



Interim Report

1. This interim report concerns a single issue. It is whether I should recommend that, as soon as practicable, interim payments should be made and, if so, the scope of those interim payments.

The Background

2. The Inquiry formally began on 2 July 2018.
3. Just over two years later, on 13 July 2020, the Rt Hon Penny Mordaunt MP, as the then Paymaster General, wrote to the then Chancellor of the Exchequer. She pointed out that *“successive sponsoring Ministers have committed publicly to supporting the completion of the Inquiry’s work as quickly as thoroughness allows. This work remains urgent for many victims - justice delayed is justice denied as the fall-out from this tragedy continues to claim lives... I fully expect the Inquiry Chair, Sir Brian Langstaff, to make recommendations about levels of financial support, and I believe it to be inevitable that the Government will need to provide substantial compensation. The costs are likely to be high... I believe we should begin preparing for this now, before the Inquiry reports, and my officials are working with DHSC colleagues to consider approaches to compensation.”*
4. Following further correspondence, she announced the Government's intention to *“appoint an independent reviewer to carry out a study, looking at options for a framework for compensation”* on 25 March 2021.

5. On 8 July 2021, thus now some three years after the Inquiry formally began, Sir Robert Francis QC was appointed by the Paymaster General “... *to 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.*”¹
6. Sir Robert was tasked to submit his report and his recommendations as quickly as possible, and no later than February 2022: a date which was in due course amended to 14 March 2022.
7. He duly delivered his report to the Minister for the Cabinet Office and Paymaster General, the Rt Hon Michael Ellis QC MP, on 14 March 2022.
8. On 7 June 2022 the report was published. Five weeks later, on 11 and 12 July 2022, Sir Robert gave evidence to the Inquiry about his conclusions and its recommendations.
9. His first recommendation was in these terms “*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.*”
10. Recommendation 14 added “*I recommend that the Government should immediately consider offering a standard figure by way of substantial interim payments, on*

¹ Terms of Reference of Sir Robert Francis’ study.

account of awards likely to be paid 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.” Though he accepted (paragraph 1.10) that this recommendation was an unusual measure, he justified it in these words “... 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 scheme² as recommended getting going before the conclusion of the Inquiry. This is unfortunate for the many 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. ...If at all possible, it is a matter of justice that as 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.”

This Interim Report – Process

11. It was the force of Sir Robert’s recommendation of an interim payment, as amplified by him in the course of his oral evidence to the Inquiry, that caused me to reflect on whether I should exercise my powers under section 24(3) of the Inquiries Act 2005 to make an interim report. If after considering submissions on the issue, the Inquiry (a) supported Sir Robert’s recommendation as made by him, (b) supported it but differed in some material respects, or (c) rejected it, it could then set out which of these options it preferred and explain why.
12. Elementary justice required that I consider this question. If I did not, but waited for the final report of the Inquiry to recommend a compensation scheme including an interim payment, those who might benefit from the recommendation would have been kept waiting for relief which was both necessary and urgent. If, by contrast, I waited till then only to recommend there should be no interim payment, the consequence

² i.e. the compensation scheme recommended by Sir Robert Francis.

would be that many participants in the Inquiry would have had their expectations raised, only to be dashed, and their disappointment would be made all the worse because of the delay in my saying so. In short, whichever view I took on the question of whether to recommend interim payments, waiting to the conclusion of the Inquiry would be failing many of those the Inquiry had undertaken to put at its heart. Not to make a decision is in itself a choice: and since the issue has been raised fairly and squarely by Sir Robert's report and evidence, the issue should not be ducked.

13. Accordingly, I called for submissions to be made about the issue set out at paragraph 1 above. Because the issues had so recently been fully explored through Sir Robert's oral evidence, and the report which Sir Robert wrote was itself so full and detailed, a reasonable time for those submissions to be made in writing to me was by close of business on Monday 25 July 2022. I received no objections to this timetable.
14. In the event, I have received 15 submissions from recognised legal representatives and unrepresented core participants. I also received several hundred individual responses, indicative of the strength of feeling among Inquiry participants.
15. The governmental core participants, including the Department of Health and Social Care, do not consider it is appropriate for them to express any view. The Department of Health Northern Ireland makes no submissions, because of the lack of a functioning executive in Northern Ireland. NHS Blood and Transplant, though considering it has no proper role to make submissions as to recommendations, expresses the hope that all infected and affected people receive fair recompense.
16. All the other submissions urge me to make a recommendation that interim payments should be made. They differ to some extent in identifying whether or not a wider class than those who are alive, and infected, should be paid; and some suggest that the figure proposed by Sir Robert as representing a genuine pre-estimate of a likely minimum award (£100,000) is too low.

17. Overwhelmingly, the submissions unite in pointing out that many of those likeliest to be eligible for an award are likely to be living on borrowed time. They have waited years. In addition to any challenges of age, many have the legacy of hepatitis C infection and the after-effects of treatment for it; or have the continuing infection with HIV and its legacy; or are co-infected with both. Many suffer the physical, mental, social, financial, marital and employment consequences of these dreadful infections: and all too many have seen members of their own families or close friends suffer a dreadful death which might have been their own. The effects of stigma have meant that many have felt compelled to hide their infection even from their children or close family.
18. For present purposes, this Interim Report need not set out the full details of this suffering and the serious need which has resulted. It has been sufficiently described in the evidence of many individual witnesses; in the written and oral evidence of the Inquiry's psychosocial expert group; in Sir Robert's report itself; and has been acknowledged by almost every witness who has given evidence so far. It makes a compelling case for significant relief as a matter of urgency.
19. I shall however refer to one of the personal responses I have received, which expresses – with economy – what was said generally. It is a deeply poignant letter. It did not use the word recommendation. It simply said it wished to remind me that she, the writer, was suffering from terminal cancer as a result of her infection. Just that. No more. But it is difficult to think of a more eloquent plea for speed.

Further Consideration

20. The predecessors of the current blood support schemes were established as ex gratia payment schemes. Compensation was repeatedly disavowed.
21. The effect of this approach is that the payments could be (and were) significantly less than compensation would be. They were not compensation. Indeed, the evidence is to the effect that they were not calculated by reference to any assessment of need.

The consequence has been that from the very first payments made to the Macfarlane Trust until today it has repeatedly been said by many witnesses that the payments being made were simply inadequate to provide the financial relief that was needed.

22. A justification for ex gratia payments and not making more generous payments, repeated over the years by or on behalf of Government, is that those who had suffered infection had been given the best available treatment in the light of what was known at the time. Such an approach leaves no place for fault, let alone legal obligation.³
23. If, however, it were accepted that there had been some fault on the part of Government or parts of the system for which the Government bore responsibility, the basis for payments being ex gratia would be undermined, and the case for more generous support significantly strengthened.
24. A significant shift in Government thinking became apparent on 25 March 2015, at Prime Minister's Questions. Rory Stewart MP asked "*One of the most disturbing scandals has been the infection of thousands of people across the nation with HIV and hepatitis C through contaminated blood. Today Lord Penrose publishes a report which follows nearly 25 years of campaigning by Members on both sides of this House to address this scandal. Will the Prime Minister, as the last act of his Government, ensure that there is a full apology, transparent publication, and, above all, proper compensation for the families terribly affected by this scandal?*" The Prime Minister, David Cameron, responded: "*My hon. Friend is absolutely right to raise this, with the Penrose report being published today. I can do all of the three things he asked for. 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 feeling of unfairness*

³ The Inquiry has no power to make any finding of civil or criminal liability, but this does not preclude a finding of individual or systemic fault or responsibility or both.

*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.***"⁴

25. The then Prime Minister's words do not stand on their own. On 26 September 2018 at the preliminary hearing of this Inquiry, Eleanor Grey QC, as Counsel instructed by the Department of Health and Social Care, first reminded the Inquiry that Theresa May, as Prime Minister, when she announced the establishment of an Inquiry in 2017, spoke of "*an appalling tragedy which should never have happened.*" The Chancellor of the Duchy of Lancaster and then sponsoring minister to the Inquiry, the Rt Hon David Lidington MP, had later echoed this: "*The infected blood scandal of the 1970s and 1980s is a tragedy that should never have happened*". Eleanor Grey QC went on to say "*Those are words from government ministers. However sincere they are, they cannot convey or comprehend the full knowledge and experience of those directly affected by the events that you are charged with investigating. But, **on behalf of my clients, I do say that those words, the acceptance that this should not have happened, is an acceptance that things went wrong. Things happened that should not have happened, and so, on behalf of my clients, I say, unreservedly, that we are sorry. We are sorry that this should be so, that this happened when it should not have done.***"⁵

26. In the course of his evidence to the Inquiry the Rt Hon Jeremy Hunt MP, who was Secretary of State for Health from 2012 to 2018, and was thus in post when the Inquiry was set up, and who is the current chair of the Health and Social Care Select Committee, was clear that in his view there had been failings. He recalled that when he came into office "*what I could see was that the State had supplied infected blood which had taken away the lives of many people, and limited the lives of many others and ruined the lives of many, many families, and that was a terrible injustice*", adding

⁴ Emphasis added.

⁵ Emphasis added.

later *"I think when you look at the anguish that families were facing, but actually, the simple fact that people were dying without getting access to the additional compensation for their families or support that they needed with their lives, I don't think anyone can be proud of the performance of the British state over the last 25 years,"* and summed up much of what he had to say in the following exchange:

"Q. [The Prime Minister, Theresa May] described it, as I recall, as "an appalling tragedy which should simply have never happened"; would you agree with that?

A. Yes.

Q. She described thousands of patients being failed. Would you agree with that?

A. Yes."⁶

27. I have yet to hear all the evidence that bears upon the Terms of Reference of this Inquiry. Without considering all the evidence and listening to the submissions of those who are core participants I cannot reach any final conclusion. At the outset of this Inquiry I promised that I would reach those conclusions without fear or favour, affection or ill will: and I have as part of that to consider impartially what the facts show and make recommendations in the light of those findings which are there to be made.

28. However, I can be clear that the statements of two recent Prime Ministers, a Cabinet Office Minister, a recent Secretary of State for Health and the QC instructed by the Government Department centrally concerned with the issues which the Inquiry is investigating, which I have set out above, all represent considered views. They are all the stronger because they represent a change of position from the earlier positions. Those earlier positions underpinned the rationale for making only limited and ex gratia payments rather than payments of a compensatory nature; the more recent statements tend to undermine it.

⁶ Transcript, 27 July 2022, p.134.

29. In front of the Inquiry the then Secretary of State for Health, the Rt Hon Matt Hancock MP, came close to accepting that there was a need to provide fairer and more appropriate redress for the particularly horrific consequences of the administration of infected blood and blood products to patients under NHS care. When he spoke on 21 May last year⁷ he said: *“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 – wasn’t properly considered and 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.”*

30. I am entitled to take those expressions of current view at face value. They support the view which Sir Robert Francis expressed in his report as to the strength of the moral case for a compensatory scheme, irrespective of the eventual findings of the Inquiry. His words in the following passage are consistent with the Ministerial observations quoted above: *“In my view, one of the special features of this case is that whatever it can be said about fault or no fault, the injuries that have been inflicted on people, firstly have been inflicted on them by the state, putting it bluntly. The state-delivered Health Service has done this to people. It seemed to me, and without wishing to pre-judge this Inquiry, that much of what happened, and it is not for me to make the judgment, was in retrospect avoidable. In other words, if we look back on things from now it could be avoided for many if not all cases.”*⁸

Interim Payment: The Principle

31. Where suffering is in the here and now and recompense is likely, but will not be concluded for some time, and payment unlikely to be made promptly or immediately thereafter, there is a case for making a payment in advance. Not to do so is potentially

⁷ Transcript, 21 May 2022, pp. 97 - 98.

⁸ Transcript, 11 July 2022, p.50.

unjust. It exposes people to continued pain, difficulty and disability, the worst of which can be alleviated now. It therefore should be alleviated to the extent this can reasonably be done. It benefits the payor, as well as the payee, since in general, the longer payment is delayed the greater the losses (in both amount and nature) that will then fall to be paid for.

32. Though this principle has been stated shortly it contains three essential elements: a) the severity of current suffering or difficulty; b) the likelihood of an award of increased payment reflecting the extent of that suffering or difficulty; and c) the length of time before the final sum due is likely to be determined. A fourth can properly be added: the extent to which the passage of time disadvantages the payee.

a) Severity of current suffering or disability

I need not repeat what I have already said above about the extent of suffering, save in respect of one class of persons, bereaved partners. It is unnecessary to spell out the severity of the consequences of the infections with which this Inquiry is centrally concerned. I think it would be difficult to find anyone, whatever their perspective or initial expectations, who could fail to have been deeply moved by the testimonies of those who had been infected. A number of politicians have described how their views have been affected, even changed, by as little as a single encounter with individual constituents or small groups of those infected. By contrast, the evidence given at the outset of the Inquiry occupied a full three months. Similar evidence of profound physical and mental suffering was repeated over and over again in public. It showed that the experiences which those politicians recounted were not simply those of a single individual or small group, but were broadly and generally shared across a wide breadth of backgrounds, from a diversity of places, in a variety of personal circumstances.

In recommending interim payments Sir Robert had in mind a payment to every living infected person. A number of the submissions I received argued that

bereaved partners who have been accepted by any of the schemes should be no less entitled. They fall within the scope of Sir Robert Francis' second recommendation.⁹ It is plain that Sir Robert himself was significantly influenced by meeting and talking to many of the infected and affected participants in the Inquiry. Yet he did not expressly include bereaved partners as candidates for the interim payments he proposes.

However, he has acknowledged repeatedly - and appropriately - throughout his report that the Inquiry has heard more, over longer, from a greater class of people, and in greater depth than he was able to do, despite his intense schedule. Had he heard what the Inquiry has heard, to the depth it has considered it, I suspect he may well have recommended that those accepted by the current support schemes as affected partners of a deceased infected person have also suffered in a way that suggests that they, too, should receive an interim payment on account of any subsequent compensation likely to be awarded.

The mental and psychological impact of being told early in life that you are soon to die of an infection that you should not reveal to anyone, and that you may expect the process of death to be painful and lingering is substantial: that is obvious. But it is equally obvious that those who care deeply enough to be partners by marriage, civil partnership or by long-term relationship of a person in that position may suffer just as much. They could see a fate that seemed to be inevitable slowly unfolding in front of their eyes and had to deal with it, often in isolation. They had to face the choice of abandoning someone they cared for who was in need, or shouldering the burden of caring for them themselves. If they chose the latter they could expect little life of their own - social, educational, or vocational - and their choice to care meant living always with the threat that they might suffer from the same infection. This would especially be so if they were fully to express their mutual affection. Ambitions for a family were often thwarted.

⁹ See page 75 and the text that precedes it.

The consequences of this for partners who cared were long term disadvantages on the labour market, on top of the psychological burden which many bore. Those who were partners of people infected with hepatitis C bore the brunt of the effects of the infected person's treatment with Interferon and Ribavirin for the two decades following 1990, and sometimes thereafter. "Ribavirin rage" (as it has been called) arose as a label to describe the often violent outbursts which characterised a reaction to the drugs used in treatment. Treatment itself was long term - often a year. It was hit and miss whether it succeeded – the chances were often less than evens that it would. If it failed, it might be repeated. It might, and often did, fail again. The physical and mental effects of the treatment when it occurred were not the end of the story. Further conditions often developed as a result of the treatment – an indirect rather than direct consequence of the underlying virus. The changes of character which treatment and its aftermath wrought imposed particular strains upon their loved ones, and made the care they wanted to give more demanding still to deliver.

The way partners suffered from the knock-on effects of the treatment given to their loved ones, on top of the ravages of the illnesses those loved ones had, was often so marked that those listening to or reading the testimonies of the affected would be bound to reflect whether they could have coped if put in the same position.

The task of caring had more than social, psychological or physical consequences. It was likely to have affected earning potential, sometimes at a time (early in a career) when the loss of early opportunities tends to have long term effects. The lack of opportunity to earn meaningfully in the labour market occurred whilst a partner cared for an infected person, or sheltered a family from the worst effects of the Ribavirin rage of the infected person, and had the potential to (and often did) create a cycle of debt and disadvantage.

Not all who are registered as affected bereaved partners within the schemes will have suffered to precisely the same extent. Just as is the case with those infected, a scheme such as Sir Robert Francis proposes would result in some eventually being entitled to more than others. However, it is difficult to think that many would not have suffered in terms of employment, loss of opportunity, housing, and servicing of debt, on top of the physical and mental consequences of first caring and then bereavement.

Thus far, what has been described are the effects of another's infection during their life upon a partner, and the feelings caused by their death. But the loss suffered by a partner is more than a matter of direct personal impact. It is also a loss of the contribution – by their income if they had been uninfected, and by their abilities to make other contributions to a couple or family which are measurable in “money or money’s worth” and which the deceased partner would, if unaffected, have made to the couple and to their family. If this were a case brought under the Fatal Accidents Acts the assessment of financial loss would be described as a “matter of hard pounds, shillings and pence”¹⁰. It is a real financial loss.

Having regard to both the personal impact on a partner and their own earning capacity and to the loss of any financially measurable contribution from the infected person, I am satisfied that there is a broad parity between the need for recompense for those who were infected, whether with HIV or HCV, expressly recognised by Sir Robert, and for those who were affected by the suffering of their infected partners before death.

What is said above can be summed up in one neat example. If bereaved partners are not included in the scope of people who can claim an interim payment, then suppose a person who is infected and alive at the date a decision is taken to pay interim payments, but who dies before a payment can be made. Before death,

¹⁰ Mallet v McMonagle [1970] AC 166.

their spouse, civil partner or long-term partner would have expected to share the benefits an interim payment would bring to their straitened circumstances. Now the infected person has died, they have to wait till a scheme is finally determined. Yet their need is just as great, and just as immediate, if not more so, as that of the infected person would have been because of the effects of having to deal with their contemporaneous bereavement.

b) The likelihood of an award of increased payment

Sir Robert Francis' view that there is a compelling moral case, irrespective of the findings of the Inquiry, speaks for itself. The ministerial statements and opening words of Counsel for the Department of Health and Social Care as set out above imply an acknowledgement that the Inquiry is likely to find that the basis upon which ex gratia payments have thus far been made is no longer sustainable as a restriction upon the extent of those payments.

c) Length of time before an award can finally be determined

Sir Robert, in his report and evidence, saw a large disadvantage in adopting the Irish scheme of compensation in the UK, because the assessment of awards under it takes so long. His own proposed scheme endeavours to ensure a significant underpinning by providing basic support for all whilst recognising the need for personalisation in addition¹¹. The scheme he proposes involves a setting up of an immediate legal and medical panel, involves hearing directly from the individual, and has an element of personalised award. There are processes of review and then appeal built in to the scheme. He recognises such a scheme would take some time to set up: and it ought, in principle, to be agreed between each of the four home nations since the origins of the disaster were common to all. Once up and running any scheme, whatever its details, will have a large number of

¹¹ See paragraph 1.12.

applicants with whom to deal. Demand for consideration, one by one, leads initially and inevitably to a long queue. It is practically impossible to deal with all applicants within days of setting up the scheme. The process is likely to take many months, if not longer. It will, of course, only begin if and when the Government decide to introduce such a scheme. There must be a very real possibility that the Government will choose not to come to a decision on this matter at least until after the Inquiry has delivered its final report. Thus the period of time before any such scheme of payments begins may be measured more in years than months.

By contrast interim payments in a set amount made to those who are currently registered with the schemes can be paid very quickly. No assessment is needed; payment routes are well established; eligibility is established; the administrative infrastructure to deliver it is present. All that is needed is a funding commitment by the relevant government.

d) Disadvantage through the passage of time

The letter I singled out for mention above from the individual suffering from terminal cancer is all I need to mention. It brings home the fact that significant numbers of people have died since the Inquiry was established and will continue to die before the Inquiry can complete its work.

Bereaved Parents and Children

33. I was asked by some to recommend interim payments to bereaved parents and children. Many have waited not just years but decades for any recognition of their loss. The moral case for compensation is beyond doubt. The submissions I have received had different views on how to make interim payments. As Sir Robert Francis recognised, his proposals are linked to the ease and speed with which an interim payment can be made. Achieving this appears to be difficult at this stage, though no one can doubt that a parent who lost a child, or children, or a child who lost a parent,

or parents, and has lived for many years without acknowledgement of that loss should be recognised as among those for whom a moral case for recompense is compelling. Further, assessing the amounts it is proper to pay involves a far greater degree of personal individualisation: the approach and eventual amounts of any sums are thus more complex to determine, and I should hear arguments about that first before reaching any conclusion. I shall do that when I hear submissions following the conclusion of the evidence.

34. Having regard to everything that I have set out above, and having carefully considered the submissions that have been made to me, I have decided to exercise my power to make a recommendation that interim payments should be made to those who are alive and infected, and to bereaved partners. I set out the terms of that recommendation below.

Other Considerations

35. Sir Robert Francis envisaged that the support schemes would continue to make the payments they were already making, whether or not compensation under the scheme he proposes was made. I recommend not only that an interim payment should be made as already set out, but that this does not and should not affect the operation of existing arrangements.
36. Steps should be taken (as a matter of priority) to ensure that if interim payments are made they will be treated in the same way as the payment of damages through the courts would be, that it is free of income tax¹². The interim payment should be disregarded for the purpose of social security payments. Not to do so would be to reduce the impact, which is intended to help individuals' current, pressing and severe difficulties. It would help them to plan for the rest of their lives and for those of their loved ones.

¹² See Recommendation 15 in Sir Robert Francis' report.

Conclusion

37. I recommend that:

(1) An interim payment should be paid, without delay, to all those infected and all bereaved partners currently registered on UK infected blood support schemes, and those who register between now and the inception of any future scheme;

(2) The amount should be no less than £100,000, as recommended by Sir Robert Francis QC.

A handwritten signature in blue ink that reads "Brian J Langstaff". The signature is written in a cursive style and is underlined with a long horizontal stroke.

Sir Brian Langstaff
Chairman
Infected Blood Inquiry
29 July 2022