Infected Blood
Compensation Authority

Infected Blood Compensation Authority

Recommendations of Sir Robert Francis KC to the Government on the proposals for a compensation scheme

August 2024

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Executive Summary

My original study into a compensation framework was published on 7 June 2022. In that study I said:

> “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.”

None of their determination has been lost, all working with a view to getting the justice they and their community are entitled to. Sadly, another two years of waiting has transpired, but thanks to the efforts of many, progress has finally been made towards delivering a scheme which will provide the compensation they seek. Given the background, I welcome the previous Government’s proposal for a compensation scheme and the previous Government’s request that I ask the community of infected and affected people what they think of the scheme.

It is important to recognise that most of my and Sir Brian Langstaff’s recommendations are reflected within the proposal. For brevity’s sake, I will not describe in this report all the elements that correspond with those recommendations. If an element of the scheme is not mentioned here it is either because it is a sufficient match with what was suggested, or it was not raised by people during the engagement period. I urge those reading the proposal and this report not to look for perfection, nor to insist on all the details of the previous recommendations being reflected precisely in the proposals.

They should be judged on whether they are likely to deliver broadly fair and proportionate compensation to those entitled to it. Frankly, time does not permit a lengthy search for perfection and delay, which is now in any event prohibited by Parliament, and would only add to the pain and distress of those still waiting to know what the financial future holds for them.

The proposal is, by necessity, lengthy and complicated. It has to take into account the numerous people who have been infected or affected – and their multitudinous circumstances. It follows then that neither my report nor the list of my recommendations is short. They are representative of the issues that people told me they saw with the scheme. I hope my recommendations represent some sensible ways to remedy those issues.

A comprehensive list of my recommendations is in annex A. In this executive summary I summarise the key themes and areas they cover. In particular, my recommendations are intended to ensure that:

- People are enabled to continue to receive their existing support payments in a format they recognise in addition to compensation which, together, provide as appropriate a recognition of their injury and loss as money can provide;
- Sufficient details and explanations are provided on the proposal and, when finally settled, the details of the scheme, so that people can understand it and have a better idea what they are likely to receive;
- Because we should learn from the experience of applying to the scheme and operating it, there should be a review after a year of the scheme’s operation;
- An additional severity band equivalent to the Special Category Mechanism (SCM) or equivalent measure is introduced;
- The imposition of unethical research should be reflected by an additional award for loss of autonomy to those who were involved without informed consent, in particular those who were children at the time;
- It is made explicitly clear that support and compensation payments are tax-free and should not be considered when assessing someone’s right to benefits;
- Funding for legal support and financial advice should be made available to those due compensation.

This engagement exercise and report is imperfect. Very little time was made available for undertaking this work. It was severely limited by the time required to prepare the regulations needed to set up the scheme by the deadline of 24 August set by Parliament. The extent of the engagement permitted has also been constrained by long-established restrictions on what it is possible to publish during a pre-election period. I regret that. However, in the interests of moving the scheme forward for all those who have been waiting such a long time for it, and in recognition that most of what is needed is present in the scheme proposal, I submit my recommendations for the Government's consideration on how they could improve the scheme and respond to the concerns expressed by the infected and affected communities.

Sir Robert Francis KC
12 July 2024

Introduction

On my appointment as interim chair of the Infected Blood Compensation Authority, brought into existence by the Victims and Prisoners Act 2024, it was agreed that I should conduct an engagement with the infected and affected communities, consider the proposals for the scheme and report on the feedback I received and my recommendations about the proposals. What follows is my report on the result of that process.

I address some of the challenges of that task in the following section, but I would like to make clear some overall conclusions about the proposals and the way forward at the outset of this report.

The overall framework is the result of a genuine attempt to achieve, in the time available, details of a scheme which aligns in spirit with the recommendations in my framework report and Sir Brian's recommendations arising out of that. It provides a credible means of offering significant – and in many cases – life-changing sums to persons infected and affected by this terrible scandal.

It is inherent in such a scheme that its detail will not satisfy entirely all interests because a balance has to be maintained between recognising as closely as is practicable the individuality of each case and the needs of all for a resolution of their entitlement to compensation as quickly and simply as possible. Such a balance can only be achieved by taking a broad approach to many issues, which, in litigation, would be the subject of considerable complexity. To resolve all those complexities in this sort of scheme would be as overwhelming for applicants as it would be for the administration of the scheme itself.

The law requires the scheme to be in place by 24 August 2024. It is simply impracticable to reject the proposals root and branch – there is not time to start again without causing enormous damage to those who seek and are entitled to compensation. In any event, as the proposals in my view largely achieve their objective, it is unnecessary to do that. What may well be advisable, however, in the very short time available, is to examine some particular matters of detail which could well be changed to improve the perception of fairness, the better recognition of individual circumstances, the ease of processing applications, the understanding of the scheme and the reasoning underlying the scheme.

I was appointed interim Chair of the new Infected Blood Compensation Authority on 21 May 2024. I agreed with the then Deputy Prime Minister, Oliver Dowden, that it was important to conduct an engagement with the infected and affected communities on the Government’s proposals. At the time it was understood that the Victims and Prisoners Bill would receive Royal Assent in July, which would have meant that the three-month deadline for making the regulations to establish the scheme would have expired in September. However, on 23 May 2024 a general election was called. In order to be passed before the dissolution of Parliament, Royal Assent of the Act was granted on 24 May 2024, meaning that the statutory deadline for laying the required regulations fell on 24 August 2024. Thus, the period for engagement and the time for drafting complex regulations was significantly reduced, and in practice this meant that the results of the engagement have had to be reported now. Further, the practice governing announcements during an election period limited the details of what officials could publish with regard to the proposed scheme.

In the course of the engagement period, I met 36 representative groups, and as at 3 July have received some 160 written submissions from representative groups and individuals.

While as described the conditions for engagement were far from ideal, I am satisfied that the process reached a representative range of those likely to be able to claim compensation.

It will be impracticable to refer to each point made in these meetings and submissions separately without making this report impossibly long. I will deal with what appear to be the major themes in the concerns that have been expressed. If a point is not mentioned in the report, it is because I feel it would be better addressed by the Cabinet Office, on behalf of the Government proposing this scheme, to answer directly.

I would like to end this introduction by expressing my assessment of, and appreciation to, those who have participated in the engagement I have conducted.

Firstly, in spite of their understandable scepticism about the nature of the process, the representative groups who at my invitation have attended engagement events, have responded in a highly impressive and constructive manner. Many of those attending have had, once again, to repeat and relive experiences they would rather put behind them and have made important points on behalf not only of themselves but many others. As they did during my framework review, they have done so conscientiously, courteously and with great dignity. This was at not a little personal cost to them in terms of the stress, and distress of having to do this, as they would see it yet again. I am also very grateful to all those individuals who have submitted written observations, which I have taken into account. If I have not agreed with or understood correctly all they have put to me, that is not through any lack of effort on their part, but is solely my responsibility. I can only seek to demonstrate that gratitude by assuring them that their concerns have been heard and by this report relayed to the Government. I can only hope that the Government’s response will result in a replication of the positive reaction many had to the publication of the Inquiry Report.

Secondly, I would like to make it clear that I am completely satisfied that the expert advisory group on whose work under testing circumstances the proposals for scheme are based, have worked with conscientious diligence, independence of judgement and good faith. Through Professor Montgomery they have engaged constructively with me to consider and review points made to them and where they have thought appropriate to undertake to revise their recommendations. For that I am grateful. It of course remains a matter for the Government to decide whether to accept any recommendations, whether made by the expert group or by me.

Thirdly, I would like to express my gratitude to the team working to support me in the IBCA and also Cabinet Office officials who have been involved in the formulation of Government policy. At all times they have assisted me with explanations, offered resources as requested and patiently offered support while meeting all the challenges put in their way by having to perform their duties in the pre-election period before a general election.

Finally, in coming to the conclusions and recommendations in this report, my objective has been to identify how trust can be built into the proposed scheme so it is a fair and proportionate means of compensating the victims of what can rightly be described as the worst scandal in NHS history. Sadly, it is evident from the feedback I have received that such trust is currently absent. I very much hope that the recommendations I am making will go some way to allowing such trust to grow. It will remain the solemn duty of the IBCA to implement the scheme as finally determined by the Government in the regulations which must be laid by 24 August.

Sir Robert Francis KC
12 July 2024

Development of the proposals and engagement

Concerns expressed by contributors to the engagement

During the engagement exercise, a constant theme at all meetings supported by representations made by others in writing, was dissatisfaction with the process by which the proposals under consideration had been announced. I was told at every meeting that when published on 21 May, the Inquiry's report had been received with approval, and even rejoicing, and a feeling among the infected and affected community that their many complaints had been heard and accepted. My impression is that they were happy that the Inquiry had delivered to them all that they could have expected by way of describing the wrongs done to them. However, the mood changed dramatically on the following day when the Government's proposals for compensation were released. These caused, I was told, great distress and anxiety and a feeling that what was announced fell far short of the expectations raised by the Inquiry's second interim report on compensation. During my meetings strong concerns were expressed, among them that:

- they did not believe that the engagement was a genuine attempt at obtaining feedback from the community but a ‘tick-box exercise’;
- they had not received a full account of the proposals or the reasoning behind them;
- they had had no input to the expert advisory committee;
- the additional documentation given to them in preparation for the meeting did not enable them to understand many aspects of the proposals;
- they had not had sufficient time to obtain advice and consult with those they represented.

I quote from two written submissions received, one from a representative organisation:

> “Those infected and affected by contaminated blood and blood products had less than 24 hours to digest the enormity of the Infected Blood Inquiry’s final report before the Government published its compensation scheme.
>
> As the details of the scheme began to sink in, the feelings of elation and vindication which had resulted from the Inquiry’s findings quickly evaporated, to be replaced by more familiar emotions of suspicion and uncertainty.
>
> It had happened again. The government had created a major scheme without one word of consultation with

> people it was designed to support. The blinkered way in which this scheme was built is shocking."

And one from a solicitor:

> "Prior to making these submissions about the Scheme, [the solicitor] wanted to raise several queries and concerns regarding the same, specifically we request further information where the position is not clear from the published documentation regarding the Scheme. Until this information is made available, the Community cannot meaningfully engage with the consultation process. We are concerned that without this meaningful engagement the Scheme (once finalised) will be rejected."

In short, they complained that they had not been properly involved or consulted and, therefore, that they had no confidence or trust in the proposals.

Comparison between process adopted and previous recommendations

The process which has led to the production of the current proposals has been described above. It is fair to say that this does not align with the process recommended in my report, or by Sir Brian in his second interim report.

In my report, I recommended that the Government should set out a framework of tariff-based range of compensation awards[1] within the categories[2] I described on the basis of recommendations by two independent expert panels, one medical and one legal:

> "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.[3]
>
> 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

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[1] Compensation Framework Study report - 7th June 2022: Recommendation 10, page 125

[2] The categories I recommended were injury impact, social impact, care, autonomy, financial loss for infected persons, and injury impact, social impact, family care, bereavement and bereaved family financial loss. Compensation Framework Study report - 7th June 2022: Categories of Award for the Affected, pages 84-85

[3] Compensation Framework Study report - 7th June 2022: page 87

> 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."[4]

With regard to the injury impact award:

> "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."[5]

I pointed to various sources which might inform the identification of appropriate ranges of injury impact award, including the Judicial College guidelines parts of which were attached to the report, judicial awards, and tariffs for criminal injuries compensation. I accepted that a range of awards could only be arrived at on an impressionistic basis.[6] I then set out some illustrative

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[4] Compensation Framework Study report - 7th June 2022: page 89

[5] Compensation Framework Study report - 7th June 2022: page 90

[6] Compensation Framework Study report - 7th June 2022: page 94

figures of my own but emphasised the importance of obtaining a broader set of opinions from experts:

> "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.
>
> 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.
>
> 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."[7]

With regard to social impact awards, I recommended that it should be for the expert panels to decide whether or not the stigma and social isolation experienced difference according to which of the relevant diseases were contracted.[8] I suggested that awards for loss of chance to have children and for loss of marriage prospects, where relevant, could be included in the social impact award.[9]

With regard to care awards, while proposing an approach which avoided detailed examination of the hours of care provided, self-assessment should be encouraged, but with the need for this limited by 'expert-based standardised presumptions' and a range which could be prescribed by the legal panel in consultation with appropriate nursing care experts.[10]

The resulting tariff table or tables could then be used as the basis of assessment by the scheme's assessors. The same approach could be adopted for creating a matrix of tariffs for the affected.[11]

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[7] Compensation Framework Study report - 7th June 2022: page 94

[8] Compensation Framework Study report - 7th June 2022: page 98

[9] Compensation Framework Study report - 7th June 2022: pages 99-100

[10] Compensation Framework Study report - 7th June 2022: pages 102-103

[11] Compensation Framework Study report - 7th June 2022: page 110

With regard to user involvement, I stressed the importance of learning from user experience in relation to the management of the scheme and any changes proposed to be made to it.[12]

Sir Brian Langstaff made it clear that all he had to say about a compensation scheme was to be found in his second interim report. There he stated that with some modifications he agreed with my report. Among the modifications were the way in which the scheme was to be defined:

- The scheme was to be administered by an ALB as I had recommended, but specified that the decision-maker should be the Chair (who should be a current or past High Court Judge of England and Wales, or the equivalent from Scotland or Northern Ireland). They were to be advised by a small advisory board, which should include beneficiaries of the scheme, and the principles it adopted were to be public and transparent.[13]
- The ALB should, he said, have two advisory panels, medical and legal, containing appropriate relevant expertise. He clearly envisaged that it would be these

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[12] Compensation Framework Study report - 7th June 2022: Recommendation 16, page 138

[13] Infected Blood Inquiry, The Inquiry's Second Interim Report: page 12

panels who would advise on the severity banding and levels of award:

> **Since both panels are there to advise on the scheme of banding and levels of award which are appropriate, and if adopted by the Chair their views will have a direct impact on beneficiaries of the compensation scheme, the panels should be expected to talk to, engage with and consult widely with beneficiaries. There is a parallel with this inquiry. It set out to put people at its heart and anyone who has observed these proceedings closely can see that doing so has added to its understanding of what happened and why. I believe that their experiences have helped open my eyes as they have the eyes of others. Those experiences should be available at a formative stage of the 'banding and levels' process.**[14]

- Sir Brian also recommended that the rates of compensation should be based on the advice of the independent clinical and legal panels and 'set by the scheme'.[15] The context makes it clear that he was referring to the panels to be part of the ALB and the rates were to be set by it.

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[14] Infected Blood Inquiry, The Inquiry's Second Interim Report: page 22

[15] Infected Blood Inquiry, The Inquiry's Second Interim Report: Recommendation 8, page 86

The Government has chosen a different route to fixing the terms of the schemes, the rules about eligibility and the categories and rates of award. It appointed an expert advisory panel of clinicians under the chairmanship of Professor Sir Jonathan Montgomery which obtained legal expertise from a firm of solicitors, Browne and Jacobson. This group was tasked with making recommendations as to the scheme to align with the Inquiry's recommendations. They produced advice which the Government has largely accepted as can be seen from the attached summary (annex B) of their proposals. The identities of the members of the panels have only recently been disclosed, and the group's terms of reference did not permit engagement with the infected and affected communities. It has been noted that Browne Jacobson is a member of the panel of solicitors which advises NHS Resolution on negligence claims.

I should say immediately that I am satisfied that the advisory group and Browne Jacobson have acted entirely in good faith and sought to fulfil their brief of impartially seeking to suggest a scheme aligning with the recommendations of the Inquiry.

Effect of difference in approach

Clearly it was and is the right of the Government to decide whether or not to follow any inquiry's recommendations, particularly, it might be thought, when a very large sum of public money is at stake. However, it is fair to observe that the Inquiry made serious criticisms of the Government's response to the second interim report.[16] Unfortunately, the absence of any involvement of the infected and affected communities in the working out of the details of the government's proposals has exacerbated their deep mistrust and their lack of confidence that the proposals represent a fair remedy for the injustices they have suffered. This lack of confidence has been compounded by sharing full details of the proposals only very shortly before our meetings, and without them being circulated to the community as a whole. Some have even suggested that for the proposals to have been announced in this way has appeared to them to be a repetition of the State's behaviour in imposing measures on them without their knowledge, let alone consent. I have heard complaints from representatives of victims' organisations that they have not been able to obtain the informed views of their members, and that in so far as details have been

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[16] Infected Blood Inquiry, The Inquiry Report: Volume 7 The Response of Government

released to the wider public, this approach has caused much confusion and distress.

I have done the best I can in the very short time given me, amounting to no more than three weeks, to arrange meetings with those organisations which between them represent a broad spectrum of the infected and affected likely recipients of compensation. Our meetings were attended by Professor Montgomery and other colleagues able to explain the thinking of the expert group. They clearly welcomed the chance to talk about many points in the proposals with people conveying to them lived experience, and undertook to reconsider those. However, the engagement that has been possible is very far from the involvement in the creation of the scheme envisaged either in my report or that of Sir Brian. Although some groups have succeeded in conducting helpful surveys of their members, there has been no realistic opportunity for the wider membership of the infected and affected groups to inform, in particular, the definition of the severity bandings, or the range of possible awards within the various categories. Not surprisingly, therefore, there was widespread reluctance to accept that the proposals offered compensation which met the overall objective of providing a remedy having regard to – but not limited to – the compensation that might be awarded in court. As was pointed out more than once, the result of this is likely that many may be encouraged to seek awards by the supplementary route or, worse, to resort to litigation.

Some concerns may possibly be capable of being met by reassurance. Having met Professor Montgomery, I am fully satisfied that he has led the expert group in total good faith with a view to trying to produce a scheme which fulfils the objectives set out in my framework report as modified by Sir Brian’s interim report. He would, I am sure, acknowledge that the inability of his group to interact directly with the infected and affected communities was a disadvantage; one they sought to remedy by reference to the published evidence obtained by the Inquiry and the professional experience in practice of the clinicians in his group, whose identities have now been made public.

I am advised that in order to meet the statutory deadline for the laying down of the regulations required to put the IBCA on an operational footing, there is no window of time for further engagement. In other words, the next opportunity to debate the proposals will be when the regulations are debated in Parliament. At that point they can either be accepted in whole, or rejected. It will not be possible to amend them.

What can be done to mitigate the concerns raised?

So what can be done to mitigate the lack of trust that has been engendered by this manifestly unsatisfactory situation? I should make it clear, that so far as I am aware, no one has suggested that the statutory three-month deadline should be extended – even if that is theoretically possible for Parliament to achieve. These victims have already waited far too long for justice, and the time has come for the IBCA to get on as quickly as possible in processing claims and awards. Candidly, no compensation scheme is going to be completely successful in matching the injuries of all individual victims, while ensuring a relatively simple and expeditious process. A struggle for perfection must not be allowed to be the enemy of overall justice.

Recommendations

In my view the following measures should help to mitigate the lack of confidence and trust in the setting up of the scheme:

1. A greater degree of transparency should be adopted:
    a. The full reports of the advisory group and the full detail of the proposals we have been considering should be published immediately.

   b. A full explanation of how the recommended ranges of awards, or formulae for financial and care awards have been calculated should also be published, including identifying any comparators or statistics which have been relied on.

   c. The expert group's response to the points made in the engagement exercise and any modification of their previous recommendations should be published.

   d. The Government's response to the recommendations made by the expert group and in this report should also be published as soon as possible without waiting for the publication of the regulations.

2. The IBCA will undertake to be transparent in its decision-making in setting up the processes by which applications will be received and assessed, and awards made, and will set up mechanisms for ensuring that this is informed by the involvement of the infected and affected communities in their production.

3. I recommend that a provision is included in the regulations that there should be a review of the operation of the scheme after one year. This review should include and have regard to the feedback of scheme applicants and award recipients, and should consider whether any amendments are required. So

far as possible, this should focus on issues which have led to the exclusion of categories of applicants, or denial of entitlement to defined award categories rather than re-opening cases in which an award has already been made.

4. Finally, I suggest that an early and public acceptance of the recommendations made in this report, in particular those concerning the continuity of support payments, will go a long way to allaying concerns that have been raised in the engagement process.

Support scheme payments

The proposal

My understanding of the Government's proposal with regard to the relationship between past and existing support payments under the various schemes is as follows:

- Existing periodical support payments, uprated for inflation, will continue for the life of the recipient or until an award of compensation is accepted.
- In assessing compensation for past losses, no account or deduction will be made of any support payment received.
- If on assessment compensation for past and present care needs and future, but not past, financial losses amount to less than the value of the support payments which would otherwise have been to be received after 1 April 2025, the compensation award will be increased to a value equivalent to that of the support payment which would have been expected but for the compensation scheme.
- Where the annualised gross future assessed care and financial losses exceed the amount of the support payments the recipient will have the option of

- continuing to receive a lump sum payment equivalent to the capitalised value of the support payment and the balance of the future care and financial loss awards as periodical payments, uprated for inflation, for life;
- or, a lump sum representing the gross combined total of the care and financial losses discounted for acceleration of receipt in lieu of a continued support payment;
- or, a continued regular payment equivalent to the support payment as a periodical payment and a lump sum representing the balance of the future losses discounted for acceleration of receipt.

My understanding is based on my reading of the written details of the proposal as shared with attendees at the engagement meetings, and explanations provided by Cabinet Office officials. If I have misunderstood the intention, no doubt I will be corrected.

I am advised that it is not possible, or at least not practicable, within the Parliamentary deadline to produce secondary legislation to transfer the functions of the current support schemes to the IBCA. The legal and administrative framework under which each scheme operates is different and complex: they are administered by the NHS Business Services Authority for England and in the devolved nations by their administrations. The Scottish scheme is set up under devolved regulatory powers. The Welsh scheme is founded on directions issued by Welsh Ministers under devolved powers. In Northern Ireland a support scheme was set up by the Northern Ireland Department of Health. In England the scheme is also founded on non-statutory directions.

I am also advised that it will not be possible to match compensation precisely against support payments, in particular because the proposed tariff-based compensation for care is intended to be an overall package based on general assumptions about the varying levels of care required during an infected person's lifetime. These assumptions do not claim to identify when during the infected person's lifetime particular levels of care will be required, as opposed to suggesting that most such victims will require periods of different levels of care at different times, equating in total to the figure arrived at by applying the proposed formula. Therefore, it is impossible to differentiate between the past and future elements of the care award for a living infected person.

There is also a possibility that compensation for bereaved partners will not equate the support payments they receive, as explained below.

Previous recommendations

In my framework report I said this about support payments and their relationship with a compensation scheme [emphasis supplied]

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.

Sir Brian Langstaff, in his second Interim report, agreed with me [emphasis supplied]:

I confirm that it is my view, as it is his, **that it is fair that support payments made to date by any of the support schemes should not be set off against any part of the compensation award. However, future support payments should be taken into account in respect of future loss calculations.**[17]

Concerns raised during the engagement

The one voice of the beneficiaries described here has been repeated to me during the current engagement process, if anything even more forcibly than before. Virtually all representatives of community organisations have told me they have been inundated with concerns

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[17] Infected Blood Inquiry, The Inquiry's Second Interim Report: page 51

from distressed infected and affected people expressing the fear that their support payments were somehow going to be taken away from them. For example, one organisation quoted one response to their survey:

The illustrative figures provided represent a fraction in support payments I would receive if living for another 30 years – which is very possible.

Another organisation told me that 99% of people polled wanted to retain regular payments.

There seem to be four strands to the arguments advanced to me by or on behalf of the infected and affected communities.

Firstly, many have developed a reliance and trust on the system which makes these payments, and they do not wish to see this disturbed under any circumstances. The Haemophilia Society submitted:

It is clear that a substantial minority of people would not accept the removal of the support schemes under any circumstances…

For some people no amount of compensation will make the removal of the support schemes acceptable.

This was supported by the responses to a survey carried out by the Haemophilia Society in which over 50% of respondents said they would not accept the ending of the current support scheme – even if they were no worse off under the new scheme.

Secondly, and this was not advanced by all those expressing the first concern, there were some who believed that the support payments received should not be taken into account in assessing the financial or other losses for the purposes of compensation – to them ‘support’ was a different concept from ‘compensation’ and one was not part of the other. One organisation submitted that it was ‘completely unacceptable’ for future support payments to be deducted from people’s **total** compensation. This was said to be contrary to my recommendations which were that future support payments should only be deducted from **part** of the award.

Thirdly, some would say that the award of compensation (as opposed to support) should result in recipients being ‘better off’ and not just ‘not worse off’. Otherwise, they would ask what is the point of compensation as opposed to support?

Fourthly, objection is taken to the proposal that representatives of estates and surviving affected relatives will not be given the opportunity of taking compensation or support payments as periodical payments.

Proposals for addressing concerns included:

- offering an option to applicants to waive assessment of future financial losses in exchange for continued receipt of support payments;
- offering clearer assurances that no one would be worse off under the proposals;
- retaining the existing schemes, particularly in Scotland, because of the nature of undertakings given to recipients under their scheme;
- preserving the advantages of local support currently offered;
- ensuring deductions from compensation to take account of continuing support payments are only made on a like for like basis;
- awarding all those who have not received a lump sum from a support scheme an equivalent sum to ensure parity of treatment with those who have.

A written contribution from an individual member of the community summed up the feelings expressed by many:

The support payments have been a lifeline for me and my family over the years. They eventually replaced a wage I haven’t been able to earn for over 13 years, due to ongoing physical and mental illness, all linked to my HIV infection. I have also been caught in the benefits system to supplement those payments. Between my annual payment, my child payments and extra winter payment my annual income from

EIBSS is currently over £40,000. This was going to be my 'pension' for my future as I haven't been able to build up a personal pension of my own. … Given the delay in justice, the severity of the cover-up and the fact that they were promised to beneficiaries for life, the support payments should be left in place as an addition to the proposed tariffs and held in the same regard as an ongoing pension.

Comparison between Government undertakings and the proposal

Submissions made to me on both these themes commonly relied on undertakings expressed on behalf of the Government. In particular, they relied on statements by the then Secretary of State for Health and Social Care, Matt Hancock. I am not sure his statement has been fully understood.

Among other things he said to the Inquiry were:

> "should the Inquiry's recommendations point to compensation, then of course we will pay compensation and Sir Robert Francis's Review on compensation is there in order that the Government will be able to respond quickly to that … what I can say to you is that we will respect the outcome of the Inquiry and **if the Inquiry points to compensation,**

> **as opposed to a support scheme, in the future then the Government will pay compensation.**"[18]

In his oral evidence to the Inquiry Mr Hancock was asked:

MS RICHARDS: We looked a little while ago at a document which talked in terms about these being…. Ex gratia…. It's always been expressed as ex gratia…. 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 assurances 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 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 the Government to those affected for as long as they are needed….[19]

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[18] Infected Blood Inquiry, The Inquiry Report: Volume 1 Overview and Recommendations, page 185 [emphasis supplied]

[19] Infected Blood Inquiry evidence, INQY1000121 - London - Friday 21 May 2021: transcript pages 132-135

MS RICHARDS: We had some evidence to suggest that the Scottish government had felt able to give an assurance to its infected and affected community that there was an expectation of payments for the lifetime of the recipient.

MR HANCOCK: Yes

MS RICHARDS: Is that your expectation, Mr Hancock?

MR HANCOCK: Yes, I would absolutely give a commitment to anybody receiving a payment, any of the beneficiaries infected or affected, that I would expect that to continue for their lifetime, absolutely. That's my expectation. I would say it goes without saying, but sometimes it needs to be said.

MS RICHARDS: Governments change, obviously, and you may not be able to bind future governments…

She then made the point that there appeared, however, to be a cross-party approach to this issue. Mr Hancock went on:

MR HANCOCK: Well I certainly think that [cross-party discussions] is reasonable. However, that isn't how a scheme like this would be made permanent because one Parliament cannot bind a future one. The best way to make it permanent is for the Secretary of State responsible to declare it should be and will be permanent and I'm very glad to do that.

He went on to say that no consideration had been given to primary legislation on this point but that:

> "I think it is absolutely everybody's expectation within Government that support should continue for as long as it's needed, and I don't think that anybody who would either – anybody in Government or who might expect to be in Government would demur from that."

I find it significant that Sir Brian expressed his agreement with my recommendation with regard to the support schemes after receiving this evidence. In my view it is a reasonable interpretation of what was said for recipients of support scheme payments to expect they would continue to receive from the State such payments for the life of the recipient, but that no undertaking was given as to how such payments would be administered, or whether they would be taken into account in any compensation scheme. I consider that if payments equivalent in value to the support payments payable under the existing schemes were continued as long as recipients wish to receive them, it would not be a breach of any undertaking for the Government to change the means by which the payment is made. The fact that in future such a payment may be made by the IBCA, rather than the current providers, that would not be contrary to any undertaking of which I am aware.

With regard to the relationship between support payments and awards of compensation under the scheme, the Government's proposal would not be in breach of the undertaking I have described, to the extent that it broadly follows my recommendation as endorsed by Sir Brian. Mr Hancock, as noted above said support (i.e. support payments) would continue **'as long as it's needed'** and also for the lifetime of the recipient.

To complaints about taking support payments into account against awards of compensation for future losses, it may be answered that there are many who are eligible for compensation, but have not been entitled to a support payment. While they are certainly going to receive more than previously, they may feel that they would be unfairly treated if some account was not taken of the benefit of support payments as against at least compensation for future losses.

To the point that some recipients will not see any compensation over and above the value of the support payment, that is not correct. Because past payments are not to be taken into account against compensation for past financial losses, or injury, social impact or autonomy awards, all of which include future suffering as well as the past, recipients will receive recognition for that suffering in excess of the measure of compensation alone.

They will also continue to have the benefit of the security of a government undertaking – reinforced by statutory regulation – with regard to the regular payments they will receive, both by way of the support element or a compensation award, to the extent that they choose to accept periodical payments. Therefore, the element of security currently provided for support payments will continue for the substituted support and compensation awards, to the extent that they are paid by periodical payments.

Unfortunately, though, there remain some important points which may mean some recipients are ‘worse off’ compared with their current position, or feel they are being treated unfairly.

Relationship between care award and support payments

Firstly, for the reasons explained above, it is not possible to divide the proposed care award into past and future elements. Therefore, if as proposed, the care award is included in the total to be compared with the support payment, this has the effect of discounting the resulting award for the past as well as the future elements of the care award. This is contrary to the Inquiry recommendation. It may be argued that this is balanced by the disregard of past support payments, but such an argument is undermined by the reason for the disregard, namely that previous support payments have been ex gratia. In any event this exception will have variable effects in individual cases.

Position of persons who have not previously applied for support payments

Secondly, there is a group of people who may be eligible for a support payment but who have not yet applied for, or received one. They will have no floor below which their compensation cannot go, unless they receive a retrospective equivalent of a support payment.

Entitlement of estates and bereaved affected family members

Thirdly there is an issue concerning the status of support payment to which bereaved partners receive. Currently partners of deceased infected persons receive, in addition to certain lump sum payments, a continued support payment, at 100% for the first year after the death and 75% thereafter. This was intended to continue for the life of the dependent partner. The current support payment for an infected [HCV] person is £21,467, or £32,555 if the SCM applies plus a winter fuel payment. 75% of those figures is £16,100.25 and £24,416.25 respectively.

Under the current proposal for the compensation scheme, this would continue until the bereaved partner's claim for compensation is assessed. The compensation will include where appropriate a bereaved financial loss claim. This is calculated at £16,682 a year, representing a fixed proportion of the deceased notional net annual income less a deduction for the expense the deceased would have incurred on themselves. The period of the loss is taken as being the period between the date of death and the healthy life expectancy of the deceased. This could be longer or shorter than the life expectancy of the bereaved partner.

It appears that both the multiplicand [the annual sum awarded] and the period of future loss taken are less or could be less than the amount expected at the moment under the support payment. Therefore, if bereaved partners are not to be 'worse off' almost all of them will have to be paid a 'top-up' equating to the difference.

While there is much to be explored to show how this might work out in different cases, the implication is that the recipient should be entitled to periodical payments of at least the value of the support payment, albeit that it is now relabelled as compensation. If a periodical payment is chosen it will continue for the actual lifetime of the recipient; if taken as a lump sum it will presumably be calculated as a capital sum discounted for accelerated receipt, based on an assumed healthy life expectancy of the deceased infected person. If it is correct that a bereaved partner would not be entitled to choose a periodical payment, I agree that would be unfair. While in some cases there may be factors favouring a lump sum as the preferred option, in many cases it will be more prudent to choose the certainty of a guaranteed income for life.

Non-financial relevant factors

Fourthly, the valid point is made that deciding whether someone is ‘worse off’ is not just a matter of money, but requires consideration of the distress and anxiety caused by uncertainty and the burden of deciding what is best for themselves. However, so far as monetary compensation is concerned, it is intended as far as it can, to put a person in the position they would have been but for the injury inflicted by the wrong. Of course, even in litigation that can never be achieved, and in a compensation scheme the added needs for comparative simplicity and speed mean a broad approach has to be taken.

In the circumstances, including the necessarily brief details currently available of the proposals, and the short time those most closely interested in them to consider the implications, it is perfectly understandable that people will feel uncertain about what they stand to receive, and seek in preference the complete certainty which would be offered by a continuation of the existing schemes. The fact is that the intention is to close the existing schemes and replace them with payments made by the Authority. It is far from clear from what has been disclosed by the Government to date how closely the new arrangements would match the benefits of the existing schemes – let alone ensure that no one was worse off.

Conclusion on whether proposal is consistent with previous undertakings and recommendations

I consider the proposals as described above are potentially consistent with the Government’s undertakings about support payments, and with the recommendations both Sir Brian and I have previously made. Unfortunately it cannot be said with certainty that this is the case on the basis of the information currently made available. Whether this impression is correct needs to be tested against a full explanation of the intended scheme and the calculations which result. It may be that this can only be done by testing the details of the proposal against real applications for compensation. In any event, it is clear that the mistrust arising from the support recipients’ experience of the way they have been dealt with over many years and more recently in the Government’s attitude to compensation has led to genuine distress and suspicion about the true effect of the proposed changes. I believe this could be mitigated by a clearer understanding of how the various components of payments are made up and by a demonstration of how the circumstances of victims are to be fairly and proportionately met.

Level of continuing support payments

A submission by a solicitor has pointed out that in my framework I said that [emphasis supplied]

> "All annual support payments… 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**."[20]

It is fair to say that the underlined passage did not make its way into my Recommendation 15 (b) and (c):

> The current annual payments under the support schemes should be continued (or merged into the compensation scheme...
>
> Such continued awards should be taken into account in assessing awards for future financial loss and care provision.

Sir Brian's report accepted Recommendation 15 and was silent on what was said in the earlier paragraph quoted.

The solicitor argues that without the increases referred to that will lead to discrepancies and reductions in what beneficiaries are likely to receive. I suggest

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[20] Compensation Framework Study report - 7th June 2022: Exexcutive Summary, Financial losses, Status of support payments: § 2.53

that this analysis needs to be considered before the scheme is finalised.

Eligibility of persons living abroad

A subsidiary point of concern was raised by one contributor relating to the entitlement of recipients of support payments and/or compensation to receive them if living abroad. I have seen no suggestion that this is not the case, but as it could be the source of uncertainty and anxiety, I suggest it be confirmed that place of residence has no effect on either support payments or entitlement to a compensation award assessed in the same way as for any other eligible person. One proviso may have to be included about tax. The government could not be expected to give any warranty as to the impact of foreign taxation on such payments.

Recommendations

I recommend that:

5. In order to create and maintain trust – and to respond to the very clear message from the infected and affected community – the existing support payments should continue to be paid under that name to all who currently receive them or are otherwise shown to be entitled to them. For the avoidance of doubt, that should include both living infected and living

bereaved affected who currently receive such payments. However, given the advice that there are insuperable practical and legal obstacles to merging the support schemes into the compensation scheme within the time available, I suggest the Government considers preserving the existing schemes as they are currently administered with the compensation scheme assessing a compensatory award for support payment recipients to reflect their needs and losses not fully addressed by those payments. This arrangement could be continued for as long as is necessary to create the legal framework required to merge the support schemes into the IBCA under a framework arrived at in consultation with the infected and affected communities.

6. It should be open to anyone not yet in receipt of a support payment but who meets the eligibility criteria of the existing support scheme, to make an application for one, up until 1 April 2025.
7. As proposed already, support payments should not be taken into account in an award of compensation in the assessment of:

    a. Injury impact, social impact, autonomy awards. Again for the avoidance of doubt this includes that the elements of such awards which reflect future injury, distress and deprivation as well as past experiences;

   b. Financial loss awards in so far as they relate to care or losses occurring before the date of the award;

   c. Care awards in so far as they relate to past care. The currently proposed care award is to be made as a lump sum through a tariff-based calculation which does not differentiate between past and future needs. If that is maintained, a method should be devised to apportion part of the care award as a fair reflection of the applicant's future care needs for their life expectancy. The resulting lump sum should then be converted into a notional annual sum by a calculation which converts a lump sum into a notional annuity, adopting the discount rate used for the calculation of future damages.[21] The resulting notional annual figure can then be added to any annual financial loss award for comparison with any support payment being received.

8. If and when support payments are replaced by payments made through the IBCA, in assessing care and financial support awards, the scheme compensation assessment should include an account of the support payments which would have continued after 1 April 2025 but for the creation of

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[21] See footnote (22) below for details of this rate.

the compensation scheme. If the support payments which would have been payable exceed in value the assessed care and financial loss awards for future care and losses, applicants should continue to be entitled to the equivalent of support payments in full. As support payments are intended to continue for the life of the recipient, their value should be assessed on the same basis. The regulations should make it clear whether any exceptions to this principle are to be allowed.

9. Consideration should be given to my recommendation that support payments and their assessed equivalent as recommended above should be increased in accordance with what was said in paragraph 2.53 of the Framework report, and the potential effect on the sums received by eligible persons if that is not implemented, in the context of the undertaking that no one will be worse off.
10. In addition to receiving as a lump sum that part of the compensation award which consisted of the injury impact, social impact and autonomy awards, together with awards for past financial loss, the recipient who have been in receipt of support payments should continue to receive as periodical payments an equivalent sum. They should be given the choice of receiving the balance of their awards for future care [identified as described above] and future financial losses either capitalised as a lump sum or as

guaranteed periodical payments. I also see no reason why a bereaved partner should be denied the option of a periodical payment reflecting the value of the care award, future financial losses for their lifetime.

11. To the extent that awards are taken as periodical payments, they should be uprated annually for inflation by the same measure used for court ordered periodical payments.[22]
12. If taken as lump sums, awards should be capitalised in accordance with a method of calculation set out in the regulations. I recommend that the method adopted should be the same as used for calculating lump sum awards for future losses in court damages actions, namely by use of a multiplicand, multiplier and the discount rate prescribed under sections A1 and 1 of the Damages Act 1969, as amended by section 10 of the Civil Liability Act 2018.

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[22] An order for periodical payments made by a court in an award of personal injury damages must specify that the payments should vary annually by reference to the retail prices index unless otherwise ordered by the court: Civil Procedure Rules r41.8(1)(c). It is now common practice for periodical payments reflecting future care costs to be inflated by reference to the ASHE index for the remuneration of care providers: ASHE 6115, applying a specified percentile of that occupational group: Tameside & Glossop Acute Services NHS Trust v Thompstone [2008] EWCA Civ 5. Likewise appropriate occupational group indices from ASHE can be used for periodical payments reflecting future loss of earnings: Sarwar v Ali [2007] EWHC 1255. See generally McGregor on Damages 21st edition chapter 41 §41-024 – 41-030.

13. It would be reassuring for recipients of continuing support payments if the arrangements for payment and communication while administered by the IBCA adopted the best practice of the existing national schemes.
14. The Scheme should confirm that entitlement to awards is available regardless of whether an eligible person is resident in the UK or elsewhere.

Severity bands

The Government's proposes that awards for HBV and HCV and coinfections should be divided into bands of increasing severity as follows:

- HBV acute –
  infection shorter than 6 months
- HCV acute –
  infections shorter than 6 months
- HCV or HBV chronic –
  infections longer than 6 months
- HCV, HBV cirrhosis –
  serious scarring of the liver caused by long-term damage
- HCV, HBV decompensated cirrhosis, liver cancer and/or liver transplantation

HIV will have one band as it is a lifelong infection in which the vast majority of people have experienced advanced disease including AIDS and have died. Those who have survived will continue to be severely impacted.

There will be bands of increasing severity for those co-infected with HIV and HCV and/or HBV.

In each case the expert advisory group has advised that there are clinical markers which will be readily available and enable each case to be banded easily, usually from medical records.

HBV

The observation was made in the course of the engagement that there had been little representation for people with lived experience of HBV. A wider entitlement to compensation for this group was recommended by Sir Brian Langstaff than I had suggested in the framework review. I understand the advisory group considers it has taken sufficient account of this group. Had there been more time I might have been able to take a more proactive approach to soliciting the views from HBV sufferers.

On the material available at the moment, I am unable to say that the proposals are unfair to them.

Distinction between HIV and HBV/HCV

Some comment has been made to the effect that as HIV is not subject to a severity banding, neither should HCV and HBV. This is not the view of the expert advisory group, and their reasoning for adopting a different approach for each infection is based on their understanding of the progress of each disease, and therefore, seems to me to be a reasonable justification for accepting their recommendations. Had there been a longer period available for engagement, it would have been preferable to test that advice against a wider range of lived experience and indeed to engage with a wider group of experts.

Given the imperative to get compensation out as soon as possible, I accept that their approach on the distinction between HIV and hepatitis to be adopted.

Extra hepatic Manifestations (EHMs)

It has been questioned whether the severity bands for HCV took into account EHMs. I doubt that this is so but clearly the description of the criteria of the bandings should be extended to include the injuries caused by the infection and not be restricted to the liver related symptoms. I make a recommendation about this below.

Severity bandings for HCV

Contributors submitted that the proposed bandings do not reflect the complexity of the condition. Examination of the responses recorded in a survey of the community reveals a wide range of opinions [round figures adopted]:

- In answer to the question whether the proposed banding adequately reflected the range of experience, about 30% said it did, 40% said it did not, and 30% did not know.

- In answer to what should be done about the banding, 30% said there should be more bands, 20% said there should be fewer bands, 25% favoured greater individualisation.

Contributors also point to a range of conditions directly related to infections recognised by the support schemes which they claim are not recognised, or at least not described in the proposals. As one submission put it:

> “I just want to reiterate that the current list of Tariffs published by the government do not include the category I fall within and this needs to be addressed. In my situation I was co-infected with hepatitis C then B and C again over two decades, all of which became chronic illnesses, as well as being exposed to Nv CJD in 1993. I have suffered severe cirrhosis since 2004 and had liver cancer in 2020.

> I required two courses of antiviral chemotherapy treatment, the first in my early thirties, which was a particularly damaging and vicious treatment from which I needed a great deal of care because I was so ill. This was comparable to haemophiliacs being co-infected with HIV/Hep C but it is not reflected in the financial tariffs of compensation being suggested currently. I would like this issue to be looked at urgently please.”

These responses demonstrate both the complexity and the need for bandings to provide sufficiently broad ranges of impact to allow for a tariff-based approach to compensation. It is important that triggers for identifying in which band each case falls are easily applied by assessors and understood by applicants. They need to specify the conditions which are specific to each band.

I recommend that these concerns should be referred to the expert group for clarification as to whether the factors mentioned by contributors have been taken into account, and if not, what if any modifications are required, and, in particular whether a high level of severity or enhancement is called for.

I note that 60% of the survey respondents thought that the suggested awards within the bandings were not high enough. The current levels were devised by the legal experts in the advisory group relying on the Judicial College Guidelines and the Northern Ireland equivalent. This is consistent with the approach I advocated in the Framework Report. Given the differences in banding adopted, so far as I can see the figures proposed to be adopted are also consistent with this approach. Understandably some will believe that these figures are inadequate, but realistically there has to be a range of reasonable figures which has to be set within the limits of what the courts currently award for injuries of maximum severity and disability.

While the injuries suffered by this community are terrible, it is impossible to say that they should generally be regarded to be at the maximum end of the scale. However, I think it would be helpful if the reasoning of the expert group, and particularly its legal experts, in so far as this has been accepted by the Government, were set out in detail. I believe that in order to foster trust and ideally acceptance of the fairness of awards, it would assist if the eligible community and their advisers are able to understand the rationale behind the figures.

Recommendations

I recommend that:

15. The advisory group review the proposed bandings in the light of the submissions made about them as described above.
16. The detailed reasoning leading to the proposed range of figures for awards be published.

Omission of SCM from banding

The precise nature of the clinical markers has not been disclosed and, therefore, I have been unable to seek specific views on them in the course of the engagement [see above for further comment on this issue]. However, many contributors have commented that the suggested bandings do not align or appear to take account of the

Special Category Mechanism [SCM] which has been introduced into all support schemes; albeit with differing criteria in each nation. In its written submissions, one representative organisation supported this concern by reference to its survey in which some 55% of respondents wanted to see a banding for additional day-day banding, for example the SCM. In the course of the meetings, Sir Jonathan Montgomery undertook to take this point back to the expert group for consideration.

I believe that he intends to recommend that those with conditions as defined in SCM criteria should be recognised as a distinct severity band, or to add more explicit criteria to the existing bands where this is more appropriate.

I agree that there is a strong case both in terms of ensuring the severity bands reflect as a minimum the criteria for support payments, and to avoid supplementary applications being made because of the omission of this category. This is an area in which both I and the Government will be dependent on the expert advice.

I understand that the expert group is to advise that for those who were eligible for an award under a Special Category Mechanism in one of the support schemes should be eligible for an enhanced care award under a bespoke supplementary category. In the case of those applicants who have not been in receipt of a support payment, they would qualify for an enhanced award if they can show they would have met the criteria for the SCM in their country. The expert group considers that this is a fairest way to reflect the purpose of the SCM as being to support particular needs rather than because their infection of resulting symptoms are different from those reflected in the injury impact awards. While the acceptability of this solution to applicants will depend on the actual figures offered, as an approach, I would consider this to be a fair one.

Recommendation

17. I recommend that the advice of the expert group is followed with regard to the recognition of SCM eligibility.

Tariff rates for coinfection

A solicitor, in their submission, points to a distinction between the sum of £225,000 to be awarded to an HCV/HBV co-infected person with liver cancer whereas an HIV/HCV co-infected person with liver cancer is to be awarded £270,000. I understand that the recommended awards for co-infection with HIV and Hepatitis were arrived at by applying, as a base rate, the award for HIV and then adding 25-50% of the proposed award for Hepatitis. In the case of co-infection with HBV and HCV, a base rate was taken from the proposed award for a single Hepatitis infection and then adding 25-50% for the additional Hepatitis infection. Thus explained, I do not see an objection to the proposed approach. But, this is an example of the difficulties that may stand in the way of acceptance of the scheme because of the need for a more detailed explanation.

vCJD

The engagement produced complaints that the threat of vCJD had not been considered. I believe that the very rare cases where vCJD has actually been contracted have been eligible for compensation under the vCJD scheme, although some expressed the belief that this had not occurred. A more common and highly distressing experience has been the receipt of letters warning the recipients of the risk that they might have been infected with vCJD which could remain symptomless for a very long time. Sir Brian Langstaff reported that[23]

A significant number of people who received blood products and some who refused blood transfusions have since been told that they are at an increased risk of vCJD and should alert their medical practitioner or dentist prior to treatment. This in turn has compromised their access to such treatment.

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[23] Infected Blood Inquiry, The Inquiry Report: Volume 1 Overview and Recommendations, page 2

He deals in detail with the debate about whether people should or should not have been informed of the risk in volume 5 of the report. It appears that in 2004 it was announced that clinicians had been given information enabling them to identify potentially infected batches of plasma and that patients identified as ‘at risk’ should be notified by clinicians together with being given supporting information.[24] As a result, in September 2004 haemophilia centres informed people with a bleeding disorder who had attended a centre between 1980 and 2001 of the risk and were given the chance to discuss the implications and to find out if they had received an implicated batch if they wished. By January 2005 about 4,000 people had been notified. People who had received blood transfusions were only notified if a donor went on to be diagnosed with vCJD. Further discussion resulted in 2013 in patients who had received plasma products between 1980 and 1989 being ‘de-notified’, i.e told they were no longer to be considered ‘at risk’. In a very detailed consideration of the way in which the risks around vCJD were handled, Sir Brian compares the approach favourably to that which had been taken with regard to the risks of HIV and hepatitis.

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[24] Infected Blood Inquiry, The Inquiry Report: Volume 5 What happened and why?, page 315

In his second interim report Sir Brian recommended that any additional anxiety caused by a notification should be assessed as part of the injury impact award.

Being warned of a risk of vCJD would undoubtedly have been alarming and may in some cases have had a detrimental effect on access to treatment. However, the circumstances of individual cases are so variable I am not persuaded that more than the most general recognition can be given in the tariff-based impact awards to the anxiety that many will have suffered from this warning. I cannot, therefore, discern that the levels of award proposed are not sufficient to take account of that anxiety.

Psychological illness

Many contributors to the engagement considered that insufficient attention had been paid to psychological illness as opposed to general distress, anxiety and depression caused by these terrible infections and their aftermath. Sir Jonathan Montgomery undertook to take this point back to the expert group for consideration.

It is indeed the case that psychological symptoms are not mentioned in the documentation of the proposal shared in the engagement process. It is, therefore, unclear to what extent these have been taken into account either in the severity bandings or the associated injury impact tariffs. That there were widespread adverse psychological effects caused by these infections is not in doubt. In the course of evidence to the Inquiry Professor Weinman and others were asked:[25]

MS RICHARDS: The psychological impact described by individuals to the Inquiry, both orally and in writing, include witnesses who have been diagnosed with recognised psychiatric disorders, including post-traumatic stress disorder, OCD, bipolar affective disorder, anxiety and depression in particular anxiety and depression.

… is this fair: that it’s entirely plausible to think that infection with HIV, infection with hepatitis C and the kind of circumstances we’ve seen described in the statements might lead to the development of a psychiatric disorder of that kind?

PROFESSOR WEINMAN: yeah, I mean we know that for any major long-term health problem, a proportion of people will develop, you know, major mood change. Typically anxiety in the early stages but often leading to depression. So, you know, a group of patients I know well, something like 20, 25% of those patients will develop those major mood problems, because of the changes that are brought about by the

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[25] Infected Blood Inquiry evidence, INQY1000050 - London - Monday 24 February 2020: transcript pages 134-136

condition. But I think what we're dealing with here is not just the psychological reaction to the condition… What you're dealing with are people who experience massive stigma… where communication has been poor, where they've perhaps not felt supported or even felt rejected by the healthcare system. I think it's the whole plethora of changes that are really responsible for, you know, the much greater likelihood of people developing, you know, serious psychological problems and reactions…

MS EDWARDS: You add the treatment and specifically these treatments, particularly interferon and ribavirin which are debilitatingly – the depression of an extreme type… so the amount of factors that actually result in a depressive and sometimes serious psychotic illness is not surprising.

This evidence suggests that a level of psychological distress, anxiety and mood change will have been suffered by virtually all infected people. However, some will have suffered more severe conditions, namely diagnosable psychiatric illness or disorder, sometimes leading to serious consequences.[26] While the first

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[26] A study of suicide by middle aged men found that 52% of the cohort had physical health conditions, 33% chronic conditions. Many had experienced 'adverse life events': Appleby et al, Suicide by middle aged men. National Confidential Inquiry into Suicide and Safety in Mental Health, 2021: The University of Manchester, full report.

category of suffering is best taken into account by way of the standard tariff as it avoids unnecessarily intrusive inquiries into the lives of applicants, the more serious, diagnosable illnesses and disorders might occur for any infected person, whatever the severity of their infection, depending perhaps on their vulnerability.

Recommendation

18. I recommend that the best way of taking this form of psychiatric injury into account might be to allow a supplemental award for those who can show they suffered from one or more of a defined number of diagnosed mental illnesses or disorders, alternatively those who have suffered serious consequences as a result of a mental illness or disorder associated with an eligible infection. This might be achieved by adding this criterion to those supporting eligibility for the additional severity band equivalent to SCM I have referred to above, or by creating a separate supplementary enhancement.

Effects of treatment

Many contributors to the engagement commented that the banding and staging of injury impact awards did not appear to take sufficient account of the effects of treatment. It is clear from the inquiry reports and evidence that the effects of treatment, in particular interferon can in many cases be as bad or worse than the disease itself. In the course of the meetings Sir Jonathan Montgomery undertook to take this point back to the expert group for consideration.

Recommendation

19. If in fact the tariffs proposed by the expert group have taken into account the range of effects commonly experienced after treatment, I recommend that they should be invited to explain their reasoning for arriving at the tariffs they specify. My interpretation of the feedback from the community is that they consider the currently proposed figures to be too low to take into account the effects of treatment suffered by many. If the advisory group, on reflection, concludes that it needs to review tariffs to accommodate this point, I recommend that either their originally suggested tariffs should be increased to take into account the deleterious effects of treatment, alternatively, a supplementary tariff be introduced for those applicants who can show serious effects over and above the generality of experience taken into account in the core tariff. Over 40% of one representative organisation’s survey respondents thought that those treated with Interferon should form a separate award category. I recommend that regard should be had to the revised view of the expert group on whether to adopt one or other of these options.

One of the concerns raised was that it did not necessarily follow from 'successful' treatment, (particularly the earlier forms of treatment) that the infected person could return to work either in full or in part. I have invited the expert group to consider this point.

If, on considering the evidence, they advise that some different account needs to be made, either in defining a case for a supplemental financial award or a more general increase to the standard tariff for loss of earnings, I recommend that the Government adjusts the proposals accordingly.

Clarification of clinical criteria for severity bands

I have already commented that the clinical criteria for qualifying for each severity band have not been spelt out in detail in the documentation shared in the engagement. For the sake of transparency and shared understanding of how the scheme will operate, it is important that these criteria are spelt out in detail publicly, and in the regulations.

Recommendation

20. I recommend that the clinical criteria for severity bands are set out fully to ensure that assessments can be concluded objectively and transparently.

Provision for deterioration

Contributors raised the issue of how awards could be adjusted in the event of an unexpected deterioration after the award was made. I can see no provision in the published proposals for provisional awards or review. I understand, though, that the advisory group's working assumption was that re-applications would be permitted.

Generally, in the interests of finality – principally for award recipients, but also for the efficient administration of the scheme – I consider that the awards for living applicants should be assessed taking into account all future contingencies and risks. The structure of the tariffs lends itself to this approach in that assumptions are already built into the assessment of severity bands.

A submission has raised a connected issue with regard to the proposed time limits for making applications. The final year in which it is intended to accept applications is 2031, but the question is asked as to what will happen to an applicant given an award in 2025 and then wishes to re-apply following a deterioration in 2032. I suggest that this issue is avoided if initial awards take account of future contingencies and risks.

Recommendation

I suggest that the ability to return for a revised award should be limited, if allowed at all, to cases where there are substantial changes to the applicant's condition which could not and were not taken into account in making the original award. For example, if, after an award is made on the basis of the applicant suffering from one infection, it transpires that another has emerged.

21. With regard to the provision for deterioration, I recommend that applications for a revised award should be entertained only in the most exceptional circumstances, which were not taken into account during the initial assessment, and which would result in a manifest injustice to the applicant unless a revision of the award were allowed.

Supplementary route

Some contributors asked whether it would be open to make a supplementary route application in respect of injury impact, social impact and autonomy awards. The current proposal appears to limit the supplementary route to claims for care and financial losses awards.

The logic of the tariff approach is that broad justice is offered to all – or substantially all – because there is a sufficient commonality between various individual lived experiences and to provide for a scheme which has as few complexities and delays as possible. In theory, at least, it should be possible to design categories of injury and suffering derived from a particular disease in this way. It is fair to observe that the more generous the standard tariff is, compared with the likely range of outcomes in litigation, the less strong the case is for offering a bespoke route, in the case of the award categories loosely equating to or supplementing common law remedies. I suspect that the possible differentials resulting from more bespoke examination of exceptional cases, would be a relatively small proportion of the overall award, and the effort required to establish entitlement might well be disproportionate for the applicant and the scheme. In contrast the likely range of care needs and financial losses is such that justice and fairness are far more likely to require a bespoke approach for exceptional cases.

Recommendation

For those reasons I do not recommend that a supplementary route be made available otherwise than for care and financial loss awards, but the government should consider the competing justifications for such a route itself.

Proof

Concerns have been expressed about the difficulties of providing proof, particularly with regard to the date or cause of infection where this is relevant; but in reality, with regard to any matter which is relevant to the assessment in any given case. A particular difficulty mentioned is the absence of relevant medical records, some of which have been destroyed. As is clear from the Inquiry report, earlier support schemes were bedevilled with challenges with regard to the evidence needed to establish a claim, causing untold distress and anxiety to many applicants.

By way of reassurance, it is intended that the Authority's approach to applications will be to be as proactive and sympathetic as possible, and consistent with appropriate and proportionate safeguarding of the integrity of the scheme:

- The Authority will proactively seek out supportive information to minimise the burdens placed on applicants to investigate their own case.
- Where there are medical records, the Authority has statutory power to require their disclosure – as is the case for any other information relevant to its assessments.
- It will accept as conclusive proof of the criteria required for eligibility to the compensation scheme evidence that an applicant was accepted by a prior support scheme.

- Evidence given to the Inquiry will be a valuable source of information which will avoid the need for much repetition by applicants.
- Rejection by a scheme will not be regarded as conclusive.
- Where there are no medical records and no previous acceptance of eligibility for a support scheme, a sympathetic approach will be taken towards such information as is available, with a willingness to draw favourable inferences from circumstantial information.
- The recollections of applicants are themselves evidence which must be treated with respect and understanding, and not approached with any adverse presumption.

I intend to ensure that the Authority consults with and involves the community in the design of the application and assessment processes. Therefore it is to be hoped that the understandable concerns people have about how eligibility is to be established can be met by measures such as these.

Recommendation

22. I recommend that the regulations make it clear that the Authority can devise its own assessment and decision-making procedures, including its approach to what supporting evidence is required.

Social Impact Award

Proposal

The proposal is that there should be a tariff, flat rate, award to both infected and affected persons regardless of the length of the infection or consequent suffering, but varying to a small extent depending on the type of infection, and to a greater extent in relation to co-infections. The estate of a deceased infected person would receive an equivalent award. Affected persons would also receive a flat rate social impact award of a significantly lower figure. In summary it is proposed that:

- Living infected persons with any single infection other than HBV or acute HCV should receive £50,000; a person infected with acute HCV only would receive £5,000 and no award is recommended in respect of HBV;
- A living infected person co-infected with HIV and any form of HBV or HCV should receive £70,000;
- The estate of a deceased infected person should receive an award corresponding with the above;
- The social impact award for affected persons in any category should be £8,000.

Comparison between infected persons with blood disorders and those who received transfusions

At the engagement sessions, concerns were raised that the social impact award did not sufficiently reflect the aggravating effect of the infection related stigma on persons with bleeding disorders given that these disorders already caused stigma. The Haemophilia Society's survey regarding the proposed scheme showed that over 80% of respondents thought that they should receive higher awards than those without blood disorders. It was submitted that

It did not matter which infection they had, people were treated with suspicion and, in some cases, open hostility leading to social isolation.

For the reasons similar to those set out below, I do not consider that the gravity of stigma can be distinguished between victims who had bleeding disorders and those who did not. There may have been an underlying stigma attached to haemophilia which could possibly have increased the vulnerability of an infected person to suffering from the effects of stigma, but the suffering itself is likely to be indistinguishable from that of the person who was infected through a transfusion.

Comparison between HIV and HCV cases

I accept that it is reasonable to treat the impact of infection-related stigma of HCV to be comparable with that associated with HIV. Obviously, in relation to the many unfortunate people who were infected with both diseases, it is impossible to disentangle the effects of one from the other. I note that in relation to HCV infections that the psychosocial expert group advised the inquiry that

Hepatitis C as a stigmatised condition shares some characteristics of HIV, with its normal route of transmission through handling blood, particularly in the context of illicit drug use, linking it with publicly unacceptable behaviour. The main difference was that no major educational campaigns specifically targeted hepatitis C. The public therefore had very limited knowledge about hepatitis C and as witnesses commented, they therefore drew on their knowledge of HIV, which they thought would be very similar, and this frightened them. As with other conditions that are stigmatised, both HIV/AIDS and hepatitis C can lead the possessor to experience 'felt' stigma. This describes an individual's awareness of possessing a condition that is socially disvalued in the community and which differentiates them from the normal non-stigmatised population in a

deeply discrediting way (Goffman, 1963). For those who received contaminated blood products or blood their stigmatised condition was the result of medical treatment. However, notions of individual responsibility and blame are inherent to stigma and those with HIV and hepatitis C were assumed by the public to have brought it on themselves.[27]

The report goes on to give many harrowing examples of the impact of the stigma but, so far as I can tell, does not explicitly distinguish between the effects of each infection, or between those who treatment was because of a bleeding disorder and those who were treated for other reasons. The report makes it clear that the psychological impact on any individual is only partly related to the severity of their condition, as opposed to other factors such as their perception of their condition, their coping responses and the support available to them. The report noted that while the timing and pattern of psychosocial impact may be different in people being treated for an ongoing condition (such as haemophilia) from those who were previously healthy and infected through blood transfusions following accidents or childbirth, the effects were ‘equally profound’.[28] I see no suggestion in this

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[27] Infected Blood Inquiry evidence, EXPG0000003 - Expert Report to the Infected Blood Inquiry: Psychosocial Issues - 01 Jan 2020: pages 20-21

[28] Ibid page 2

evidence that the overall impact was generally different between these two groups.

Indeed, it might be observed with sadness that the social stigma associated with HIV and HCV was not wholly dependent on whether the victim was infected at all. I fear that many persons with bleeding disorders who were fortunate enough to escape infection, and thus not be eligible for compensation under the scheme, would have been subject to the same fears on the part of uninformed neighbours and contacts as those who were infected. They are just as likely to have wanted to avoid disclosing their condition to others. As much is apparent from a survey respondent quoted in the Haemophilia Society's submissions:

Persons with bleeding disorders and their families were affected by the same level of stigma/discrimination/harassment regarding HIV/AIDS irrespective if they were infected with it or not – especially during the 80s. Even today some people are still reluctant/cautious about telling others about their bleeding disorder.

The compensation is due for the social impact caused by the infection, not any background social impact of having a bleeding disorder. Therefore, I consider the expert advisory group is entitled to conclude that the stigma was likely to be comparable regardless of the specific infection.

Differences in length of period of adverse social impacts

A further point has been made about the difference in experience according to the length of time the stigma was suffered, and also the differing impact on those who suffered the injustice of unnecessary treatment with blood products because of misdiagnosis.

The approach in the proposal is to give a flat rate sum for all levels of severity other than for acute HCV regardless of these variables. This is a different approach to the one I recommended which was for an award differentiated according to both the severity of disease and the length of time it was suffered. By implication Sir Brian accepted this approach, but did not specifically comment on whether there should be a differential amount for these variable factors. The Government's proposal, in accepting a flat rate approach, has adopted figures which are, in any event, at the top end of the scale I had tentatively suggested.

It is unclear what, if any, comparators or principles led to the figures proposed by the Government. In the course of the engagement, I received no substantive submissions on these from which it might be inferred that there was no general dissatisfaction with them as a matter of principle. However, the strength of such in inference is markedly reduced by the short period of time anyone had to digest and consider the details of the scheme.

In addressing the injury impact award, Sir Brian referred to the Vento Bands as being an appropriate comparator, quoting from the case in which these bands originated: Vento v Chief Constable of West Yorkshire Police and are intended to reflect.[29]

Subjective feelings of upset, frustration, worry, anxiety, mental distress, fear, grief, anguish, humiliation, unhappiness, stress, depression and so, and the degree of their intensity.

The court in this case accepted, as we must in considering the figures to apply to the proposed scheme, that

courts and tribunals have to do the best they can on the available material to make a sensible assessment, accepting that it is impossible to justify or explain a particular sum with the same kind of solid evidential foundation and persuasive practical reasoning available in the calculation of financial loss or compensation for bodily injury.

The Vento bands are used as guidance by Employment Tribunals in awarding compensation for the impact of discrimination and harassment. I understand that the

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[29] Infected Blood Inquiry, The Inquiry's Second Interim Report: page 45

Government's proposals may have had regard to the Vento Bands with regard to the injury impact award, but not the social impact award, in line with Sir Brian's report. Nonetheless, they may be of some assistance in assessing the proposed figures for social impact, so long as this does not lead to double counting.

Insofar as the Vento guidance helps, I note that with the exception of the lower band there is no explicit differentiation on the grounds of length of exposure to stigma and distress, as opposed to its gravity. I note that the proposal for the social impact award for infected persons, for all but the acute HCV and HBV cases, is higher than the maximum Vento figure and is presumably designed to reflect the enormity of what so many infected persons faced. These figures appear reasonable to me, and I accept that it is also reasonable to propose a flat rate without reference to time across all but the least serious banding. This achieves broad justice, greater simplicity of assessment and a less challenging requirement with regard to supporting evidence.

Differential between awards for infected and affected persons

A question on which I suggest the Government might wish to give further consideration is whether the differential between the social impact on the affected and the infected should be so marked.

Many of the impacts described in the psychosocial experts reports to the Inquiry appear to have been commonly suffered by both infected and affected. To take some quotations:

- All long-term illnesses have psychological impacts on those with the illness and those who are close to them.
- There was a wide range of serious psychological impacts, on both infected individuals and those caring for them over a long period of time.[30]
- Infected and affected individuals also had to cope with considerable uncertainty about the infected person's condition, as well as their future health.[31]
- Witnesses describe how the loss or potential loss of a sibling/parent/carer due to infection had a significant impact on their mental health. Parents described how they were unable to provide the emotional closeness they believed they should have been able to, as a result of frequent medical treatment and hospital admissions.

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[30] Ibid page 1

[31] Ibid page 2

- There are also negative effects on family relationships between relatives and the affected child or family members and different members of the family including arguments, tension and a lack of understanding of feelings.[32]
- For both infected and affected individuals, their psychological state was often exacerbated by deteriorating relationships with healthcare professionals.[33]
- For many, their parents lived with the knowledge and struggled with the challenge of keeping secrets from their children and siblings, as well as feeling guilty for allowing them to have received blood products.[34]

More specifically the report's consideration of the evidence of the impact of stigma makes it clear that many affected persons experienced events which were equally distressing to the infected persons involved.[35] For example:

- The husband and wife who were both physically attacked;

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[32] Infected Blood Inquiry evidence, EXPG0000042 - Expert Report to the Infected Blood Inquiry: Psychosocial Issues (Supplementary) - 01 Sep 2020: page 3

[33] Infected Blood Inquiry evidence, EXPG0000003 - Expert Report to the Infected Blood Inquiry: Psychosocial Issues - 01 Jan 2020: page 3

[34] Infected Blood Inquiry evidence, EXPG0000003 - Expert Report to the Infected Blood Inquiry: Psychosocial Issues - 01 Jan 2020: page 3

[35] Ibid pages 23-25

- A daughter physically bullied, had stones thrown at her, and her dress torn off at school because her father was infected;
- Families who moved homes and employment to avoid victimisation;
- Relatives and friends ceasing to visit because of a family member being known to be infected;
- Abusive graffiti daubed on their homes or cars;
- Stones thrown at graves of infected family members;
- Lives ‘ripped apart’ and ‘wrecked’ for infected individuals and their families.

I accept that the effect of such terrible experiences will have been greater for the infected person by reason of being the immediate – if totally unjustifiable – cause of the ill-informed and cruel reactions of others. And, also because the impact was more likely to be constant for them. Therefore, a higher level of award is justified, but it might be asked whether a difference of between roughly 6 and 8 times is justifiable.

The figure of £8,000 across the board for affected persons does not, in my opinion, reflect the gravity of the sustained victimisation many appear to have described. Even if it is thought that the majority of affected persons did not suffer an impact at the most serious end of the scale, almost all have surely suffered more than the ‘one-off’ impact referred to in the description of the lowest level of award. That might be appropriate for eligible family members and friends not living with the infected person, but it is difficult to see how those who are living with the infected person would not sit more reasonably within the middle band.

Recommendations

23. I consider it reasonable to offer one flat rate lump sum for social impact. The way in which victims have been impacted is so variable that it is impracticable to reflect those variations in a tariff-based award with any accuracy. It is possible, for example, for a very severe impact to result from a short-lived experience suffered by a person with a low band of infection, and a less severe impact to be suffered over a longer period by an infected person in a more serious condition.
24. I recommend that the social impact award for affected persons be reconsidered. I suggest an increased figure be awarded to those affected persons most likely to have been particularly close to the infected. Given that there may be difficulties in proving cohabitation for a specified period, the increased figures could be offered to partners, children under 18 at the onset of infection, parents of infected children under 18 at the date of onset of infection and siblings. I suggest that for these groups a standard figure of £12,000 would be appropriate.

Tariffs

A number of points have been made by contributors about the recommended tariffs:

- It is suggested that the injury tariffs are inadequate compared with the Horizon compensation scheme tariffs. While I have already suggested that the advisory group could be asked to give more detailed reasons for their figures, it is fair to comment that the circumstances of the Horizon victims are very different and difficult to compare with the experience of the victims in this case.
- It was submitted by one solicitor that the tariffs were not acceptable and would mean most of their clients would choose to apply via the supplementary route unless they were improved.

The concerns expressed point to the importance of sufficient justification being provided in published material supporting the scheme for the tariff figures to demonstrate that they fall within the range indicated by recognized comparators, such as the Judicial College Guidelines, or the Vento guidelines. The risk is that if the community and their legal advisers fail to be satisfied that the figures proposed are fair and proportionate, many will choose to make supplementary route applications, or, worse, consider litigation.

Provisionally, my impression is that the figures proposed do fall within a reasonable range, but given the way the Government has chosen to develop the proposals for the scheme, it is for them to justify the figures proposed – not the Authority, nor myself.

Recommendation

25. It is important that, with the assistance of the expert advisory group and legal advisers, the Government publishes a full rationale for the tariff figures it proposes, explaining how they arrived at them, and with what comparators they are to be compared.

Punitive damages

I have been reminded that in the Framework report, I suggested that the position with regard to punitive or exemplary damages should be revisited in the light of the findings of the Inquiry report. It has been submitted that the findings now published include criticisms on which a claim for such damages could be mounted.

I note that the Inquiry report does not make recommendations in this regard. I note, however, that the Horizon Group Litigation Order Compensation Scheme does in certain circumstances allow for an award of exemplary damages – of £75,000 in the case of unsuccessful malicious prosecution. Under that scheme, each case is to be considered on its merits.

Were claims for exemplary awards to be considered by this scheme, it would entail a process akin to adversarial litigation. It would require a detailed consideration of each case to assess the degree, if any, of misconduct involved in it. In my view that would be a substantial hindrance to the processing of more general claims for compensation. While it may be a matter the Government might wish to consider separately from the Scheme, I am unable to recommend such an addition to an already complicated scheme.

Autonomy award

The autonomy award is intended as a novel award to reflect the lack of consent for treatment, the failure to inform patients of the risks, the distress of having these diseases and the impact on family and social life, including the loss of the chance to have children. It is to be noted that the impact of stigma is addressed by the social impact award. The advisory group took as comparators compensation awarded in the Windrush scheme and the 'Vento' guidelines. The suggested awards for an infected person vary in accordance with the nature of the disease, and the severity stage [in relation to HBV and HCV]. The range is between £10,000 and £60,000 for mono infection of a living infected person, £70,000 for all forms of recognised co-infection of a living infected person. For affected persons, the award is from £16,000 for a partner, £6,000 for a parent or child [where the age limit of 18 is satisfied] and nothing for siblings or carers. The maximum award is also given for a deceased infected person.

Some contributors contended that the figures proposed for the autonomy award were inadequate. However, at first impression, the figures seem to me to be reasonable recompense for the general insult to victims in relation to the imposition on them of treatment without warning of the risks and the interference with their private and family lives, including the interference in their choices with regard to relationships and having a family.

Research

One specific point was raised by several contributors contending that an additional award should be made for those subjected to unethical research. So far as I can tell, the proposed award for autonomy was not intended to include an element for this and, as I understand it, the advisory group did not take this aspect into account in their recommendations. Not all victims will have been part of a distinct research project. The reported experiences inflicted on the children at Treloar's is perhaps the most striking example, but the Inquiry report highlights others. It seems to me that the insult of being subjected to unethical research without consent or warning is an invasion of victims' human rights which deserves compensation and explicit recognition. It should properly be considered as an element of the autonomy award, but as a specific additional element over and above the generally recommended tariff award for the generally experienced invasion of autonomy by being treated with an infected product. Should an award not include this as an element in appropriate cases, there is an increased risk that members of the infected community who were subjected to research will feel inadequately recognised.

Arriving at an appropriate figure is challenging, but in accordance with the general intention of the scheme it is right that a broad approach is taken to encompass the general experience involved, rather than to undertake the complexities involved in an individual bespoke assessment. Having said that, I suggest that it should be possible to distinguish between two categories. It is in my view bad enough to have been subjected to covert research at all, but it is an especially egregious interference when inflicted on children. If that is accepted, it would follow that there should be two levels of award: one for children and one for adults. With regard to the appropriate amount for the tariff, I am reluctant to suggest figures myself, or do more than offer guidance as to the principles by which it might be determined.

However, in view of the shortness of time, I will suggest a possible range -although the Government would be well advised to seek the views of the advisory group and, in particular, the lawyers involved.

Firstly, it must be recognised that being treated as a research subject in itself involves no separate, or different, physical injury to those who have suffered the effects of the infection treatment in any event. The advisory group should be asked whether the tariffs for injury impact awards recommended include the impact of treatment as described in the evidence to the Inquiry; regardless of whether it was the result of a research project. If so, then the additional compensation is for the denial of the right to consent to or refuse experimental treatment, and the resulting distress at the denial of autonomy. There will have been an infinite variety of reactions to the lately acquired knowledge which need to be included in considering a tariff figure.

A useful reference for cases involving injury to feeling and distress following unlawful assaults in the leading textbook on damages may be thought to be a helpful guide.[36] Review of the cases cited there suggests to me that the range recommended for the autonomy award are consistent with the awards in those cases. It is difficult in many of them to separate the sum given for ‘indignity, mental suffering, disgrace and humiliation’ from any physical and mental injury and the element of aggravation due to, as the text puts it, the ‘flagrancy, malevolence and particularly unacceptable nature’ of the offending behaviour.[37]

To the extent that it is possible to identify what is added for such aggravation, the authors suggest it may be between 10% and 20%.[38] However, later cases have warned that aggravated damages should not be awarded

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[36] McGregor on Damages: chapter 43 sections 1 and 2

[37] Ibid §43-002. It should be noted that many cases involve physical abuse such as persistent rape, which might be considered very different from the considerations relevant here.

[38] Ibid § 43-001

on top of damages for injured feelings which are part of the injury award. In the most closely comparable case mentioned, Appleton v Garrett [1997] 8 Med LR 75, [1996] PIQR P1, a judge increased by 15% damages awarded to 8 dental patients who had been subjected to gross overtreatment after being misled as to what was intended. More recently, however, the Court of Appeal has warned against treating injury to feelings in assault cases as aggravated damages when the compensatory award includes damages for injured feelings:[39]

It is and must be accepted that at least in cases of assault and similar torts, it is appropriate to compensate for injury to feelings including the indignity, mental suffering, humiliation or distress that might be caused by such an attack, as well as anger or indignation arising from the circumstances of the attack. It is also now clearly accepted that aggravated damages are in essence compensatory in cases of assault. Therefore we consider that a court should not characterise the award of damages for injury to feelings, including any indignity, mental suffering, distress, humiliation or anger and indignation that might be caused by such an attack, as aggravated damages; a court should bring that element of compensatory damages for injured feelings into account as part of the general damages

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[39] Richardson v Howie [2004] EWCA 1127 [2005] PIQR Q3 CA

awarded. It is, we consider, no longer appropriate to characterise the award for the damages for injury to feelings as aggravated damages, except possibly in a wholly exceptional case.[40]

Recommendations

26. Applying these principles as best I can, I suggest that in cases where the infected person has been subjected to an unethical research project, it would be appropriate to add a modest sum to the general autonomy award tariff in the region of £10,000 to all categories of autonomy award. While this might seem generous in the case of the recommended award in HBV cases, the insult caused by being subjected to research is surely the same irrespective of the disease. For the avoidance of doubt, I recommend that this enhancement should be available to any infected person whose treatment was part of one of the unethical research projects explicitly identified in the Inquiry report. I suggest that agreement is sought with groups representing the community as to the identity and dates of such projects, and how involvement in such a project might be established.
27. I would suggest consideration of one exception to this general figure; namely that an enhanced figure could be awarded in the cases of children who

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[40] Ibid § 23

> were subjected to research while resident at an institution, such as Treloar's. The feelings of injury are likely to have been exacerbated by the fact that the research was not only unethical in a clinical sense, but also because it was a breach of trust at an institution intended to be a place of safety. In such cases, I suggest an enhanced award of £15,000 could be considered.

I emphasise that these are merely my own views, informed by a summary study of the law and without having received any technical submissions on the subject. I repeat that – in so far as time permits – the views of the expert group but also the infected community should be sought.

Care awards

Proposal

This award is intended to compensate infected persons for their past and future care needs, including domestic support, personal and nursing care, including palliative, end of life care. The recommendations recognise that care needs will vary at different stages of an infected person's experience of disease as reflected in the severity bands. As would be the case in a court based personal injury claim, the claim is made by the infected person for an award to reflect their needs, and not by any relatives or others who have actually provided care or will do so in future. Court based awards of this nature are made in the expectation that the claimant will pass the money for past care on to those provided it, although the means of enforcing this are somewhat uncertain.

The approach advocated by the expert group has been to identify a UK-wide average commercial rate charged currently for comparable care. Their proposals are intended to provide for the average care requirements for an infected person in each infection severity band. No deduction is to be made from awards for past care for support payments, DWP benefits, time in hospital or other state funded care, thus producing a more generous result than might be the case in a personal injury action. The proposals contain detailed tables of the estimated hours care required at each stage, ranging from 6 hours a week for minimal domestic and support care to 24 hours, 7 days a week support for end of life care.

It is proposed to apply a 25% discount to the calculation for past care to reflect the fact that when care is provided gratuitously by relatives they will not incur taxation on the sum received, they do not necessarily have any professional qualifications, and, if living with the injured person, they will not have to travel to work. No such discount is proposed in respect of future care so that recipients are free to pay for care if they wish to do so. It is not entirely clear how this works through to the calculation of an overall award for care which encompasses both past and future care without specific reference to the point in time at which the assessment is made.

A core award would be made for care costs based on this method of calculation without the need for any evidence of care need, over and above that needed to establish the relevant eligibility as an infected person. However, the recommendations accept that there may be cases where a person’s care needs or costs have, or will be higher than, those assumed in these average calculations. It is suggested that, in such a case, an application could be made for a supplementary award which would need to be supported by evidence [‘additional documentation’].

The precise way in which the care award is calculated on an individual case is dependent on a choice of severity band. It is also submitted that the assumptions fail to observe that care requirements can be significant at the onset of an infection as well as later on in its progress.

The first of these concerns should be capable of being addressed by a more detailed explanation of how the factors of length of each severity band apply. The second concern could be recognised by a supplementary application, but this would have to take into account that the award is made on the assumption that over the applicant’s lifetime the assumed hours or different levels of care will be required, without necessarily assuming they will be needed in linear order of ascending gravity.

Comparison with a claim in a court based personal injury action

The framework for compensating an injured person for the need for care when that has been provided by family or friends for free is the subject of an extensive line of case law. There is more than one way in which a court might calculate the award.

Where care has actually been paid for, the court will usually award the actual costs, subject to that being reasonable given the nature of the injured person's needs. Where the care has been provided gratuitously by a person who has not given up remunerative employment, the court will have regard to evidence of the commercial cost of providing the equivalent care, less, in respect of past care, a percentage to reflect the matters referred to above. It is this approach which has been the starting point of the expert group's recommendation and the Government's proposal. It is important to reflect, however, that there is no 'conventional' percentage reduction, which will depend on the circumstances. A recent review of the discounts applied in cases has suggested that the range is between 0% and 33%, and that every case depends on its facts.[41]

In the case cited it was said the factors involved included:[42]

- Tax and national insurance will not be deducted.
- The weight and complexity of the care given will vary between cases.

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[41] CCC v Sheffield Teaching Hospitals NHS Foundation Trust [2023] EWHC 1770 (KB), [2024] 1 WLR 1307, Ritchie J §134

[42] Ibid §146

- The times at which the care is provided may range from midweek daytime to 24 hour care including waking night care and at weekends.
- There may be other calls on the care provider's time which have to be incorporated inconveniently into the schedule.
- The carer may have had to give up income from employed work.
- Where the carer is a parent or partner there is likely to be a level of care and support which would have been provided in any event had there been no injury.

In this review, the judge decided to make no deduction after looking at the reality of the care provided and the facts that in intensity, skill and devotion it far exceeded the general nature of the work that a care support worker – the grade on which the rates claimed had been based. As the judge's description of those differences may resonate with some of the carers whose claims will be considered under the scheme, I attach an extract from the judgement after this section.

There will be cases where the care provider, usually a partner, has given up well-paid work to provide care. The pay lost may be considerably higher than the commercial cost of care. The leading case on the award of damages for gratuitously provided care suggests that the limit of what can be awarded is the commercial cost of providing comparable care.[43]

However, the leading textbook on damages suggests this is not an invariable rule, and that it does not sit easily alongside the principles of mitigation of damage which allow recovery of increased costs where it is reasonable to incur them to alleviate suffering: for example, where it is reasonable to receive the care of a loving partner, rather than an unknown carer. It is argued that, if giving up work to care was reasonable in the circumstances, recovery of the loss of earnings could be allowed. There is, therefore, a degree of legal uncertainty about this issue.

Overarching observations on the proposal

I note that the responses to one organisation's survey showed majority support of 40% in favour, 20% against [28% don't know] for the care award in respect of a deceased infected person to be paid directly to the affected persons at the request of the estate administrator.[44] This is an option under the proposals.

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[43] Housecroft v Burnett [1985] EWCA Civ 18; [1986] 1 All ER 322 CA

[44] I note that later in the Society's submissions they argue that individual affected persons should be able to make their own claim for a care award. For the reasons given below I disagree.

Given the general rule and practice in injury claims, at least to date, the overall approach of the expert group does not appear to be unreasonable subject to four qualifications:

- The actual hourly rates adopted are not set out in the proposal, although it may be possible to deduce them by dividing the annual sums mentioned by an annual total of hours. There is no description of the precise grade of carer or nurse taken as the comparator, but I note that reference is made to ‘domestic support’ and ‘personal care’. I am not sure that such rates would necessarily be sufficient to reflect care which, in some cases, might equate better to nursing care, particularly during periods of serious incapacity and illness. There is no explanation for the reliance on whatever rates were used. While domestic and personal care rates – if that is what has been used – may be appropriate generally, it may mean that supplementary route claims will be required when the care required goes beyond basic care, and could be better reflected by a higher scale of charges, such as for qualified nursing care, or involves many more hours a day.

Recommendation

28. It would be of considerable assistance to the Authority in assessing supplementary claims to be

given a more precise description of the type of care that is intended to be covered by the proposed core approach. There is a risk, which I cannot quantify, of a large number of supplementary claims of this nature, which could be better addressed by a more generous core award formulation.

- In the present state of the law, it is not unreasonable to limit core claims to the commercial cost of comparable care, and not to allow supplementary claims based on loss of earnings.

Recommendation

29. It could be made clear that a supplementary claim could be made in respect of exceptional care needs by way of reducing or eliminating the proposed discount.

- If the commercial costs of providing comparable care are to be used for the award in respect of future care, it is right that there should be no deduction to tax etc. for that element of the award. The infected person should be entitled to relieve their loved ones of the burdens of the past and, therefore, they should be free to replace that with paid carers. It would also be realistic to add an element for the fact that most recipients would probably have to access the provision of care via agencies which charge a commission for their services.

Recommendation

30. The expert group should be asked to identify the appropriate rates for compensating for agency charges.

- In order for the award to reflect as closely as possible the actual cost of care in cases of this sort, where awarded by way of periodical payments, the uprating for inflation should by reference to the Annual Survey of Hours and Earnings [ASHE] Table 26 (care workers and home carers) [formerly ASHE 6115],[45] rather than by a retail or consumer price index as is the court based practice: see Thompstone v Tameside and Glossop Acute Services NHS Trust[46] and Public Guardian v CC[47].

Recommendation

31. I recommend that reference index is changed accordingly.

- Although it may be implicit in the proposal, where an infected person has actually paid for care in the past in excess of the sum arrived at by the core route formula, a supplementary route claim

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[45] https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/datasets/careworkerssocashetable26

[46] [2008] EWCA Civ 5

[47] [2015] EWCOP 29 (Senior Judge Lush) §§30-31

should be allowed to recover this cost to the extent that the cost incurred was reasonable in the circumstances of the case.

Recommendation

32. I recommend that the actual cost of paid for care be allowed, if reasonable.

- A concern was raised that insufficient allowance has been made for palliative care [6 months]. As I understand it, the expert advisory group considered that this period reflected the majority of experience.

Recommendation

33. I consider that where this is shown not to be applicable in individual cases, a supplementary claim should be allowed, as it should be wherever there is evidence that the core award would underestimate the length of any particular stage of care needed.

- A solicitor has noted that the framework for core route care awards do not reflect the reality of their client’s experience in terms of stages of need for care. In the end, this must be a matter for expert guidance as to an overall pattern of care need which in their opinion reflects the majority of cases.

Recommendation

34. It would be helpful if the reasons for the expert group’s recommendation in this regard were spelt out.

Administration of care awards to an infected person

As noted above, the Government’s proposal is that the claim for a care award is made by and paid to the infected person, rather than directly by and to the carers. This follows the practice in personal injury actions.

Some concern has been expressed at the burden this may place on the infected person, or their estates in identifying who should receive this award, or a share of it. The concern has also been expressed that carers ought to be able to claim a care award directly. However, the basis for making a care award at all is that the infected person had a need for care, and that it is only right that they are in a position to recompense those who provided it. To make awards directly, with the Authority determining who and who has not contributed care effort would be a further removal of autonomy from the primary victim.

In Hunt v Severs the House of Lords held that the purpose of the award was to enable the claimant to recompense the carer.[48] Accordingly, they said, the award was held by the claimant on trust for the benefit of the carer or carers. The result is that the claimant has an obligation to reimburse the carer.[49] There is some uncertainty about how this is to be enforced in cases where there is a dispute about who provided what care, or where the claimant for good or bad reasons would prefer to use the award differently. Where the claimant lacks decision making capacity, their attorney or deputy would likely have to fulfil the obligation or seek directions from the Court of Protection. Where the claimant is deceased, this responsibility will fall to the executors of administrators of the estate.

There may of course be disputes among family members or others about who provided what care. In principle, I consider it ill-advised for the Authority to be asked to intervene in such private and sensitive family issues. Purely pragmatically it could substantially delay the award and delivery of awards in contentious cases. There would, however, be less difficulty, as proposed in assisting to the extent of making payments direct to carers nominated by the infected person in respect of the past care element of the award. However, this would only be prudent so long as it was accepted that the

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48 [1994] 2 AC 350

49 Griffiths v British Coal Corporation [2001] EWCA Civ 336 §51

responsibility for complying with their obligation to identify all care providers remains with the infected person.

It would also be possible to encourage affected persons to submit their own evidence about care provided.

Clearly awards for future care needs must always be paid to the infected person direct so that they remain free to make their own choices about care provision.

Recommendations

In summary my recommendations in so far as they depart from the proposal are as follows:

35. A more precise table of hourly rates, and hours care provided for should be published, together with an identification of the source for the rates used.
36. Supplementary applications should be allowed to award the actual cost of past care provided where this was paid for and the amount of care provided and its cost were a reasonable reflection of the infected person’s needs.
37. It should be clarified whether or not a carer’s loss of earnings can be claimed by the supplementary route to reflect the value of care provided, or whether such claims would be limited to seeking recompense for a greater number of hours care and/or a lesser discount form the commercial rate relied on.

38. The uprating for inflation to be applied to periodical payments for future care should be by reference to the ASHE Table 26 [care workers, home carers and senior care workers] index.[50]
39. If the IBCA agrees – at the request of the infected person or their estate – to pay a care award direct to a nominated carer or carers, it should be on condition that the responsibility for meeting the obligation to compensate carers remains with the infected person or estate.
40. The procedure for making claims should allow for intervention by an affected person to offer evidence of their contribution to the provision of care.

Extract from the judgement of Mr Justice Andrew Ritchie in CCC v Sheffield Teaching NHS Foundation Trust [2023] EWHC 1770 (kb) §147

The rate used by Miss Sargent is not for RGN nurses. It is for support workers based on the National Joint Council published rates. It is an aggregate rate for weekday and weekend work (£9.45 ph in 2015 rising to £12.39 ph in 2020). This, in my opinion, undervalues

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[50] Formerly ASHE 6115: ONS Earnings and hours worked, care workers: ASHE Table 26

those parts of the care M gave which were waking night care, nursing care, team leader care, case management and physiotherapy. The care was equivalent to nursing care for a not insubstantial fraction of the day. M was from time to time a team leader, a physiotherapist and a case manager, all of which roles are paid at higher hourly rates than the National Joint Council rates. I take into account the sleepless nights M has spent dealing with the Claimant’s nappies full of diarrhoea, long after able-bodied babies would have been continent. I take into account the PEG feeding every day, the titration of drugs of a dangerous nature which she has carefully syringed into the Claimant and the heavy load she has carried up and down stairs and into and out of vehicles, as the Claimant grew older; the back pain and the psychological fears she has endured whilst caring alone, without the father, to keep the Claimant alive and healthy without commercial care or local authority care before liability was admitted and interim payments were made. I take into account the weekends, bank holidays and the national holidays when she laboured alone, whilst also caring for her son. I take into account the holidays M has forgone and the social life she has been deprived of. I take into account the battles she has had to take part in with schools and authorities to obtain services for the Claimant. I take into account that the Claimant has never had bed sores despite her disability and immobility. I have considered the fact that M has lived rent free in the new properties rented by her for the Claimant after they moved for which she pays no rent, but her claim for gratuitous care is limited and stops in March 2020, so this is barely relevant. I would have taken it into account if the claim had been run all the way up to trial. In all the circumstances of this case I consider that no deduction should be made from the gross figures agreed by the parties for gratuitous care by M.

Scope of supplementary applications

Contributors have pointed out that the supplementary route is proposed to be available only in relation to claims in respect of the care and financial loss awards and not for other heads of claim. This is acceptable if the injury, social impact and autonomy tariffs are sufficiently broadly defined and generous to capture fairly and proportionately all conditions and severities which may have been suffered as a result of the infections prescribed as the gateway to eligibility for compensation. This is, therefore, another reason why it is important that the full details of the rationale for the severity bands are explained and published: as one contributor put it:

[The supplementary route] should only be needed by exception rather than as a rule. The core route should be designed to be sufficiently generous that it allows the ‘buy-in’ of the community with the vast

majority not requiring to go down a supplementary route. The ‘buy-in’ would also allow victims to feel the need not to take legal action.

Financial loss awards

Proposal

The proposal is that a financial loss award may be paid to an infected person, if living, in respect of their past losses and their future losses up to their life expectancy had they been healthy [HLE]. If deceased, an award may be made to their estate to reflect their financial losses up to the date of death. An award could also be made to reflect the dependency of an affected person on the income of the deceased.

While the focus of the proposal is understandably on loss of earnings, allowance is made for other expenses that may be incurred. Rather than require applicants to undertake the onerous task of listing and proving multiple items, an overarching, broad-brush lump sum for these expenses is suggested in the sum of £10,000 to be paid to all infected persons or their estates.

In line with the recommendations made by Sir Brian and myself, it is proposed that the core award for loss of earnings should be based on median UK earnings, net of tax, as evidenced by the 2023 Annual Survey of Hours and Earnings (all occupations) [ASHE] plus 5%. Past loss of earnings will be assessed for the period of the loss, but to avoid complex calculations reflecting the lower value of earnings over previous years, and then adding interest, all awards for past loss of earnings will be based on the 2023 median earnings. Nothing is said about the age from which loss of earnings might be allowed, but I now understand that it is intended that the tariff-based loss of earnings award would take the age of 16, school leaving age, as a starting point. I consider this to be reasonable, and, even generous.

The proposed tariffs are necessarily complicated but seek to avoid the need for individual assessment and burdensome evidential requirements by reflecting a ‘standard disease profile’ as recommended by the expert advisory group. This makes assumptions about the impact on earning potential of the various types and stages of diseases. For example, the stages of HCV infection are broken down into a period of chronic infection for which 20% or 40% of the annual median income, depending whether this occurs before or after the introduction of effective treatment [said to be 2016], 60% or 80% for an assumed 6 year period of cirrhosis, and 100% for an assumed 4 year period of decompensated cirrhosis and liver cancer. From the illustration given, it appears to be assumed that the chronic period is assumed to start with the onset of infection and ends 12 years before the infected person’s eventual death from liver cancer. It is, therefore, assumed that the infected person will have retained earning potential for a sustained period following the infection. I note that all the illustrations are for infected persons who had died by the time of the assessment. It is not clear to me what assumptions will be made about the progress of disease in the case of a living applicant who has yet to progress beyond the chronic stage of their disease.

It is clear that the proposals envisage further detail being added following the engagement process.

Need for clarity

The task of coming up with a detailed tariff which avoids overloading applicants and the scheme with the need for bespoke assessments in supplementary applications is particularly complex. The proposal is clearly a start in identifying such a tariff, but more work is needed. The assumptions underlying the proposed structure are that for a possibly substantial period an infected person will have a substantial earning potential. A partial earnings potential is assumed to be preserved during the cirrhosis stage. I accept these assumptions are, as stated, based on the clinical advice of the advisory group, but I suggest that their reasoning and the evidence on which it is based should be shared to enable the community to understand their formulation.

Recommendation

41. I suggest that there are a number of points where further explanation would be helpful:

    a. In relation to a living infected person, is the calculation intended to be based on their self-declared condition at the date of application, or an assumption based on the time since onset of the disease?

    b. Is it intended that all those who were out of all paid work because of their condition should have to make a supplementary application? If so, Is there any evidence to suggest what proportion of the infected cohort might have to pursue a supplementary application?

    c. It may help public understanding for the workings behind the financial loss elements of the illustrative awards at pages 21 to 26 of the proposals to be disclosed.

    d. At the point of determination of the tariff, sufficient detail must be included to enable both the Scheme and the applicants to understand what the core tariff result is for them.

    e. How is it envisaged that the various stages assumed in the progress of disease or care needs would be reflected in payments, if that is the option chosen by the applicant?

f. What account, if any, is to be taken of actual earnings, either against a core or a supplementary route award?

Impact of treatment

The proposal makes assumptions about the positive impact of treatments introduced in 2016. Many contributors have raised concerns about this, asserting that the beneficial effect of treatment on the disease were not necessarily accompanied by a return of the ability to obtain work – either because relevant symptoms continued, or because of the diminished prospects in obtaining employment after a lengthy absence due to incapacity. Sir Jonathan agreed to consult his group about this point. I understand that the group’s advice is that most infected persons were able to return to work after modern treatments. However, on reconsideration, it was agreed that those suffering from chronic fatigue, or were aged 55 or over, found getting employment significantly more difficult. For those latter groups, they recommend that the potential for returning to work should be disregarded.

Recommendation

42. On the basis of the evidence, I agree that the proposal should be amended accordingly, to allow for a disregard of the assumption, subject to the provision of some evidence of ongoing chronic fatigue, if that is the ground relied on. The implication of the advice is that not all other infected persons will have been able to return to work. Accordingly, I recommend that on production of some evidence to support such a claim, such as a medical certificate, a supplementary claim should be allowed.

The effects and costs of campaigning

It was suggested by some contributors that lives have been blighted by the need to campaign endlessly for justice and that account should be taken of this in the scheme. Reference is made to the Inquiry's second interim report, in which Sir Brian stated that he agreed that the impact of campaigning ought to be taken into account, but that it would be left to the Chair of the scheme to determine how this should be recognised. Given that the current proposal has not been, as was envisaged by Sir Brian, formulated by me as interim Chair of the IBCA, it is not for me to make that determination. However, it may assist for me to offer my observations.

The injustice suffered in this case can be said to have been responded to by victims in a wide range of ways. Some will have had their lives changed by withdrawing from social contact; others will have undertaken extensive and exhausting campaigns. The tariffs for injury and social impact and autonomy, taken together should include a reflection of the fact that the lives of all will have changed for the worse because of these infections. In some cases, this will be due to social isolation, or withdrawal from the outside world. Others will have responded with anger but kept that to themselves. Others have developed a public profile and advanced the cause, not just of themselves but others, too. In that category, some will have used their own resources, while others may have obtained financial, material and moral support from others. Undoubtedly, many of those who have campaigned for justice will have incurred expense; it has been said that some gave up their jobs to do so.

It is not to disrespect the efforts of so many on behalf of the community as a whole, to observe that it is impossible to differentiate either in terms of suffering or loss of amenity between the various ways in which infected and affected persons have responded to the ordeal inflicted upon them. Indeed, to attempt to do so would risk making invidious comparisons. Therefore, I see no case for any differential in those awards between the two groups.

I regret to say that I cannot support the inclusion of such expenses and losses in the financial loss award. It would introduce an unfair difference between members of the community and result in a contentious examination of what was and what was not reasonable. I doubt that such costs would be recoverable in litigation in any event.

Supplementary route

It is possible to envisage two types of supplementary application in relation to financial loss. The first is where the applicant or their estate can show that their earnings record or capacity was in excess of the median.

Recommendations

43. Given the universal desire to simplify the application and assessment process – and reduce the evidential burden – I suggest that, where possible, reliance should be required to be placed on comparable ASHE statistics; supported by relatively simple evidence of the infected person's employment record or capacity.
44. Reliance on employment experts or the like should be discouraged, if not completely disallowed.
45. The Government with the assistance of the advisory group should assess for itself the extent to which the current proposed standard multiplicand, based on the

ASHE median figure, is likely to accommodate the great majority of claims.

46. A second type of supplementary application, if allowed, is likely to be from those that want to challenge the assumption that an infected person retained a partial earnings capacity. Some of those have been referred to in the previous section. Guidance will be required on the approach that the IBCA should take in such cases. Would it be sufficient for it to be shown that the infected person was in fact out of work? If so, should evidence be required as to the reason for this?

Cap?

Some suggestion has been made that the proposal includes a cap on potential supplemental loss of earnings claims. While I cannot detect such a suggestion in the documentation I have seen, that would be a policy decision for Government. Any such decision would have to balance the discrepancy which would arise if a cap were imposed between what could be recovered under the scheme and what would be available in litigation.

Recommendation

47. Consideration should be given, as a matter of policy, as to whether there should be a maximum award permitted for the loss of earnings component of financial loss awards.

Lump sum for miscellaneous costs

Any personal injury lawyer will be accustomed to seeing lengthy schedules of items claimed, amounting to totals well in excess of the figure suggested here. In the course of the framework review, and this engagement, I have seen mention of many such items, ranging from increased insurance costs, loss of chance for life insurance, travel costs, removal to and acquisition of new homes, for instance due to persecution, among others.

This is another area requiring a policy decision. If a supplementary route claim is to be allowed for any form of cost said to be attributable to the disease, there is a risk of wide variety of claims being formulated and that would place a heavy burden on both applicants and administrators of the scheme. On the other hand, to deny such an entitlement is arguably a denial of the justice that is sought. Frankly, there is no answer which will satisfy all, but I suggest that the government might wish to consider whether the sum I tentatively suggested in the Framework report of £10,000 is sufficient to reflect a balance between the competing factors, of which I have mentioned but a few. There are two possible approaches that could be examined: either to look at the adequacy of the lump sum, or to consider whether the award should be related more to the period over which the infection has impacted on the applicant.

Recommendations

In summary, the recommendations I make in respect of financial loss are as follows:

48. An expanded explanation of the proposals should be published explaining in more detail all of the matters referred to above.
49. Consideration should be given to amending the scheme to reflect the revised advice of the advisory group about the impact of treatment on earning capacity.
50. It should be made clear whether there is a cap, or other form or restriction, or requirement for a supplementary route claim for financial loss, and, if there is, the reasons for the cap.
51. The sum proposed and previously recommended as a lump sum for miscellaneous costs should be reconsidered to reflect whether it provides a fair assessment of the costs that infected persons may have incurred.

Claims involving deceased infected persons and their estates

Proposal

It is proposed that claims can be made for infected person awards by their estates if they have died. The claim that can be made on behalf of a deceased infected person will include all the elements that the infected person could have made if living, awarded for the period between the onset of the infection and the date of death. A claim cannot be made for the ‘lost years’ income that is the income the deceased would have enjoyed the years between the date of death and the healthy life expectancy of the deceased but for the injury inflicted on them. Instead, a bereaved financial loss award will be available to the bereaved partner and children of the deceased. Each eligible affected person whose eligibility depends on a deceased infected person will receive the relevant tariff bereaved financial loss regard. Unlike a Fatal Accidents Act award, it will be unnecessary to apportion a ‘pot’ of money calculated on the basis of the deceased’s earnings between dependents. Thus in the case of a large number of dependents, the total sum for the family might well exceed what would have been awarded under the Act.

The estate of a deceased affected person will not be able to make a claim, in accordance with the recommendations of the Inquiry report.

The claim arising in respect of a deceased infected person will include a financial loss claim for the period following the date of death to the date of the deceased’s ‘healthy life expectancy’ to the extent that their dependants have lost a benefit – what would be called a loss of dependency in a court-based claim under the Fatal Accidents Act. The proposal is that a tariff-based approach is taken to this part of the claim to reflect the loss to the dependants arising out of the loss of benefit from the deceased’s income which would have been enjoyed but for the death. The calculation takes the net median UK earnings plus 5% used for the living infected person’s tariff and applies a percentage deduction to reflect what the deceased would have spent on themselves. It is proposed the partner of the deceased should receive £16,682 a year. This equates to a discount of 44% from the median +5% figure of £29,657. A child under the age of 18 would receive up to that age £5,561, a discount 81% or put another way a share of the income of 19%. If the child has lost both parents, the figure is increased to £22,243. It is proposed that other affected persons could claim a dependency on production of relevant evidence via the supplementary route, but no further detail is given as to the way in which such claims could be assessed. As explained above, each dependant receives this award separately.

Comparison with Fatal Accidents Act

In a claim under the Fatal Accidents Act, which for those unfamiliar with the law of damages, governs claims arising out of wrongfully caused death – and not just ‘accidents’ – a claim can be made for the loss suffered by a dependent such as a widow, of the net amount the deceased would have spent on them out of their income, and also that part of their earnings which they would have saved and which the dependent might have expected to inherit. The claim can also include the loss of services the deceased person would have provided such as child care, gardening, maintenance etc.[51] The conventional starting point for calculating the dependency of a partner in the case of a deceased person who had or could have expected regular earnings is to take the annual net income and deduct that portion which the deceased would have spent exclusively on themselves. To reflect this deduction conventionally, the annual dependency figure is taken in the case of a widow along as being two thirds the deceased’s earnings, and in the case of

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[51] This account is taken from McGregor on Damages 22nd edition chapter 42

a widow and children three quarters the earnings. This avoids, as the court in one case put it, a 'tedious inquiry into how much housekeeping money was paid to the wife, who paid how much for the children's choses etc.'[52]

From the resulting figure must be deducted the earnings of the dependant as at the date of death. Additional earnings arising after the death because, for example the widow has felt constrained to take on a new job, are not taken into account. Once an annual figure is established, a multiplier representing the period between the date of assessment to the presumed health life expectancy of the deceased but for the injury.

As with all such conventions, it is open to the court to take into account circumstances where this crude calculation is not a proper reflection of the actual facts. The convention also dates from the time when now outdated assumptions were made about the principal earner in a family was almost invariably the husband. Therefore, there are many ways in which a dependency figure can be reached.

Therefore, it is somewhat challenging to compare the proposals for the scheme with what might be the outcome of a conventional Fatal Accidents Act calculation. And, indeed I understand that the advisory group did not take this as its model. It might help the

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[52] Harris v Empress Motors [1984] 1 WLR 212 CA

understanding of those eligible to claim under the scheme if the basis of the proposed deduction was explained in more detail. I note, for instance, that there is no suggestion that any deduction should be made for any income contributed to the family pot by the affected person. As explained above, I also note that it is proposed that each dependent affected person receive a separate tariff-based sum – rather than an overall award being made to be then apportioned between dependents. In relation to the injury impact award, a bereaved partner of an infected person will receive an award which reflects not only the bereavement but also the distress and anxiety of living with the infected person. In determining whether to accept the advisory group's recommended approach and method calculation of dependencies, the Government will need to consider the extent to which this will match, or exceed expectations, of awards under the Fatal Accidents Act and the degree to which this mitigates the risk of applicants feeling obliged to choose either to make supplementary applications or to choose to litigate.

One contribution suggests that it is 'unconscionable' to propose that bereaved financial loss claims should be limited to the healthy life expectancy of the deceased infected person. I disagree. This award is intended to reflect the dependency of the partner on the income of the deceased person. But for the injury, this would notionally have ceased at the date on which the infected person would have died but for the injury. It is the injury, social impact and autonomy award which reflect these impacts on the lives of bereaved affected persons.

Distribution of awards to estates

I note that respondents to one representative organisation’s survey overwhelmingly [about 65% or respondents] thought that it was fair for awards to a deceased person’s estate to be distributed in accordance with their will, or to next of kin. There was, though, concern about money, whether by reason of a will, or the rules of intestacy passing to beneficiaries who had no connection with those who had been infected or affected. I disagree with the contention that this is ‘morally wrong’. An award to the estate represents the entitlement of the deceased person, had they still been living. A living infected person is entitled to deploy their award in any way they wish, and to leave what is left at their death in any way they wish. For the State to intervene to alter such wishes or the normal course of inheritance would, in fact, be an unwarranted interference with that person’s autonomy. The interests of family members who can establish that they should reasonably have been provided for, or were financially dependent on a deceased person, can make a claim against the estate under the Inheritance (Provision for Families and Dependants) Act 1975.

Therefore, there is already a way of correcting any obvious unfairness, and it would place a considerable burden on the scheme for it to be obliged to make decisions about sensitive family matters. It would also interfere with its ability to make awards for all as quickly as possible. In any event, family members may well have a claim as affected persons which would be independent of the award made to the estate. Accordingly, I can make no recommendation that there should be any change in the law to meet this concern.

Burdens of administration of disputed estates

The principal concern expressed in the engagement was not about the figures as such, but about the complexities facing the personal representatives of the deceased infected person's estate – particularly in cases where there were splits in families or disputes as to entitlement. There is no reason in the context of a compensation scheme why this burden cannot be eased by arranging for the IBCA in this case to undertake much of the work in calculating a dependency, so long as the tariff allows for calculations without the need to collect a great deal of detail about families and their expenditure. Unfortunately, the issues facing families in administering the fallout from the death of a loved one cannot be entirely removed, and the challenges would be much the same as if a claim were brought in court. The remedies available in law are touched upon above. I do not accept that it is appropriate in the case of family disputes to increase the awards to some parties to ease any sense of family grievance. However, it would be appropriate for the scheme to be able to offer access to a mediation service. Whether to offer any subsidy of the costs of mediation is a matter of policy and goes beyond what I would consider to be proportionate compensation. Indeed, such a subsidy might have the perverse consequence of encouraging disputes.

Recommendations

My recommendations for mitigating and supporting families in relation to claims of this nature are as follows:

52. The method of calculation of loss of dependency – whether by the core or supplementary route – should be spelt out in full in the terms of the scheme, to enable the assessment and outcome to be transparent and clearly understood, and an explanation for the reasoning leading to those terms should be published.
53. Legal support should be funded for the personal representatives of a deceased infected person to prepare and make a claim, including in a claim for the loss of dependency of all relevant affected persons. Consideration should be given to creating a panel of solicitors experienced in probate issues to whom

personal representatives could be referred to for advice. Such a panel should be selected on criteria which include those recommended for the general legal advice panel.

54. Personal representatives should be encouraged to identify to the Authority all persons they believe may have a claim as an affected person and to notify such persons they have done so. This will facilitate the Authority’s task in identifying eligible persons and establishing whether they wish to make a claim, however, this will not prevent others coming forward to make an application.
55. Consideration should be given to allowing, as part of the financial loss award, a standard sum to reflect the cost of administering the claim on behalf of the estate.
56. While the IBCA should not be required to adjudicate on or intervene in disputes between the estate and associated affected persons, consideration should be given to whether an outsourced mediation service could be made available on standard terms with regard to fees payable by the parties in disputed cases. This needs to be independent of the IBCA itself because it is likely to be affected in its views by its assessment of applications.

Age limits for children and siblings

The age of children is relevant to two eligibility categories: affected children, and siblings of eligible infected persons.

Affected children

One of the categories of eligible affected persons is for those who are children of an eligible infected person and who, while under the age of 18, were cared for and lived for a period of at least 1 year with a parent who was, or later became infected. A child who is older than 18 at the date of the onset of the eligible person's infection will still be eligible as an affected person, but the rates of compensation will be lower.

The age limit is based on my recommendation in the Framework report, which was accepted in the inquiry's second interim report.[53]

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[53] Compensation Framework Study report - 7th June 2022: Scope of Compensation, Eligibility Criteria, Eligibility for Affected Persons, Parents of infected children: § 6.21. Infected Blood Inquiry, The Inquiry's Second Interim Report: pages 34-35.

The difference this would make under the proposed tariffs for the injury impact award is that:

1) a child under 18 at the onset of their parent's infection with acute HBV leading to death in the acute period, or with HCV/HBV-cirrhosis, decompensated cirrhosis, HIV, or co-infection would be £40,400;
2) whereas if they were over 18 at onset the award would be £22,000. Whereas if the infection was HCV/HBV-chronic the injury award for both categories of children would be the same: £20,000.

In passing, it is not clear to me why there is a differential in award between the categories in the first case, but not in the second. A representative organisation has submitted that some adult siblings supported an infected family member either while living in the family home, or elsewhere. It is submitted that they, too, suffered social impact including stigma and should be entitled to a social impact award – as well as a care award.

Recommendation

57. I recommend that clarification be sought for the reason for this, and consideration given to how to provide for consistency of approach. At the same time, consideration could be given to whether the reasons for not entitling persons in

the second category above to a social impact award remain sound.

Is it appropriate to have a dividing point referable to age as an appropriate point at which to distinguish between the impact on a child in physical and psychological terms of a parent contracting these infections? I still consider it is. A child living at home and dependent on their parents will be impacted in every aspect of their lives, from domestic stability and security, to social lives and adjustment to education. Their development may be compromised by the arrival in the family of such a devastating condition.

If, on the other hand, the infection arrives when the child has reached adulthood and dependence has reduced, the impact will still be serious in terms of anxiety, concern and the need to provide support, but it is less likely to be as life changing as when this occurs in childhood. Therefore, in principle, I still support the distinction.

By way of a postscript on this topic, it may be that this condition has been misunderstood. In one contribution it was suggested that a ‘cut off’ age of 18 was unfair because many continued to provide care as adults. In such a case the now ‘adult’ child would still be able to benefit from the care award made to the infected person or their estate. Even in relation to an injury award there is no ‘cut off’, but only a reduction in the amount awarded.

Children and siblings not living with the infected parent but separated by reason of the disease or family breakup

However, a further and, I think, valid point has been made about children whose parents may have split up and shared custody, or cases where a child has been sent to boarding school for their own protection. It is suggested that in these exceptional cases they should be treated as 'living with' the infected person.

Recommendation

58. I recommend that consideration is given to the suggestion that children separated by reason of the disease or family breakup should be treated as living with the infected person.

Taxation

A question was asked in the course of engagement about taxation of earnings on any lump sum and whether self-assessment forms would need to be submitted in connection with earnings from the lump sum award.

It has, I believe, been made clear that it is proposed that any award, whether in the form of a lump sum or periodical payments, will be free of tax. In so far as a lump sum was awarded whether for past or future losses, income on investment of that fund would be subject to taxation in the normal way. I would expect a lump sum for future losses to be calculated by discounting the sum predicted to be lost in future for acceleration of receipt using a discount rate which assumes a rate of return on investment. Under the Civil Liability Act 2018 a discount rate is now set by the Lord Chancellor. The current rate is -0.25% but is currently under review. This rate, the Personal Injury Discount Rate (PIDR) is intended to

reflect the real rate of return that a recipient of relevant damages could reasonably expect to receive if they invested their award. It reflects the expected nominal investment returns, adjusted for the

expected future rate of inflation applied to claimants' damages and the effects of expenses and taxation.[54]

Assuming a rate reflecting these factors is adopted, it would follow that at least in theory that it would be expected that recipients of lump sum awards would pay tax on investment income in the same way as other citizens – subject to the exemptions available such as in ISAs.

However, this could mean that recipients would be obliged to make tax returns which they would not have been required to do but for the injury and losses leading to the award.

While many awards will consist of a lump sum for past and future injury, social impact, care and autonomy awards, future care and financial loss awards will at the option of the recipient be paid by periodical payments rather than a lump sum. The potential burden of managing a lump sum, and the taxation of income derived from it, might be one consideration which would incline some recipients to opt for periodical payments. As these are intended to reflect the actual needs and outgoings on an annual basis, the burden of income liable to tax would be likely to be diminished.

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[54] https://www.gov.uk/government/calls-for-evidence/setting-the-personal-injury-discount-rate/setting-the-personal-injury-discount-rate-a-call-for-evidence

Recommendations

Bearing in mind these concerns I recommend that:

59. The Government should clarify how it proposes that future losses should be calculated under the scheme and, in particular, to identify by what discount rate, if any, the Scheme will adopt and how factors including inflation and the incidence of taxation on investment income are taken into account.
60. The Government should confirm that awards, whether lump sums or periodical payments, are to be made free of tax.

Interest

The proposals are silent as to what, if any, interest might be payable on compensation awards.

In the framework, I recommended that interest should be payable on awards for past financial losses and care from the date of infection to the date of the award in accordance with the practice in personal injury litigation, or that alternatively an uplift be allowed for inflation.[55] This was accepted by Sir Brian.[56] Such a calculation will, in fact, not be required if the proposals for care awards and loss of earnings are accepted, as these are to be calculated using current rates rather than those applicable to the past. Therefore, the awards will take account of inflation and an interest calculation is unnecessary. The same will apply to the tariff sum for other expenses. Therefore, interest will only be a matter for consideration in the assessing awards for either category under the supplementary route where actual loss of earnings are taken into account.

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[55] Compensation Framework Study report - 7th June 2022: page 28 §2.68. Recommendation 13, page 38

[56] Infected Blood Inquiry, The Inquiry's Second Interim Report: Recommendation 13, page 90

I did receive a submission suggesting that an award of 2% interest should be made in respect of the injury, social and autonomy awards. In personal injury litigation such an award is made from the date of commencement of proceedings on the award of damages for pain, suffering and loss of amenity. I would not see this being appropriate in a compensation process such as this.

Legal support

The proposals for the scheme are silent as to the issue of whether any legal support should be made available to applicants. During the engagement sessions, representatives of the various organisations argued forcibly that such support would be necessary – and should be funded out of public funds. They suggested that the provisions of the scheme were complicated and difficult for people without legal experience to understand, and that applicants could only have their distress and anxiety increased if they did not have their own trusted adviser to turn to. Many among the infected and affected communities have developed constructive relationships with their legal advisers during the Inquiry. It was also argued that the task of the IBCA would be made easier if applicants were assisted by their own trusted advisers in formulating and responding to claims. As to what stages of the process support would be most required, most focused on the making of the application and on the decisions whether to accept the initial assessment, whether to apply for a supplementary award, and in whether to choose a lump sum or periodical payment where these were offered. It was also suggested that funding should be available to support any appeal from an IBCA decision. Finally, anxiety was expressed that without legal support applicants could be vulnerable to exploitation by arrangements involving the surrender of a percentage share of the award to an adviser.

In the Framework report,[57] I recommended that legal support should be offered, citing the Home Affairs Committee's recommendation in relation to the Windrush scheme as a comparator. I suggested that support could be provided by a support unit in the IBCA and/or funding of legal advisers for applicants. I ventured that there could be a panel of such lawyers eligible to receive such funding.

Sir Brian agreed[58] with my recommendation, adding only that the scheme's legal advice service should be staffed by a lawyer or lawyers who would give advice confidentially and under the same duty of confidence as they would in private practice. He accepted the suggestion that where legal representation from independent lawyers was to be funded, fees should be capped at public service rates and that there should be a panel of recognised lawyers with experience of the scandal recommended to applicants. However, applicants should also be free to choose their own lawyer not on the panel – provided it was recognised that only very limited funding could be available for such lawyers to familiarise themselves with the issues.

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[57] Compensation Framework Study report - 7th June 2022: page 139 §12

[58] Infected Blood Inquiry, The Inquiry's Second Interim Report: page 55

Recommendations

I consider that the case for legal support remains a strong one and I make the following recommendations:

61. The IBCA should be funded to make arrangements for an independent legal advice service available to all applicants, who are not otherwise legally represented to offer advice on their entitlement to make an application, and to support their decision whether or not to accept the offer of an award.
62. The IBCA should be empowered to appoint a panel of solicitors accredited as having demonstrable experience in the scandal and its effects to provide legal services to the victims.
63. The IBCA should, on application, agree to offer funding at prescribed rates and on such other conditions as the IBCA thinks fit to a legal representative retained by any applicant to assist and advise them in the making of their application and in understanding an offer of an award and their resulting choices.
64. Any offer of legal support funding should be conditional on the legal representative undertaking to the IBCA and their client that they would not charge their client any further fees for their work on those matters, and not enter into any agreement with the client or place them under any obligation to pay any

part of an award to them, whether in connection with funded work or any other work in connection with the application.

I do not recommend that funding should be available to conduct appeals or applications for judicial review against the IBCA. There will be cases where appeals will be appropriate, and I should hope such cases would be rare, but I do not consider that a public body can be expected to support, or indeed objectively assess, the merit of funding appeals against itself. By the time an applicant might have to consider whether to appeal against an award decision, it is likely that they will have funds which, if they chose, they could deploy to fund an appeal. While their money is then at risk, if they have previously received funded legal support in line with the conditions mentioned above, this would give those who might bring an appeal some protection against having to risk paying a contingency fee.

Psychological support

Many contributors to the engagement expressed concern about the lack of bespoke psychological support services for the community. It was suggested that one or more of the devolved nations had better facilities on offer for this.

The provision of psychological support is essentially a matter for the DHSC to address. I understood from the previous Secretary of State, Victoria Atkins, that the issue is under active consideration by the Department. A point has been made in the course of the engagement that the process of applying to the scheme, and sorting out any intra-familial disputes, can add to the pre-existing distress and that, therefore, the DHCSC might reasonably be asked to consider how the support service might be extended to address such difficulties. As pointed out in a submission the Authority needs to be mindful of the impact of its processes on applicants.

I consider it is important that these needs are addressed consistently across the four nations. However, this is not a matter on which the IBCA can offer realistic assistance.

Financial and other advice and support

I have addressed the issue of legal support separately. Many contributors said that the community was anxious at the prospect of receiving a large sum of money and being faced with the burdens of administering it. There were also concerns that some vulnerable people would be at risk of being defrauded. Further complaints continue to be received of inappropriate and ill-informed approaches from tax and benefits authorities with regard to the status of awards and recipients clearly need support and protection against this. It was therefore submitted that there was a strong case for making financial advice available to award recipients.

It has also been pointed out that the support schemes offer other specific payments and access to advice and support. For example, the English scheme offers a funeral grant, ‘one off’ annual payments for talking therapy costs and employment training, and also means tested payment for the costs of bringing up children of an infected beneficiary.[59] It is not unreasonably asked how these are to be taken into account if not continued.

Recommendations

I recommend there are a number of ways in which the IBCA could be equipped to mitigate these risks:

65. When an applicant has to consider the options of taking a lump sum or a periodical payment, a detailed statement of the amounts receivable under each option should be given to the applicant.
66. The IBCA should also offer an objective comparison of the financial consequences of each option.
67. The IBCA should be able to offer, or direct award recipients towards a source of, high-level independent financial advice about the options for safely managing the award monies.
68. Funding for independent legal and financial advice, at the option of the applicant, should be offered to provide independent advice to assist the applicant choosing the option which is best for them, in particular children or those otherwise lacking the capacity to make this sort of decision for themselves.

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[59] There is a means threshold for this payment for infected beneficiaries of a household income of less than £37,900 and for a bereaved beneficiary of less than £28,401.

69. The IBCA, in line with the practice of some of the current support scheme administrations, should, on request, be empowered to offer certified statements and assurances as to the sums being awarded, including the security of periodical payments.
70. The IBCA must be empowered to offer statements to award recipients certifying the status of awards in relation to tax and social security benefits, and to intervene with relevant agencies in support of recipients where that is necessary and requested.
71. The Government should ensure that all relevant departments and agencies understand the status of a compensation award and implement procedures to protect recipients from unjustified investigations, inquiries and demands.
72. The Government should make provision for informing and advising award recipients of the risks of fraud and on how to avoid it.
73. The benefits offered by the scheme to eligible recipients for financial and other support services should be no less than those offered by any of the current support schemes.

Equalities impact

Several submissions have been made about the equalities impact of the proposals with some suggestions that they discriminate against women. In the time available I have been unable to take expert advice on this topic, but it is important that the Government satisfies itself that there is no unlawful discriminatory effect produced by its scheme as finally determined.

Recommendation

74. The Government should publish a statement of the equalities impact of its proposed scheme alongside the regulations it lays down for approval by Parliament.

Annex A: List of Recommendations

Development of the proposals and engagement

1. A greater degree of transparency should be adopted:
   a. The full reports of the advisory group and the full detail of the proposals we have been considering should be published immediately.
   b. A full explanation of how the recommended ranges of awards, or formulae for financial and care awards have been calculated should also be published, including identifying any comparators or statistics which have been relied on.
   c. The expert group's response to the points made in the engagement exercise and any modification of their previous recommendations should be published.
   d. The Government's response to the recommendations made by the expert group and in this report should also be published as soon as possible without waiting for the publication of the regulations.

2. The IBCA will undertake to be transparent in its decision-making in setting up the processes by which applications will be received and assessed, and awards made, and will set up mechanisms for ensuring that this is informed by the involvement of the infected and affected communities in their production.
3. I recommend that a provision is included in the regulations that there should be a review of the operation of the scheme after one year. This review should include and have regard to the feedback of scheme applicants and award recipients, and should consider whether any amendments are required. So far as possible, this should focus on issues which have led to the exclusion of categories of applicants, or denial of entitlement to defined award categories rather than re-opening cases in which an award has already been made.
4. I suggest that an early and public acceptance of the recommendations made in this report, in particular those concerning the continuity of support payments, will go a long way to allaying concerns that have been raised in the engagement process.

Support scheme payments

5. In order to create and maintain trust – and to respond to the very clear message from the infected and affected community – the existing support payments should continue to be paid under that name to all who currently receive them or are otherwise shown to be entitled to them. For the avoidance of doubt, that should include both living infected and living bereaved affected who currently receive such payments. However, given the advice that there are insuperable practical and legal obstacles to merging the support schemes into the compensation scheme within the time available, I suggest the Government considers preserving the existing schemes as they are currently administered with the compensation scheme assessing a compensatory award for support payment recipients to reflect their needs and losses not fully addressed by those payments. This arrangement could be continued for as long as is necessary to create the legal framework required to merge the support schemes into the IBCA under a framework arrived at in consultation with the infected and affected communities.
6. It should be open to anyone not yet in receipt of a support payment but who meets the eligibility criteria of the existing support scheme, to make an application for one, up until 1 April 2025.

7. As proposed already, support payments should not be taken into account in an award of compensation in the assessment of:
    a. Injury impact, social impact, autonomy awards. Again for the avoidance of doubt this includes that the elements of such awards which reflect future injury, distress and deprivation as well as past experiences;
    b. Financial loss awards in so far as they relate to care or losses occurring before the date of the award;
    c. Care awards in so far as they relate to past care. The currently proposed care award is to be made as a lump sum through a tariff-based calculation which does not differentiate between past and future needs. If that is maintained, a method should be devised to apportion part of the care award as a fair reflection of the applicant's future care needs for their life expectancy. The resulting lump sum should then be converted into a notional annual sum by a calculation which converts a lump sum into a notional annuity, adopting the discount rate used for the calculation of future damages.[60] The resulting notional annual figure can then be added to any annual financial loss

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[60] See footnote (61) below for details of this rate.

award for comparison with any support payment being received.

8. If and when support payments are replaced by payments made through the IBCA, in assessing care and financial support awards, the scheme compensation assessment should include an account of the support payments which would have continued after 1 April 2025 but for the creation of the compensation scheme. If the support payments which would have been payable exceed in value the assessed care and financial loss awards for future care and losses, applicants should continue to be entitled to the equivalent of support payments in full. As support payments are intended to continue for the life of the recipient, their value should be assessed on the same basis. The regulations should make it clear whether any exceptions to this principle are to be allowed.
9. Consideration should be given to my recommendation that support payments and their assessed equivalent as recommended above should be increased in accordance with what was said in paragraph 2.53 of the Framework report, and the potential effect on the sums received by eligible persons if that is not implemented, in the context of the undertaking that no one will be worse off.

10. In addition to receiving as a lump sum that part of the compensation award which consisted of the injury impact, social impact and autonomy awards, together with awards for past financial loss, the recipient who have been in receipt of support payments should continue to receive as periodical payments an equivalent sum. They should be given the choice of receiving the balance of their awards for future care [identified as described above] and future financial losses either capitalised as a lump sum or as guaranteed periodical payments. I also see no reason why a bereaved partner should be denied the option of a periodical payment reflecting the value of the care award, future financial losses for their lifetime.
11. To the extent that awards are taken as periodical payments, they should be uprated annually for inflation by the same measure used for court ordered periodical payments.[61]

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[61] An order for periodical payments made by a court in an award of personal injury damages must specify that the payments should vary annually by reference to the retail prices index unless otherwise ordered by the court: Civil Procedure Rules r41.8(1)(c). It is now common practice for periodical payments reflecting future care costs to be inflated by reference to the ASHE index for the remuneration of care providers: ASHE 6115, applying a specified percentile of that occupational group: Tameside & Glossop Acute Services NHS Trust v Thompstone [2008] EWCA Civ 5. Likewise appropriate occupational group indices from ASHE can be used for periodical payments reflecting future loss of earnings: Sarwar v Ali [2007] EWHC 1255. See generally McGregor on Damages 21st edition chapter 41 §41-024 – 41-030.

12. If taken as lump sums, awards should be capitalised in accordance with a method of calculation set out in the regulations. I recommend that the method adopted should be the same as used for calculating lump sum awards for future losses in court damages actions, namely by use of a multiplicand, multiplier and the discount rate prescribed under sections A1 and 1 of the Damages Act 1969, as amended by section 10 of the Civil Liability Act 2018.
13. It would be reassuring for recipients of continuing support payments if the arrangements for payment and communication while administered by the IBCA adopted the best practice of the existing national schemes.
14. The Scheme should confirm that entitlement to awards is available regardless of whether an eligible person is resident in the UK or elsewhere.

Severity bands

15. The advisory group review the proposed bandings in the light of the submissions made about them as described above.
16. The detailed reasoning leading to the proposed range of figures for awards be published.

17. I recommend that the advice of the expert group is followed with regard to the recognition of SCM eligibility.
18. I recommend that the best way of taking this form of psychiatric injury into account might be to allow a supplemental award for those who can show they suffered from one or more of a defined number of diagnosed mental illnesses or disorders, alternatively those who have suffered serious consequences as a result of a mental illness or disorder associated with an eligible infection. This might be achieved by adding this criterion to those supporting eligibility for the additional severity band equivalent to SCM I have referred to above, or by creating a separate supplementary enhancement.
19. If in fact the tariffs proposed by the expert group have taken into account the range of effects commonly experienced after treatment, I recommend that they should be invited to explain their reasoning for arriving at the tariffs they specify. My interpretation of the feedback from the community is that they consider the currently proposed figures to be too low to take into account the effects of treatment suffered by many. If the advisory group, on reflection, concludes that it needs to review tariffs to accommodate this point, I recommend that either their originally suggested tariffs should be increased to take into account the deleterious effects of

treatment, alternatively, a supplementary tariff be introduced for those applicants who can show serious effects over and above the generality of experience taken into account in the core tariff. Over 40% of one representative organisation's survey respondents thought that those treated with Interferon should form a separate award category. I recommend that regard should be had to the revised view of the expert group on whether to adopt one or other of these options.

20. I recommend that the clinical criteria for severity bands are set out fully to ensure that assessments can be concluded objectively and transparently.
21. With regard to the provision for deterioration, I recommend that applications for a revised award should be entertained only in the most exceptional circumstances, which were not taken into account during the initial assessment, and which would result in a manifest injustice to the applicant unless a revision of the award were allowed.
22. I recommend that the regulations make it clear that the Authority can devise its own assessment and decision-making procedures, including its approach to what supporting evidence is required.

Social Impact Award

23. I consider it reasonable to offer one flat rate lump sum for social impact. The way in which victims have been impacted is so variable that it is impracticable to reflect those variations in a tariff-based award with any accuracy. It is possible, for example, for a very severe impact to result from a short-lived experience suffered by a person with a low band of infection, and a less severe impact to be suffered over a longer period by an infected person in a more serious condition.
24. I recommend that the social impact award for affected persons be reconsidered. I suggest an increased figure be awarded to those affected persons most likely to have been particularly close to the infected. Given that there may be difficulties in proving cohabitation for a specified period, the increased figures could be offered to partners, children under 18 at the onset of infection, parents of infected children under 18 at the date of onset of infection and siblings. I suggest that for these groups a standard figure of £12,000 would be appropriate.

Tariffs

25. It is important that, with the assistance of the expert advisory group and legal advisers, the Government publishes a full rationale for the tariff figures it proposes, explaining how they arrived at them, and with what comparators they are to be compared.

Autonomy award

26. Applying these principles as best I can, I suggest that in cases where the infected person has been subjected to an unethical research project, it would be appropriate to add a modest sum to the general autonomy award tariff in the region of £10,000 to all categories of autonomy award. While this might seem generous in the case of the recommended award in HBV cases, the insult caused by being subjected to research is surely the same irrespective of the disease. For the avoidance of doubt, I recommend that this enhancement should be available to any infected person whose treatment was part of one of the unethical research projects explicitly identified in the Inquiry report. I suggest that agreement is sought with groups representing the community as to the identity and dates of such projects, and how involvement in such a project might be established.

27. I would suggest consideration of one exception to this general figure; namely that an enhanced figure could be awarded in the cases of children who were subjected to research while resident at an institution, such as Treloar's. The feelings of injury are likely to have been exacerbated by the fact that the research was not only unethical in a clinical sense, but also because it was a breach of trust at an institution intended to be a place of safety. In such cases, I suggest an enhanced award of £15,000 could be considered.

Care awards

28. It would be of considerable assistance to the Authority in assessing supplementary claims to be given a more precise description of the type of care that is intended to be covered by the proposed core approach. There is a risk, which I cannot quantify, of a large number of supplementary claims of this nature, which could be better addressed by a more generous core award formulation.
29. It could be made clear that a supplementary claim could be made in respect of exceptional care needs by way of reducing or eliminating the proposed discount.

30. The expert group should be asked to identify the appropriate rates for compensating for agency charges.
31. I recommend that reference index is changed accordingly (from RPI/CPI to ASHE for care costs).
32. I recommend that the actual cost of paid for care be allowed, if reasonable.
33. I consider that where this is shown not to be applicable in individual cases, a supplementary claim should be allowed, as it should be wherever there is evidence that the core award would underestimate the length of any particular stage of care needed.
34. It would be helpful if the reasons for the expert group's recommendation in this regard were spelt out.
35. A more precise table of hourly rates, and hours care provided for should be published, together with an identification of the source for the rates used.
36. Supplementary applications should be allowed to award the actual cost of past care provided where this was paid for and the amount of care provided and its cost were a reasonable reflection of the infected person's needs.
37. It should be clarified whether or not a carer's loss of earnings can be claimed by the supplementary route to reflect the value of care provided, or whether such claims would be limited to seeking recompense

for a greater number of hours care and/or a lesser discount form the commercial rate relied on.

38. The uprating for inflation to be applied to periodical payments for future care should be by reference to the ASHE Table 26 [care workers, home carers and senior care workers] index.[62]
39. If the IBCA agrees – at the request of the infected person or their estate – to pay a care award direct to a nominated carer or carers, it should be on condition that the responsibility for meeting the obligation to compensate carers remains with the infected person or estate.
40. The procedure for making claims should allow for intervention by an affected person to offer evidence of their contribution to the provision of care.

Financial loss awards

41. I suggest that there are a number of points where further explanation would be helpful:
    a. In relation to a living infected person, is the calculation intended to be based on their self-declared condition at the date of application, or

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[62] Formerly ASHE 6115: ONS Earnings and hours worked, care workers: ASHE Table 26

an assumption based on the time since onset of the disease?

b. Is it intended that all those who were out of all paid work because of their condition should have to make a supplementary application? If so, Is there any evidence to suggest what proportion of the infected cohort might have to pursue a supplementary application?

c. It may help public understanding for the workings behind the financial loss elements of the illustrative awards at pages 21 to 26 of the proposals to be disclosed.

d. At the point of determination of the tariff, sufficient detail must be included to enable both the Scheme and the applicants to understand what the core tariff result is for them.

e. How is it envisaged that the various stages assumed in the progress of disease or care needs would be reflected in payments, if that is the option chosen by the applicant?

f. What account, if any, is to be taken of actual earnings, either against a core or a supplementary route award?

42. On the basis of the evidence, I agree that the proposal should be amended accordingly, to allow for a disregard of the assumption, subject to the provision of some evidence of ongoing chronic fatigue, if that is the ground relied on. The implication of the advice is that not all other infected persons will have been able to return to work. Accordingly, I recommend that on production of some evidence to support such a claim, such as a medical certificate, a supplementary claim should be allowed.
43. Given the universal desire to simplify the application and assessment process – and reduce the evidential burden – I suggest that, where possible, reliance should be required to be placed on comparable ASHE statistics; supported by relatively simple evidence of the infected person's employment record or capacity.
44. Reliance on employment experts or the like should be discouraged, if not completely disallowed.
45. The Government with the assistance of the advisory group should assess for itself the extent to which the current proposed standard multiplicand, based on the ASHE median figure, is likely to accommodate the great majority of claims.
46. A second type of supplementary application, if allowed, is likely to be from those that want to challenge the assumption that an infected person retained a partial earnings capacity. Some of those

have been referred to in the previous section. Guidance will be required on the approach that the IBCA should take in such cases. Would it be sufficient for it to be shown that the infected person was in fact out of work? If so, should evidence be required as to the reason for this?

47. Consideration should be given, as a matter of policy, as to whether there should be a maximum award permitted for the loss of earnings component of financial loss awards.
48. An expanded explanation of the proposals should be published explaining in more detail all of the matters referred to above.
49. Consideration should be given to amending the scheme to reflect the revised advice of the advisory group about the impact of treatment on earning capacity.
50. It should be made clear whether there is a cap, or other form or restriction, or requirement for a supplementary route claim for financial loss, and, if there is, the reasons for the cap.
51. The sum proposed and previously recommended as a lump sum for miscellaneous costs should be reconsidered to reflect whether it provides a fair assessment of the costs that infected persons may have incurred.

Claims involving deceased infected persons and their estates

52. The method of calculation of loss of dependency – whether by the core or supplementary route – should be spelt out in full in the terms of the scheme, to enable the assessment and outcome to be transparent and clearly understood, and an explanation for the reasoning leading to those terms should be published.

53. Legal support should be funded for the personal representatives of a deceased infected person to prepare and make a claim, including in a claim for the loss of dependency of all relevant affected persons. Consideration should be given to creating a panel of solicitors experienced in probate issues to whom personal representatives could be referred to for advice. Such a panel should be selected on criteria which include those recommended for the general legal advice panel.

54. Personal representatives should be encouraged to identify to the Authority all persons they believe may have a claim as an affected person and to notify such persons they have done so. This will facilitate the Authority's task in identifying eligible persons and establishing whether they wish to make a claim,

however, this will not prevent others coming forward to make an application.

55. Consideration should be given to allowing, as part of the financial loss award, a standard sum to reflect the cost of administering the claim on behalf of the estate.

56. While the IBCA should not be required to adjudicate on or intervene in disputes between the estate and associated affected persons, consideration should be given to whether an outsourced mediation service could be made available on standard terms with regard to fees payable by the parties in disputed cases. This needs to be independent of the IBCA itself because it is likely to be affected in its views by its assessment of applications.

Age limits for children and siblings

57. I recommend that clarification be sought for the reason for this, and consideration given to how to provide for consistency of approach. At the same time, consideration could be given to whether the reasons for not entitling persons in the second category above to a social impact award remain sound.

58. I recommend that consideration is given to the suggestion that children separated by reason of the disease or family breakup should be treated as living with the infected person.

Taxation

59. The Government should clarify how it proposes that future losses should be calculated under the scheme and, in particular, to identify by what discount rate, if any, the Scheme will adopt and how factors including inflation and the incidence of taxation on investment income are taken into account.
60. The Government should confirm that awards – whether lump sums or periodical payments- are to be made free of tax.

Legal support

61. The IBCA should be funded to make arrangements for an independent legal advice service available to all applicants, who are not otherwise legally represented to offer advice on their entitlement to make an application, and to support their decision whether or not to accept the offer of an award.

62. The IBCA should be empowered to appoint a panel of solicitors accredited as having demonstrable experience in the scandal and its effects to provide legal services to the victims.
63. The IBCA should, on application, agree to offer funding at prescribed rates and on such other conditions as the IBCA thinks fit to a legal representative retained by any applicant to assist and advise them in the making of their application and in understanding an offer of an award and their resulting choices.
64. Any offer of legal support funding should be conditional on the legal representative undertaking to the IBCA and their client that they would not charge their client any further fees for their work on those matters, and not enter into any agreement with the client or place them under any obligation to pay any part of an award to them, whether in connection with funded work or any other work in connection with the application.

Financial and other advice and support

65. When an applicant has to consider the options of taking a lump sum or a periodical payment, a detailed statement of the amounts receivable under each option should be given to the applicant.

66. The IBCA should also offer an objective comparison of the financial consequences of each option.
67. The IBCA should be able to offer, or direct award recipients towards a source of, high-level independent financial advice about the options for safely managing the award monies.
68. Funding for independent legal and financial advice, at the option of the applicant, should be offered to provide independent advice to assist the applicant choosing the option which is best for them, in particular children or those otherwise lacking the capacity to make this sort of decision for themselves.
69. The IBCA, in line with the practice of some of the current support scheme administrations, should, on request, be empowered to offer certified statements and assurances as to the sums being awarded, including the security of periodical payments.
70. The IBCA must be empowered to offer statements to award recipients certifying the status of awards in relation to tax and social security benefits, and to intervene with relevant agencies in support of recipients where that is necessary and requested.
71. The Government should ensure that all relevant departments and agencies understand the status of a compensation award and implement procedures to protect recipients from unjustified investigations, inquiries and demands.

72. The Government should make provision for informing and advising award recipients of the risks of fraud and on how to avoid it.

73. The benefits offered by the scheme to eligible recipients for financial and other support services should be no less than those offered by any of the current support schemes.

Equalities impact

74. The Government should publish a statement of the equalities impact of its proposed scheme alongside the regulations it lays down for approval by Parliament.

Annex B: The Government proposal on which I was asked to engage

https://www.gov.uk/government/publications/infected-blood-compensation-scheme-summary/infected-blood-compensation-scheme-summary