk that was justified in the circumstances (not something that might be expected in their normal course of work). The scheme may also cover mental injury of those who witnessed, and were present at, an incident in which a loved one was injured.

The scheme is an evidence-based claim scheme, where claimants are expected to provide proof of residency, medical evidence showing they had suffered an injury and evidence to support lost earnings or future loss of earnings, as well as evidence being sought from the police (and potentially from criminal records), and other evidence such as the character of the claimant and their behaviour before, during and after the incident (e.g. whether the victim intended to provoke an assault or fight).

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<sup>134</sup> Made under the *Criminal Injuries Compensation Act 1995*, and enacted by the *Criminal Injuries Compensation Scheme 2012*, as amended by the *Criminal Injuries Compensation Scheme 2012 (Amendment) Instrument 2019*.

Where victims have sustained more than one injury covered by the tariffs, then the scheme will pay 100% of the full tariff of the most serious injury, 30% of the tariff for an equal or second highest value, and 15% for any additional injury with an equal or third highest value (the scheme does not pay for more than three injuries, however, there are additional tariffs where a victim becomes pregnant, loses a foetus or contracts a sexually transmitted disease).

There is also a penalty point system to reduce awards for those with previous criminal record convictions (though this is open to some discretion, depending upon circumstances and the nature of prior convictions).

There is no national support service to assist a claimant make a claim, however, local support or other charitable organisations may offer support depending upon a victim's location (the cost of paid representation is not met under the scheme).

For injuries not serious enough to fall within the tariff of injuries as set out by Parliament, the Government introduced a Hardship Fund<sup>135</sup> (covering England and Wales), which provides temporary relief from financial hardship to very low paid workers who are temporarily unable to work because they have been the victim of a violent crime.

The scheme is designed to be an avenue of last resort, where claimants have exhausted opportunities to pursue compensation or damages elsewhere, including any available social security benefits or insurance payments (and evidence may be asked to support this). The scheme also covers UK residents who have been injured because of a violent crime in another country - though victims are encouraged to apply to compensation schemes in other countries, where those schemes exist. For members of the Armed Forces (and their dependents) who are victims of violent crime while serving outside Great Britain, the Ministry of Defence operates a separate Criminal Injuries Compensation (Overseas) Scheme.

Applications must be made as soon as practicably possible, and if an adult, no later than two years after the occurrence (though extensions may be granted for exceptional circumstances). The scheme requires all incidents for which claims are made to be reported to the police. Awards may still be made if a victim's assailant is not known or is not convicted.

Decisions on claims are made on the basis of the 'balance of probabilities' (rather than the more stringent 'beyond reasonable doubt' used by criminal courts), and does not need to wait for the outcome of a criminal trial if there is already sufficient information to make a decision on a case.

### Conclusions

The Criminal Injuries Compensation Scheme is a useful comparator by which to judge the merit of a tariff based scheme to compensate the infected and affected:

- It is founded on a notion of "*equity and social solidarity*" as expressed in the 1983 Council of Europe Convention on Compensation for Victims of Violent Crimes. This requires a last resort means of compensating such victims, as opposed to the necessity of a remedy for some failing of the State.

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<sup>135</sup> Details of which can be found here: <https://www.gov.uk/financial-support-victim-of-crime>.

- It sets out a comprehensive table of tariffs covering most common physical and mental injuries.
- It allows for compensation for loss of earnings and earning capacity calculated either from an average earnings based tariff or by reference to evidence of actual losses.
- It provides a model for administering such a scheme.

There are, however, important differences:

- There is no suggestion in the circumstances in which people are eligible to claim compensation under the scheme that a State agency was directly responsible for inflicting the injury.
- The tariffs for injury are significantly less than would be recoverable in a court based personal injury claim.
- It is explicitly a scheme of last resort which deducts from entitlement monies obtained from other sources.

The scheme also gives rise to experiences which echo the adverse experiences of the infected and affected who have given evidence to the Inquiry, or to the Study, and which point to a number of requirements for a scheme to be successful:

- The requirements for eligibility and application must be easy to understand.
- Where complexity is unavoidable, legal and other support has to be provided.
- Expectations of claimants with regard to awards, and progress of the claim, must be managed with sensitivity and transparency.
- Every effort must be made to avoid aggravating the trauma and distress of any already injured claimant.
- A scheme which provides only financial compensation needs to be supplemented with accessible support services.

## Review of the Windrush Scheme

The recent scheme to compensate the victims of the Windrush scandal offers some lessons with regard to the pitfalls to seek to avoid.

The scheme was established in April 2019. It had a number of relevant features:

- It was a time limited scheme offering an opportunity of two years<sup>136</sup> for affected individuals to apply.
- Initially the scheme offered payments for impact on life between £250 and £10,000, later raised to £10,000 to £100,000:
  - The detrimental (non-financial) impacts for which this award can be made are<sup>137</sup>:
    - inconvenience;
    - injury to feelings, including anxiety, distress and reputational damage;
    - family separation;
    - immigration difficulties when attempting to return to the United Kingdom following a trip abroad;
    - inability to attend significant family occasions, celebrations and events;
    - impacts relating to a deterioration in physical or mental health such as pain, suffering and loss of amenity.
  - Standard awards are split into 5 levels. The criteria for the highest level, for which £100,000 is recoverable are<sup>138</sup>:

*“Profound impacts on a claimant’s life which are likely to be irreversible. This is expected to involve major physical or mental health impacts, where the claimant has been permanently affected or where recovery or return to a relatively normal life is likely to take (or has taken) several years.”*

An award higher than level 5 may be awarded where:

*“... an individual’s circumstances are so compelling or severe it would be appropriate to do so...”*

A discretionary award may be made where the primary claimant estate or close family member can prove they have suffered a ‘significant’ impact, loss or detriment of a financial nature as a direct result of the primary claimant being unable to establish their unlawful status, and which is not covered by the more specific provisions of the rules<sup>139</sup>.

<sup>136</sup> The time limit has now been removed.

<sup>137</sup> *Windrush Compensation Scheme Rules*, (August 2021), Annex H §H2.

<sup>138</sup> *Windrush Compensation Scheme Rules* pages 44-46 §H8.

<sup>139</sup> *Ibid* page 46 Annex I §11.

- An early payment mechanism was introduced to offer a preliminary payment of £10,000 (the minimum impact award payable) to claimants as soon as they could demonstrate an impact on their life under the terms of the scheme<sup>140</sup>. The rationale for this change was:
  - give a clear signal of a genuine willingness to listen and respond to feedback;
  - recognise the extent of the hurt and suffering individuals have experienced;
  - effectively 'make up' for the fact that some individuals are receiving relatively small compensation awards because it is proving more difficult to evidence their losses, or because their experiences are not adequately covered by the scheme;
  - discourage individuals from seeking a review when they receive their final award, since they have already received a significant sum of money;
  - make the scheme better value for money from a casework perspective; and
  - providing it is as a minimum payment, get significant money to claimants quickly<sup>141</sup>.
- An initial 12 month cap on general awards for loss of earnings was removed and thereafter claimants were eligible to claim compensation for the full period during which they were out of work, either by way of a general award (where specific losses could not be proved) or an actual award (where the losses incurred could be specifically proved).

One of the challenges facing the Scheme was the identification of eligible claimant, with estimates ranging between 3,000 to 30,000<sup>142</sup>. This uncertainty made the task of estimating the funding required difficult. The Committee recommended a more proactive approach to identifying those potentially eligible for compensation<sup>143</sup>.

The same issue is likely to arise with this Scheme. While it should be possible to arrive at a range of likely numbers in respect of the infected, that is not so for the affected, as I am proposing the extension of eligibility to categories of person for whom no - or only limited - support has previously been offered. Therefore, it is important that proactive steps are taken to identify those who are likely to be eligible as early as possible. This exercise should not, however, delay the processing of compensation awards for those who are already known to be eligible because of their previous acceptance by one or more of the support schemes.

A number of reasons were suggested for the number of Windrush applicants being less than expected. These included:

- Lack of trust: there was evidence that a proportion of potentially eligible claimants believed the scheme had been set up to send people back to their country of origin.
- Deterred by adverse experience of others: it was thought some may have been put off applying by hearing of cases that appeared to have 'gone wrong'.

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<sup>140</sup> Home Affairs Committee report page 9 §14.

<sup>141</sup> Home Affairs Committee Report pag33 §96; the rationale was identified by the NAO from internal documents.

<sup>142</sup> Home Affairs Committee report page 12 §27.

<sup>143</sup> Home Affairs committee report page 19 §49.

The Home Affairs Committee suggested that these issues might be mitigated by setting up an independent administration for the scheme and by publication of data with regard to the level of awards made<sup>144</sup>.

The Home Affairs Select Committee report offered a series of trenchant criticisms of the way the scheme had been run:

*“Instead of providing a remedy for many people the Windrush Compensation Scheme has actually compounded the injustices faced by the Windrush generation.”<sup>145</sup>*

- At the time of the report “the vast majority” of applicants (3,022 of the expected 15,000) had received no compensation; only 5.8% (864 of those applying) had received any. During the first year less than 1,300 had applied and only 60 had received compensation (a total of £360,000); 23 people had died before receiving compensation.
- The process caused trauma for some rather than redress.
- Some victims were deterred from applying at all.
- By September 2021 (2½ years after the establishment of the scheme) only one fifth of an estimated 15,000 eligible claimants had applied.
- 23 individuals had died without receiving compensation.
- The Committee identified “a litany” of flaws in the scheme including:
  - Long delays in processing applications and making payments, compounded by the employment of insufficient case workers - when set up only 6 case workers were in post when the Home office had estimated 200 would be required;
  - Excessive burden on claimants to provide documentary evidence of impact on their lives and of losses for which they were claiming;
  - Inadequate staffing;
  - Failure to provide urgent and exceptional payments to those in desperate need;
  - Late and inadequately supported campaigns to reach eligible claimants and rebuild trust;
  - Lessons from the lessons-learned review by Wendy Williams not learnt or carried through;
  - Apologies were not always sufficient to amount to restorative justice<sup>146</sup>;

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<sup>144</sup> Home Affairs Committee Report page 15-17 §§33 - 43.

<sup>145</sup> Home Affairs Committee, *The Windrush Compensation Scheme. Fifth Report of Session 2021-22*, (24 November 2021) HC 204 page 3.

<sup>146</sup> Home Affairs Committee Report page 74 §234.

- The urgent and exceptional payment scheme set up to help claimants in need of immediate assistance and real hardship, was operated insensitively and left some claimants without support in spite of real hardship<sup>147</sup>.

The recommendations for improvement included:

- Legal support for all claimants who need it;
- Support for 'grassroots' campaigns and community outreach to reach eligible claimants and to build trust<sup>148</sup>.
  - One suggestion was that literature, that on websites and so on needs to be written in plain non-technical English. Information for claimants should also include video guides on the scheme and its processes;
  - Engagement events were found to be useful by many, but regard must be had to the needs of the elderly and those with limited digital skills and resources<sup>149</sup>;
  - Data needs to be kept on how people heard of the scheme.
- A one stage review process consisting of a demonstrably independent, possibly judge-led panel<sup>150</sup>.
- An urgent interim payment (£10,000 impact of life award) within 2 months, to all previously acknowledged as victims.
- Updating the loss of earnings award (for those who cannot document their losses) to current years National Living Wage (£9.50 per hour).
- Expectations with regard to the time taken to process a claim need to be managed effectively, and realistic estimates of staff hours required to process applications need to inform planning<sup>151</sup>.
- Better support is needed to be provided to people claiming on behalf of an estate<sup>152</sup>.
- Improved support in completing the application form, gathering evidence required and help in understanding the process, such support being complementary to specialist legal support, which is also required<sup>153</sup>.
- With regard to legal support the Committee identified four possible options:
  - Extending the Legal Aid, Sentencing and Punishment of Offenders Act 2012;

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<sup>147</sup> Ibid page 78 §249.

<sup>148</sup> Home Affairs Committee report page 24-25 §68.

<sup>149</sup> Home Affairs Committee report pages 22-23 §§54-59.

<sup>150</sup> Ibid page 85 §273.

<sup>151</sup> Home Affairs Committee Report pages 31-32 §§89-91.

<sup>152</sup> Ibid page 37 §111.

<sup>153</sup> Ibid page 42 §131, page 45 §139. Note that evidence from solicitors assisting claimants indicated that they spent 45 to 50 hours preparing a claim, whereas the scheme's support service was offering a maximum of three hours support. [see §130].

- Establishing a panel of legal firms with funding to pay for their services;
  - Agreeing a tariff payment for legal costs to be reimbursed to claimants;
  - Establishing and maintaining a dedicated fund for organisations to provide legal assistance to claimants.
- Clarification of progress towards holding “reconciliation events” with members of the Windrush generation<sup>154</sup>.
  - The ‘bureaucratic burden’ imposed on applicants under the urgent and exceptional payment scheme should be reduced<sup>155</sup>.

### *Conclusions*

As can be seen from the above, the scheme has had a chequered history. That history offers many lessons in relation to the design of this one. The formidable list of recommendations in the Home Affairs Committee Report<sup>156</sup> are almost all potentially relevant here. They reflect themes that arise out of many of the reviews of schemes, including those of the infected blood support schemes. Among those themes are:

- The toxic effect of delay in destroying and preventing the rebuilding of trust.
- The harm done to applicants by complex processes with which they are not equipped to cope.
- The need for a system of responsive interim and discretionary payments to mitigate any inevitable delays in final determinations of awards.
- The need for clear and proactive communication strategies to ensure all eligible persons are reached as quickly as possible.
- The need for realistic resources for a sensitive, responsive and efficient administration.
- The need for effective support to guide applicants through the system (the Select Committee made it clear in the case of Windrush that legal support was required).
- Alignment of the scheme, or inclusion in it, of appropriate restorative justice measures such as personalised apologies, and reconciliation events.

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<sup>154</sup> Ibid page 75 §238.

<sup>155</sup> Ibid page 78 §249.

<sup>156</sup> <https://committees.parliament.uk/publications/7936/documents/82209/default/>.

## Review of the vCJD Compensation Trust

A consideration of this Trust is of interest for two reasons. Firstly, a limited number of victims of infected blood are accepted to have contracted vCJD, and the risk of doing so has been acknowledged in many more cases. Secondly, it is a rare example in this country of a 'no fault' compensation scheme in which the compensation is intended to mirror common law principles, although in practice it may have been more limited in application than that due to the limits on the funds available to the scheme. A full description of the scheme and its operation can be found on its website<sup>157</sup> and what follows is a short summary.

According to Government guidance on vCJD issued in 2018<sup>158</sup>:

*“Four people in the UK have been infected with variant CJD following blood transfusions. Three of these patients developed symptoms of vCJD and the fourth died of an unrelated cause and their vCJD infection was detected at post-mortem. One haemophilia patient was also found to be infected with vCJD when tested at post-mortem. This patient never developed symptoms of vCJD and died of an unrelated cause. No new vCJD infections of this type have been reported since 2008. No other types of CJD are known to have spread through blood.”*

**Public Health England, Information for people who have an increased risk of Creutzfeldt-Jakob disease (CJD), 2018**

Updated guidance revised in 2021 states<sup>159</sup>:

*“In the UK, there have been 5 cases where variant CJD has been transmitted by blood transfusion. In each case, the person received a blood transfusion from a donor who later developed variant CJD. 3 of the 5 recipients went on to develop variant CJD, while the other 2 recipients died before developing variant CJD but were found to be infected following a post-mortem examination.*

*It's not certain whether the blood transfusion was the cause of the infection, as those involved could have contracted variant CJD through dietary sources. Nevertheless, steps were taken to minimise the risk of the blood supply becoming contaminated.*

*These steps include:*

*not allowing people potentially at risk from CJD to donate blood, tissue or organs (including eggs and sperm for fertility treatments);*

*not accepting donations from people who have received a blood transfusion in the UK since 1980;*

<sup>157</sup> [www.vcjdtrust.co.uk](http://www.vcjdtrust.co.uk) : in particular the article by Melville Williams QC *Setting up the vCJD Trust* and the annual accounts for the year ended March 2019, the last on the website.

<sup>158</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/727294/Information\\_for\\_people\\_who\\_have\\_an\\_increased\\_risk\\_of\\_CJD.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/727294/Information_for_people_who_have_an_increased_risk_of_CJD.pdf).

<sup>159</sup> <https://www.nhs.uk/conditions/creutzfeldt-jakob-disease-cjd/prevention/>.

*removing white blood cells, which may carry the greatest risk of transmitting CJD, from all blood used for transfusions.”*

### *The Scheme*

Following the report of the BSE Inquiry, the Government announced it would set up a scheme to benefit sufferers from vCJD and their families. This led to the setting up of the vCJD Trust in 2001. The Government committed to funding the scheme to a total of £67.5 million estimating there would be 250 victims; they also committed to reviewing this sum should the numbers increase. There was no admission of liability and acceptance of compensation from the scheme did not preclude victims pursuing legal remedies if so advised. However, any compensation received would be taken into account in the assessment of damages in a legal claim.

Mr Melville Williams QC, one of the trustees has stated<sup>160</sup>:

*“The disease strikes me, after over 40 years of personal injury practice, much of it in disease cases, as being the most horrific imaginable.”*

Interim payments of £25,000 were made in the same year to most victims. Those payments and subsequent compensation was to be disregarded for social security purposes.

The Trust deed allowed for amendments in the light of experience and some limited changes have been made. The eligibility criteria are firstly that on the balance of probabilities the victim is or was suffering from vCJD (certified by the National CJD Surveillance Unit) and secondly that, again on the balance of probabilities, this was contracted as a result of exposure to bovine products in the UK during the relevant period. Once basic eligibility has been established, payments can be made both to the victims and ‘qualifiers’ and sometimes ‘non-qualifying’ carers. Qualifiers are the victim’s spouse or partner; an ancestor or descendant of the victim; a person treated as their child or parent by the victim; siblings; aunts and uncles of the victim and their issue; dependents of the victim. Also included are ‘non-qualifying carers’ who are persons who have been significantly involved in the care of the victim “by reason of love and affection” after the “relevant time”, that is the earlier of two years before the date of death or 6 months before the date of the initial diagnosis. It will be appreciated that the number of people who could qualify is large. In one case, 88 people were identified as being potentially eligible, although nearly all had no desire to make a claim. There have been several cases with 30 or 40 qualifiers.

Payments are made under various heads including “basic” sums, expenses, participation in care, loss of dependency, loss of earnings and psychiatric injury caused by the vCJD suffered by the victims.

### *The basic sum*

This was originally £75,000 or £70,000 depending on the date of diagnosis. This has been increased to £125,000 and £120,000. This payment is made to the victim, if alive, or any court appointed guardian, an attorney or trustees. After death, the payment may be made to the victim’s personal representatives, any qualifiers, or any other person in the discretion of the trustees who

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<sup>160</sup> See his article (referenced above).

are or would have been beneficially entitled to the victim's estate, or who have made a substantial contribution to the care of the victim. The Trustees have experienced difficulties in the exercise of this discretion where there are disputes within a family. As Mr Melville Williams QC remarked:

*“In such circumstances, and it is surprising how many variations within families have emerged, the Trustees may feel that their discretion should be exercised so as to apportion the sum in order to meet the broad justice of the situation. There are three possible adverse consequences of this: first there is likely to be delay while the circumstances are properly investigated, second a feeling of resentment may be generated by the family as a result of further enquiries and at the end the decisions can lead to a feeling of injustice.”*

#### *Experience of vCJD for the victim's family*

Where the initial diagnosis was made before 26 October 2000 (the date of publication of the BSE report) the sum of £10,000 may be awarded to one or more qualifiers in respect of each victim in such shares as the Trustees determine. The sum is £5,000 if the diagnosis is after that date.

A separate sum of £5,000 is payable to qualifiers and non-qualifiers who were significantly involved in the victim's care again in such shares as the Trustees consider appropriate. Normally apportionment is by agreement with the families and has not caused many problems. It could be observed that this might be because the amount is so limited, and cannot reflect any significant degree of care in the way a court award would.

#### *Funeral expenses*

These are paid in full up to £3,000 and in excess of that to the extent that the costs are considered 'essential'.

#### *Adaptation of property*

Up to £10,000 is payable for repairs, alterations or improvements attributable to the disease and mitigating its effect. Again, this seems to be a rather modest sum, but this may reflect the extent of modifications, etc. likely to be required in this particular case.

#### *Loss of dependency*

The dependency is calculated broadly in accordance with common law principles.

#### *Psychiatric injury*

£5,000 is payable to any qualifier who has suffered a psychiatric condition caused or aggravated by the victim's vCJD. A checklist has been prepared for GPS to help them determine whether a person falls within the scheme's definition.

### *Care payments and packages*

Such payments reflecting the actual cost paid for care, or the value of gratuitous care, are payable, but only in respect of care provided before 31<sup>st</sup> March or the earlier date at which a care package was implemented. Such packages were made available by the NCJDSU from October 2000. This consists of arrangements for speedy diagnosis, informed advice and timely assistance in a coordinated package involving the NHS and local social services.

### *Carers loss of earnings*

Where a carer shows particular hardship they can claim their loss of earnings less, any payment actually received or compensation for gratuitous care. This probably goes further than a common law entitlement.

### *Victims' loss of earnings*

Again such losses are recoverable if particular hardship is shown.

### *Life insurance and mortgage protection*

Payments may be made to a dependent of a confirmed victim where they would suffer particular hardship because of being unable to obtain such insurance without a substantial additional premium. Apparently claims are likely to be rare for this.

### *Psychiatric injury- financial or emotional hardship*

If as a result of such injury particular financial or emotional hardship can be shown, awards can be made in line with the Judicial College guidelines.

### *Awards*

The annual report and accounts of the Trust for the year ending 2019 sets out a table of the awards made in respect of the case of each of 186 victims, presumably including payments made to qualifiers. The total payments made up to 2019 are £41,723,589.

### *Lessons for future schemes*

Mr Melville Williams QC helpfully identified lessons he drew from the experience of this scheme and he is worth quoting in full (emphasis mine):

*“In many ways the Trust scheme, in its attempt to balance the needs of justice in the treatment of one case compared with another, has introduced **too much complexity**. The proper balance between certainty and justice is always going to be a difficult one to achieve. Furthermore it is **likely to give rise to some dissatisfaction**. For*

*example, in individual **qualifiers with legitimate claims who may find the psychiatric investigation in psychiatric injury claims to be difficult and harassing** and so not only unnecessary but also **unacceptable for a scheme designed to provide a simple straightforward and speedy way of dealing with their need**. They are likely to remain unhappy with the way they have been treated under the scheme and a fixed payment procedure might have caused fewer grievances.*

*A scheme to be regarded as acceptable **should provide an appropriate payment with the minimum of delay and without the need for repeated and painful persistent inquiries**. As has been already mentioned there have been cases in which it has been necessary to pursue the search for family members who could claim as qualifiers but have not been in touch to set out their position. **This problem arises especially where there are, or have been, family disputes**.*

*The main message from work on the trust is that **any future schemes should be simplified to the greatest extent possible**. **If beneficiaries understand that perfect justice (if there is such a thing) may have to be sacrificed to certainty and speed then it is likely that fewer complaints will be made.**"*

These are appropriate lessons to bear in mind in relation to the scheme this Study is considering.

## Appendix 6(d)

**Review of the September 11 Victim Compensation Fund, USA**<sup>161</sup>

The terrifying tragedy of 11 September, 2001 in New York needs no description here. In the immediate aftermath, what was to turn out to be the first Victim Compensation Fund (VCF1), was set up by legislation passed by Congress and signed by the President 11 days later, on 22 September. A Special Master was appointed by the US Attorney General to administer the scheme on 26 November, and just 14 weeks after the attacks, regulations were published detailing the processes for claiming. The Fund was ready to accept claims in March, 2002. A total of nearly 7,500 claims<sup>162</sup> were filed, of which 2,968 were in relation to deceased victims, and 4,435 were in respect of persons claiming for physical injuries<sup>163</sup> suffered in the immediate area of the attacks. Only 88 claims for deceased victims were denied; but 1,755 of claims made for physical injuries were rejected. In total, \$7 billion compensation was awarded. The average award for the families of the deceased was \$2 million, and nearly \$400,000 for those injured. Remarkably, the costs of administering the scheme was just under \$86 million, or 1.2% of the compensation - although it should be noted that the Special Master and many lawyers gave their services without charge. All claims within the remit of VCF1 were processed and awards determined by 11 January, 2004. The final report of VCF1 was published on 11 January, 2004.

In relation to claims on behalf of deceased victims, the scheme set the standard award for non-economic loss (i.e. loss of enjoyment of life, pain and suffering) at \$250,000, and an additional award of \$100,000 each for the spouse, and any dependent<sup>164</sup> of the victim. There was a discretion to award more if the claimant established “extraordinary circumstances”, for example, where more than one parent was killed, or where an injured person lived for a long time after the incident. The rationale behind awarding a lump sum, rather than an award assessed in relation to each victim, was eloquently expressed by the Special Master<sup>165</sup>:

*“Each person who was killed or injured in the September 11th attacks suffered horrific and grievous harm, and experienced the unspeakable events of that day in a unique way. Some victims experienced terror for many minutes, as they were held hostage by terrorists on an airplane or trapped in a burning building. Some victims had no warning and died within seconds of a plane hitting the building in which they worked. While these circumstances may be known in some cases, for the vast majority of victims the precise circumstances are unknown.”*

Faced with the unfathomable task of placing a dollar amount upon the pain, emotional suffering, loss of enjoyment of life, and mental anguish suffered by the thousands of victims of the

<sup>161</sup> For a more complete description of this Fund see Macleod, Hodges [op cit] Chapter 13 pp 345 et seq; See also the reports of the Victims Compensation Fund in particular: Feinberg, *Final Report of the Special Master for the September 11<sup>th</sup> Victim Compensation Fund of 2001*:

<https://securitypolicy.syr.edu/wp-content/uploads/2012/09/Special-Masters-Final-Report.pdf>; *The VCF 20th Anniversary Special Report* VCF September 2021:

<https://www.vcf.gov/sites/vcf/files/media/document/2021-09/2021%20VCF%20Special%20Report.pdf>.

<sup>162</sup> Only one claim was permitted per victim, with all associated beneficiaries - such as family dependents - being required to be included in a single claim.

<sup>163</sup> There was no provision for compensation for mental injury.

<sup>164</sup> Dependents were defined to exclude any with a gross taxable income of more than \$2,300, thereby excluding virtually anyone who had employment or significant income of their own. There were a number of other exclusionary conditions.

<sup>165</sup> See *The Final Report* [op cit] p 40.

September 11th attacks, the Special Master and the Department determined that the fairest and most rational approach was to establish a uniform figure for the pain and suffering of deceased victims and their dependents.

Awards for non-economic loss of those injured but not killed in the attacks, were more complex, and sought to reflect the gravity and duration of injuries. Categories of injury were devised with a view to ensuring similar awards were given for similar injuries.

Economic loss, in the sense of the benefit to be derived from the deceased's loss of earnings, was calculated by applying prescribed presumptions. Information was obtained about the deceased's earnings history, usually<sup>166</sup> focussing on average earnings for the three years preceding the death. A deduction was then made for what they would have spent on themselves, any taxes that would have been deducted from the income, and an addition for a presumed increase in income over time, derived from national average income growth figures, and a calculation of average working life left. A further deduction was also made for potential future periods of unemployment, again based on national figures. This methodology was applied to all cases in which the earnings level was within that of 98% of individual incomes in the US at the time, around \$230,000. Claims involving incomes in the highest 3% would be presumed to have had an income at the 98% level, but the Special Master had a discretion to increase that where that amount was shown to be insufficient.

In addition to loss of earnings, compensation could be awarded for the value of loss of the deceased's services to their family, family medical expenses not covered by insurance because of the death and loss of business opportunities. In a few cases, where family members suffered from serious disabilities, the commercial cost of replacing the services of the deceased were awarded.

Benefits received as a result of a death, such as from life insurance, pensions, and state benefits, were required by the legislation to be set off against the assessed awards, which were accordingly reduced. This proved to be a contentious area for claimants. The Special Master exercised his discretion to mitigate offsets by considering:

- (1) whether the particular offsets fell within the definition of collateral source compensation;
- (2) whether beneficiaries of the Fund were 'entitled' to receive payments from those collateral sources;
- (3) whether the amount of the collateral source payment was certain or could be computed with sufficient certainty to enable its deduction; and
- (4) whether the amount deducted took into account the time value of money and contributions made before death by the victim in the nature of investment or premiums.

One interesting challenge faced by the Scheme, which has been echoed by questions raised by some of the bereaved in our meetings, was how to determine the distribution of awards made in respect of deceased victims - a matter on which the relevant statute was silent. Even lawyers representing claimants needed assistance in determining and understanding what was the applicable law. Personal representatives were required to submit a distribution plan to the Special

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<sup>166</sup> There was a discretion to choose more appropriate years if more presentative of the deceased's earning capacity.

Master, who would determine whether it complied with the applicable law and certain requirements of the regulations for the scheme.

The Special Master attributed the success of the scheme to five factors:

- The alternative of litigation threatened uncertainty and delay;
- Energetic steps were taken to ensure that families could obtain detailed information of their likely award;
- Each potential claimant was contacted to ensure they were able to obtain and present the best information in support of their claim, explaining what information would maximise their claim;
- The Fund offered informal meetings and hearings to provide claimants with a “day in court” to explain the magnitude of their loss and their views on how their particular situation should be treated;
- The Fund offered certainty without delay, and in that respect closure, although I am sure the Special Master would absolutely accept that the grief and loss involved would inevitably continue.

In considering the lessons to be learned from the experience of this fund the Special Master in his final report concluded:

- Even though the Fund was restricted to one terrorist event when there had been many others, it was a sound public policy response to an unprecedented national tragedy on the scale of Pearl Harbour, the Civil War or the assassination of President Kennedy, and was the legitimate response of the nation.
- The individually tailored components of the awards was justified, because it had been necessary to offer claimants a credible alternative to litigation, which the Scheme was designed to avoid.
- The challenge of achieving consistency was met by concentrating the decision making about presumed awards on a very small number (26) of lawyers, supported by standardised assumptions and models. However, the difference in awards, say between the family of a firefighter and a stockbroker, engendered contention and some bitterness. The Special Master ventured it might have been better to have entitled all claimants to a standard amount. I would observe, however, that this would have prejudiced the aim of avoiding litigation for the increased number who would have believed they would have done better out of litigation.

The lessons relevant to our Study, to be learned from what the Special Master described as a “*unique and unprecedented experiment in American democracy*”, include the following:

- Where a State is sufficiently determined to provide fair compensation quickly, it can be done, and done far more quickly and economically than reliance on traditional court based remedies.

- Designing a scheme which errs on the side of generosity can persuade claimants to accept its award in preference to litigation. The VCF was explicitly justified on the ground that it was necessary to save the aviation industry from collapse; claimants did have to choose between claiming on the Fund and proceeding with litigation.
- A fair balance needs to be found between the simplicity of a standardised award, and the challenges of assessments based on individual losses.
- Discounting awards for benefits received because of a death or injury gives rise to many challenges of evidence and principle.
- Any scheme of this nature will have its complexities, some of them challenging even for experienced lawyers, and they require the scheme to have detailed and proactive personalised support and advice available at all stages of its processes.

Further, there are a number of features of this scheme which were striking:

- The number of claims processed within two years.
- The extremely low administrative costs (largely due to the generosity of lawyers given their time without charge).
- The success of the scheme in satisfying claimants with an award which dissuaded them from litigating.
- The offer of a relatively generous standard award for non-economic loss with an option to apply for a higher enhanced discretionary award.
- The methodology applied to the assessment of loss of earnings aimed to satisfy all those whose earnings had been within the 98<sup>th</sup> centile of earnings in the country. Those with earnings in the top 2% were assumed to have an income at the 98% level with a discretion to increase the amount where this was shown to be insufficient.<sup>167</sup>

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<sup>167</sup> It will be recalled that a special feature of this tragedy was the large number of highly paid employees in the investment industry who were killed.

## Review of the Hepatitis C and HIV Compensation Tribunal, Republic of Ireland

The **Hepatitis C and HIV Compensation Tribunal**<sup>168</sup>, operating in the Republic of Ireland, is an example of a compensation scheme specifically set up to provide redress for infected blood.

The following is a short history of the development of the Tribunal:<sup>169</sup>

### *Litigation settlement*

In 1991 the government of the Republic of Ireland had reached a settlement of litigation with a number of victims of infected blood, with regard to their HIV infection. In 1994, the government committed itself to “fair compensation” for women infected with HCV from anti-D<sup>170</sup>.

### *Ex gratia scheme*

This was followed in 1995 by the setting up on an ex gratia basis of a scheme to compensate persons infected with HCV as a result of the use of Human Immunoglobulin Anti-D from transfusion of blood or a blood product, as well as their partners and children who were also infected. In the same year the scheme was extended to include persons who had contracted HCV from blood transfusions and other products. The Compensation Tribunal for the ex gratia compensation scheme was established in December 1995.

### *Health package*

At about the same time a “Health Package” was announced and subsequently put in statutory form<sup>171</sup>. In a country in which health services were (and are) provided by a combination of state-funded and insurance-based services, the package required victims who had contracted HCV from blood or blood products to be provided free of charge with all GP, medical and surgical services, drugs medicines and surgical appliances, dental, optical and aural services, counselling in respect of HCV, and such other services as may be prescribed<sup>172</sup>.

### *Finlay Tribunal of Inquiry*

In 1996 a Tribunal of Inquiry chaired by Mr Justice TA Finlay was set up and reported in 1997<sup>173</sup>. As at the date of its report, the tribunal had received 1,653 applications and heard 233 cases. The

<sup>168</sup> <https://hepccomptrib.com>.

<sup>169</sup> For a detailed analysis of the history of this scheme, see the judgment of Mr Justice Holman in *R (March v Secretary of State for Health* [2010] EWHC 765 (Admin).

<sup>170</sup> Finlay Report [see below] page 117.

<sup>171</sup> Health Amendment Act 1996.

<sup>172</sup> Health Amendment Act 2006 section 3.

<sup>173</sup> *Report of the Tribunal of Inquiry into the Blood Transfusion Service Board*, (1997) Stationery Office, Dublin Pn 3695.

awards ranged from £15,200 to £453,904 and a total of £259 million compensation had been awarded<sup>174</sup>. The terms of reference of this inquiry were limited to the infection of victims with HCV from blood or blood products. The report identified failings on the part of the NDAB in licensing Anti-D, the officers of the Blood Transfusion Service Board in obtaining the plasma from which the products derived and in their response to the emergence of concerns, and of the Department of Health in failing to introduce screening technique appropriately and likewise in their response to the concerns. However, the Tribunal found that:

*“In general the provision for compensation by a Tribunal on a no fault basis, as an alternative to and not excluding the right to sue at the time at which it was introduced, constituted a reasonably adequate and appropriate reaction to that particular problem by the Minister and Department.”<sup>175</sup>*

#### *Further litigation and admission of fault*

In the same year, 1997, an action brought against the State by a plaintiff infected with HCV from contaminated anti-D was settled on terms that included an apology<sup>176</sup> delivered in court from the Blood Transfusion Service Board. The apology included an admission of fault. The Tribunal became a statutory body in 1997<sup>177</sup>.

#### *Statutory Compensation Tribunal*

In 2002, the jurisdiction was extended to persons infected with HIV as a result of transfusion of a relevant blood product in the Republic by the Hepatitis C Compensation Tribunal Amendment Act 2002.

#### *Lindsay Tribunal of Inquiry*

In the same year, a Tribunal of Inquiry - in the person of Her Honour Judge Alison Lindsay - reported in September 2002<sup>178</sup>. It made no recommendations with regard to compensation because the Government had already announced the extension of the existing arrangements to cover persons with haemophilia infected with HIV<sup>179</sup>. However, it made a number of criticisms relevant.

#### *Financial services support*

In 2007, the scheme was extended<sup>180</sup> to provide for the establishment of an insurance scheme to enable those suffering from Hepatitis C and HIV to be provided with certain classes of insurance

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<sup>174</sup> Finlay Report page 118.

<sup>175</sup> Report page 152 §15.

<sup>176</sup> *Quinlan v Minister for Health and the Attorney General*, Irish Times 2 July 1997:

<https://www.irishtimes.com/news/btsb-apology-as-hepatitis-c-compensation-claim-settled-1.87113>.

<sup>177</sup> Enacted under the *Hepatitis C Compensation Tribunal Act, 1997* and the *Hepatitis C Compensation Tribunal Amendment Act, 2002*.

<sup>178</sup> *Report of the Tribunal of Inquiry in the Infectio with HIV and Hepatitis C of Persons with Haemophilia and Related Matters*, (September 2002), Stationery Office, Dublin PN 12074.

<sup>179</sup> *Ibid* page 238.

<sup>180</sup> Under the *Hepatitis C Compensation Tribunal (Amendment) Act, 2006*.

which would otherwise be unavailable to them or only available at a higher premium. This enabled the infected to obtain mortgages, as well as life and travel insurance which were previously unavailable to them - administered by the Health Service Executive<sup>181</sup>.

## **The Tribunal**

The following is a brief description of how the Tribunal operates:

### *Membership*

The Tribunal consists of a chair and six other permanent members - six barristers (including two Senior Counsel with medical and personal injury law experience) and a solicitor - appointed by the Minister<sup>182</sup>. The Tribunal may appoint its own counsel, and experts, and claimants are also entitled to be legally represented. It is understood that, in fact, the Tribunal rarely instructs its own counsel.

### *Procedure*

Awards are determined either by an offer of settlement from the Tribunal or by a determination reached after an oral hearing. Hearings are held by way of in camera oral hearings before at least two members of the Tribunal. A disadvantage for claimants of a settlement offer is that the offer is made without the claimant's oral evidence being heard by the Tribunal, a feature to which many attach considerable significance. If a hearing is requested they often last no more than half a day, and most complete within a day. The majority of the evidence considered by the Tribunal is in writing, including reports from experts. Once an offer or an award is made the claimant has the option of accepting it, and waiving any right to bring a court action, or rejecting it and remaining free to bring such a claim. An award is accompanied by a reasoned judgment which is confidential to the claimant and the Minister.

The claimant has a right to appeal against a refusal to accept eligibility or the amount of an award to the High Court, where proceedings are anonymised, but the judgment is published. Appeals hear the application afresh and while considering the evidence given at the tribunal, also receive new evidence; it is common for witnesses, including experts, to give oral evidence.

### *Eligibility*

The 1996 Act, section 4, as amended by the 2002 Act, section 4, provides for the following categories of eligibility:

- (a) a person who has been diagnosed positive for Hepatitis C resulting from the use of Human Immunoglobulin Anti-D within the State;
- (b) a person who has been diagnosed positive for Hepatitis C as a result of receiving a blood transfusion or blood product within the State;

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<sup>181</sup> *Hepatitis C Compensation Tribunal (Amendment Act) 2006.*

<sup>182</sup> Section 3 1996 Act.

- (c) children or any spouse, of a person referred to in paragraph (a) or a person referred to in paragraph (b), who have been diagnosed positive for Hepatitis C;
- (d) any person who is responsible for the care of a person referred to in paragraph (a), (b) or (c), and who has incurred financial loss or expenses as a direct result of providing such care arising from the person being cared for having contracted Hepatitis C;
- (e) where a person referred to in paragraph (a), (b) or (c) has died as a result of having contracted Hepatitis C or where Hepatitis C was a significant contributory factor to the cause of death, any dependant of such person;
- (f) a person who has been diagnosed positive for HIV as a result of receiving a relevant product within the State;
- (g) children or any spouse of a person referred to in paragraph (f) who have themselves been diagnosed positive for HIV;
- (h) any person who is married to a person referred to in paragraph (a), (b) or (f), or who has been living with a person referred to in paragraph (a), (b) or (f) for a continuous period of not less than three years, in respect of the loss of consortium S.4 of the person, including impairment of sexual relations with the person, arising from the risk of transmission of Hepatitis C or HIV;
- (i) any person who is responsible for the care of a person referred to in paragraph (f) or (g) and who has incurred or will incur financial loss or expenses as a direct result of providing such care arising from the person being cared for having contracted HIV;
- (j) where a person referred to in paragraph (f) or (g) has died as a result of having contracted HIV or where HIV was a significant contributory factor to the cause of death, any dependant of such person; and
- (k) a person referred to in section 9 in accordance with that section.

### *Awards*

Compensatory awards are made on the same basis as a lump award of damages (or provisional damages) by the High Court in tort. Further, an award of aggravated or exemplary damages can be made out of a Reparation fund established for the purpose, where the claimant establishes an entitlement against the relevant agency or ministry<sup>183</sup>. Tribunal can also award costs.

From 1996 to 2019, a total of 3,652 awards have been made totalling €751,600,089, an average of €205,805 per claim. During the same period, 405 appeals were made to the High Court resulting in a further €87,412,846 being awarded. A total of 3,944 awards of exemplary or aggravated damages have been made totalling €164,821,656<sup>184</sup>.

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<sup>183</sup> See sections 5, 11.

<sup>184</sup> A table of the annual figures for awards and costs, from the latest Annual Report (2019), is at Appendix 7.

Compensatory awards may be made on a provisional basis, which assumes that a defined deterioration will not occur. Further compensation can be awarded if the conditions of the provisional award are met.

Awards can be made to the spouses, parents or children of an infected person who has died as a result of the infection for nervous shock (PTSD) as a result of the death<sup>185</sup>. The Tribunal has regard to the decided High Court and Court of Appeal cases on damages issues. An award may also be made for “loss of consortium, including the impairment of sexual relations”<sup>186</sup>, and “loss of society” “including the loss of the care, companionship and affection of the deceased as a result of the death”<sup>187</sup>.

In Ireland general damages (damages for pain, suffering and loss of amenity) are generally subject to a “cap” of between €500,000 and €550,000. However, in compensation scheme awards this cap can be exceeded. For example, a co-infected victim will be awarded general damages separately and cumulatively for each of the infections without any deduction for the fact that both are suffered at the same time.

Where a claim is made on behalf of a deceased infected person, general damages will include recognition of the loss of expectation of life in addition to the pain, suffering and loss of amenity incurred during life.

Claims from the dependents of a deceased infected person are assessed on the principles of the Civil Liability Act 1961 (very similar to the Fatal Accidents Act 1976 in England).

Where a relative claims care costs, the loss is assessed by reference to the claimant’s loss of earnings, not the relevant commercial rate of care agencies. Thus where the carer has lost no income, they have no claim.

Where a claim is made for aggravated or exemplary damages, reliance can be placed on the reports of specified Tribunal of Inquiry Reports<sup>188</sup>. If the application is made to the Tribunal, it may make an award reflecting the legal principles by which such awards are made<sup>189</sup>. An alternative way of claiming such as award is to apply to the Reparation fund after accepting an award from the tribunal or an offer of settlement<sup>190</sup>. It is understood that a further payment in lieu of aggravated damages or exemplary damages is an automatic entitlement to be obtained in the Tribunal process, where if sought it is a 20% uplift on the whole of general and special damages. Alternatively, any applicant can seek to have aggravated or exemplary assessed<sup>191</sup>.

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<sup>185</sup> 1996 Act section 5(3)(3A)(a).

<sup>186</sup> 1996 Act section 5(3)(3B)(a).

<sup>187</sup> 1996 Act section 5(3B)(b) which reads in full: “Where a dependant referred to in paragraph (e) or (j) of section 4(1) is the child, spouse or parent of the person who died (‘the deceased’) as a result of having contracted Hepatitis C or HIV, or where Hepatitis C or HIV was a significant contributory factor to the cause of death, the Tribunal may make an award to that dependant in respect of loss of society of the deceased including the loss of the care, companionship and affection of the deceased as a result of the death.” (Loss of Society claim”).

<sup>188</sup> 1996 Act section 4(13).

<sup>189</sup> 1996 Act section 5(1); for a discussion of the principles applied in Irish law see Culleton *The Law Relating to Aggravated Damages*, [2020] Irish Judicial Studies Journal Vol 4(2) page 1.

<sup>190</sup> 1996 Act section 11(4).

<sup>191</sup> We are indebted to Raymond Bradley SC of Malcomson Law Solicitors for this information.

### *Disqualification, waivers*

A claim may not be made by any person who has received an award from a court or settlement of court proceedings in respect of any matter which could otherwise have been the subject of a compensation claim. The *making* of a claim does not constitute a waiver of any other right of action<sup>192</sup>, but if an award is *accepted* the claimant must agree in writing to waive any right of action arising of the same circumstances.

### **Illustrative cases**

It is possible to find many judgments of the High Court in Dublin on appeals from the Tribunal, which are very informative of its working and methods of assessment. Three picked more or less at random give a flavour:

#### *JC v Minister of Health*<sup>193</sup>

The Tribunal awarded the claimant in respect of the death of her father, when she was 9 years old, €120,000 for loss of society, €70,000 for psychiatric injury and €15,000 special damages for loss of opportunity - a total of €205,000. The loss of society award was not challenged. Evidence in the High Court included expert evidence from a consultant psychologist, an educational psychologist, a vocational consultant, a consultant psychiatrist and an actuary. The judge increased the loss of opportunity award to €250,000, on the basis that but for the death she would have completed education and training to enable her to be a receptionist or business administrator as opposed to the 'entry level work' to which she was now confined.

The judge drew an interesting distinction between 'damages' and 'compensation':

*"While I note that the term "damages" is very often used both in judgments on appeal and in the decisions of the Tribunal I think it appropriate at this juncture to make the following observation. In my view it would be preferable and more correct to use the term "compensation" rather than "damages". The reason is twofold. "Damages" derives from the Latin "damnum" and is a legal term that describes monetary compensation payable by a civil wrongdoer for injury and loss suffered or likely to be suffered by the victim of the wrong, whereas "compensation" is a sum of money payable to a victim in respect of injury or loss by a party other than the wrongdoer. This explains the use of the word "compensation" rather than "damages" throughout the Hepatitis C Compensation Tribunal Acts, 1997 to 2006<sup>194</sup>..."*

However, I do not discern from the judgment any suggestion that the general principles applying to damages cases were not of relevance in assessing compensation under the scheme.

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<sup>192</sup> 1996 Act section 4(2), (3), 5(10).

<sup>193</sup> [2021] IEHC 129.

<sup>194</sup> *Ibid* §49. The same judge had earlier made a similar observation in *BD v Minister for health and Children* [below] §63.

*KB v Minister for Health*<sup>195</sup>

The claimant was awarded €85,000 for PTSD, €90,000 for loss of society and €155,000 for loss of opportunity. She was the eldest daughter of her father, a lifelong haemophiliac who died and who was first diagnosed with HCV and HIV when she was 10. He died when she was 25. She first discovered his diagnosis when he gave evidence to the Lindsay Tribunal in her leaving certificate year at school. She was diverted from her first choice of career in veterinary medicine by her father's illness and death. The court increased the award for loss of opportunity to €255,000 and that for loss of society to €100,000.

*BD v Minister for Health and Children*<sup>196</sup>

The claimant received a blood transfusion associated with treatment for Crohn's Disease in 1981, and again in 1982, as a result of which he was infected with HCV from which he developed serious liver disease, and in 2014 was diagnosed as having decompensated cirrhosis. On his first application to the Tribunal, a provisional award was made of €647,000 consisting of €120,000 general compensation, €50,000 for past loss of earnings, €350,000 for future loss of earnings, €75,000 for loss of a company car, and €52,000 for loss of pension benefits. After the diagnosis of decompensated cirrhosis he made a second application and was provisionally awarded €150,000 additional general compensation, and €50,000 for child care. Evidence on appeal was given by the claimant, his sister, a nanny, and four experts. The judge rejected an argument that compensation in the scheme had to be commensurate with the "cap" in personal injury damages in cases of very serious injury. The High Court increased the general compensation to €220,000.

*C(S) v Ministry of Health and the Hepatitis C and HIV Compensation Tribunal [2012] IEHC 49*

SC was the son of an infected man who was co-infected with HCV and HIV from which he died in 1995 at the age of 43. The Tribunal awarded the son €50,000 for nervous shock and €100,000 for loss of society, and €60,000 for loss of opportunity to pursue his chosen career (as a nurse). He appealed the awards for nervous shock and loss of opportunity. He was told of his father's diagnosis and impending death at the age of 16. He witnessed his father's condition in the days and weeks prior to his death which were described by the court as "horrendous" and "shocking". His father had been admitted to hospital with an apparently minor foot infection and within days was dying. He was taken home to die, where the extended family "descended to say their goodbyes".

**Comments on the scheme**

There are a number of very positive points to be made observed about the Irish system for compensation:

- Clearly the Irish model is closely aligned to a court based approach to awarding damages for personal injury. It employs a Tribunal which hears evidence as would a court and a judicial appeal is available. There is therefore a body of law and experience easily accessible to lawyers supporting claimants.

<sup>195</sup> [2019] IEHC 905.

<sup>196</sup> [201] IEHC 173.

- The tribunal model allows for determinations to be made by an expert group of judges or lawyers, who have gained significant experience of this group of wronged individuals.
- A glance at the judgments reveals a close examination of the individual circumstances of each case, supported by very detailed factual and expert evidence. There can be no doubt that this results in a meticulous examination of the merits of each case, and in the form of the reasoned decision provides the claimant with an official acknowledgement of the harm done to them.
- It allows for a reflection of the misconduct of the State or its agencies based in part on public inquiry findings through access to aggravated or exemplary damages.
- The awards, by following the conventional structure of an award for personal injury or death, ensures that awards a fair match with what would be received in litigation without the burden of proving liability.
- The availability of provisional awards allows for deteriorations and for awards more closely to match individual circumstances.

However these advantages are balanced by a number of disadvantages:

- This is a very elaborate system, which of necessity takes time. We have been told that cases take between three and five years to resolve.
- The processes are complex and it is difficult to imagine that many cases can be progressed without the support of a lawyer.
- It is also clear that cases require the assistance of experts in many, if not all cases. From a perusal of some of the cases, it appears that there is a group of experts who appear regularly and have presumably developed an expertise in this area.
- While the High Court cases refer to the sensitivity of questioning, it is clear the scheme has the ingredients of an adversarial system: for example, on appeal both the applicant and the government are represented and present legal arguments for and against the case made by the applicant. This may be stressful and distressing for claimants who already believe they have been seriously harmed and in some cases lied to by the State.

My conclusion is that this is a system which could be copied in a form modified for the English legal context and adopted as a compensation scheme here. However, for all its apparent advantages in terms of individual bespoke awards, this would be unlikely to satisfy the requirement of many infected and affected for a simple process, delivering predictable outcomes, without a major rehearsal of their histories and the passage of considerable time to reach a determination. That is not to say that there are no elements within the Irish scheme which are worthy of consideration, as pointers to some ingredients of a less bespoke scheme.

## Annual Figures (to 2019) of the Awards and Costs of the Hepatitis C and HIV Compensation Tribunal

### Awards of the Tribunal

Year	Number of Awards	Amount Paid
1996	204	€ 28,627,096.00
1997	327	€ 56,672,735.00
1998	535	€ 105,660,817.00
1999	214	€ 43,221,011.00
2000	126	€ 31,943,504.00
2001	71	€ 23,646,314.00
2002	62	€ 18,541,096.00
2003	108	€ 27,964,437.00
2004	243	€ 39,384,189.00
2005	287	€ 42,186,950.00
2006	290	€ 46,543,469.00
2007	193	€ 57,782,743.00
2008	143	€ 39,349,934.00
2009	158	€ 32,244,590.00
2010	117	€ 30,496,254.00
2011	114	€ 17,066,854.00
2012	79	€ 15,091,916.00
2013	77	€ 16,298,493.00
2014	75	€ 16,370,641.00
2015	59	€ 15,700,074.00
2016	28	€ 14,892,384.00
2017	62	€ 13,114,428.00
2018	52	€ 10,754,172.00

Infected Blood Compensation Study

2019	28	€ 8,045,988.00
<b>Total</b>	<b>3,652</b>	<b>€ 751,600,089.00</b>

**High Court Appeals**

Year	Number of Appeals	Amount Paid
2000	41	€ 6,053,486.00
2001	113	€ 24,835,283.00
2002	52	€ 17,762,094.00
2003	29	€ 7,372,875.00
2004	43	€ 7,954,150.00
2005	23	€ 2,260,174.00
2006	26	€ 5,249,856.00
2007	15	€ 3,242,913.00
2008	10	€ 4,670,878.00
2009	12	€ 1,638,493.00
2010	14	€ 1,670,025.00
2011	3	€ 195,001.00
2012	7	€ 1,385,476.00
2013	1	€ 40,000.00
2014	2	€ 150,000.00
2015	3	€ 220,000.00
2016	2	€ 135,000.00
2017	6	€ 1,506,500.00
2018	0	€ 0.00
2019	3	€ 1,070,642.00
<b>Total</b>	<b>405</b>	<b>€ 87,412,846.00</b>

**Reparation Fund Payments**

Year	Number of Payments	Number of Payments	Amount Paid (Award)	Amount Paid (Appeal)
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Infected Blood Compensation Study

	<b>(Award)</b>	<b>(Appeal)</b>		
1997	340	-	€ 11,971,841.00	-
1998	686	-	€ 25,249,850.00	-
1999	220	-	€ 8,928,869.00	-
2000	136	39	€ 6,692,662.00	€ 1,124,269.00
2001	77	115	€ 4,889,774.00	€ 5,053,485.00
2002	67	52	€ 3,800,910.00	€ 3,552,419.00
2003	92	29	€ 4,789,220.00	€ 1,474,575.00
2004	240	43	€ 7,723,198.00	€ 1,590,830.00
2005	285	23	€ 8,355,730.00	€ 452,035.00
2006	288	25	€ 9,296,865.00	€ 1,028,715.00
2007	170	15	€ 11,146,133.00	€ 648,583.00
2008	138	10	€ 7,597,215.00	€ 934,176.00
2009	152	12	€ 6,234,917.00	€ 327,699.00
2010	112	14	€ 5,964,670.00	€ 321,405.00
2011	112	3	€ 3,388,004.00	€ 39,000.00
2012	76	6	€ 3,127,929.00	€ 263,295.00
2013	70	-	€ 2,985,965.00	-
2014	75	2	€ 2,965,048.00	€ 30,000.00
2015	54	3	€ 2,988,111.00	€ 44,000.00
2016	25	2	€ 3,040,174.00	€ 27,000.00
2017	58	6	€ 2,711,089.00	€ 289,000.00
2018	45	0	€ 2,068,654.00	-
2019	25	2	€ 1,540,214.00	€ 164,128.00
<b>Total</b>	<b>3,944</b>		<b>€ 164,821,656.00</b>	

**Legal Costs**

<b>Year</b>	<b>Number of Claims</b>	<b>Amount Paid</b>
1996	93	€ 1,737,849.00
1997	275	€ 7,518,688.00

Infected Blood Compensation Study

1998	512	€ 16,345,926.00
1999	315	€ 9,984,938.00
2000	180	€ 8,297,691.00
2001	183	€ 8,605,772.00
2002	77	€ 4,490,412.00
2003	131	€ 6,859,157.00
2004	197	€ 7,094,735.00
2005	307	€ 13,180,987.00
2006	344	€ 11,371,437.00
2007	187	€ 7,825,866.00
2008	129	€ 8,986,744.00
2009	155	€ 13,027,173.00
2010	148	€ 10,229,280.00
2011	149	€ 10,608,721.00
2012	96	€ 7,948,739.00
2013	65	€ 4,571,765.00
2014	78	€ 6,689,814.00
2015	40	€ 2,101,000.00
2016	30	€ 2,388,221.00
2017	48	€ 3,750,966.00
2018	48	€ 4,859,695.00
2019	45	€ 5,418,090.00
<b>Total</b>	<b>3,832</b>	<b>€ 183,893,666.00</b>

Appendix 8

**Awards in AA v National Blood Authority**

**Technical note on updating:** The awards have been updated using RPI of 317.7 in January 2022 and 172.2 in March 2001 (the date of the awards).

Claimant	Page Ref	Final / Provisional	Head of Damage	Amount	Updated Amount	Comments
Mrs S	105 §70	Provisional	PSLA	£7,000	£12,915	Included infection and adjustment disorder. 9 years infection; limited physical symptoms; care costs awarded.
Mr U	108 §72	Provisional	PSLA			Total £10,000 (£18,449 updated).
			Infection	£5,000	£9,224	9 years infection, 2 treatments; now cleared. Care costs awarded.
			Adjustment	£1,000	£1,845	
			Biopsies x2	£500	£922	
			Interferon x 2	£3,500	£6,457	
Miss T	111 §85	Provisional	PSLA			Total awards [provisional] - £20,500 (£37,821 updated)
			Infection	£12,500	£23,062	10 years; 2 biopsies; combination therapy; no fibrosis; no symptoms; good prognosis.
			Biopsies x2	£1,250	£2,306	
			Past Interferon	£3,500	£6,457	
			Future Costs:			
			Treatment	£3,250	£6,457	
			Insurance Handicap	£1,000	£1,845	
Mrs V	115 §92	Provisional	PSLA			Total provisional award - £22,050 (£40,681 updated)
			Infection	£6,500	£11,992	11 years infection; biopsies x 3; no physical symptoms; side effects of treatment; good prognosis; future therapy
			Adjustment disorder	£3,500	£6,457	
			Biopsies x 3	£1,250	£2,306	

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			Future Treatment	£1,450	£2,675	likely.
			Future Biopsies	£100	£184	(Adjustment disorder) lower bracket in guidelines.
			Future Costs:			(Insurance Handicap) mortgage protection and critical illness.
			Insurance Handicap	£3,000	£5,534	
Mr W	120 §102	Final	PSLA	£27,000	£49,814	PSLA included future as well as past including 3250 for future biopsies.  10 years infection to date, 7 years life expectancy.  Background of complex cardio issues.
Mrs X	124 §110	Provisional	PSLA	£45,000	£83,023	11 years of infection progressed to liver transplant after 9 years.  Assumption: she would not develop cirrhosis again or liver cancer, but including 7 miserable years, escape from death and relative disability in future.  Care costs awarded.