



Rt Hon Nick Thomas-Symonds MP
Minister for the Cabinet Office
His Majesty's Paymaster General
Cabinet Office 70 Whitehall London SW1A 2AS

30 October 2025

Dear Minister,

I am writing on behalf of the Technical Expert Group to summarise the advice we have given during the initial phase of our work programme. I am grateful to you for extending our membership to include additional expertise in transfusion medicine, haematology, psychology and psychiatry. I would also like to record my thanks to all my colleagues on the Group for working intensely to produce this initial advice in the few weeks since we were established.

The first phase of our work programme supports preparations for public consultation on aspects of the additional recommendations of July 9th 2025 from Sir Brian Langstaff, which we understand is soon to commence. More detailed summaries of our deliberations are contained in the minutes of our meetings. I understand the minutes will also be published today alongside this letter.

This is our initial advice. We will continue to work on the recommendations in accordance with our published workplan, including developing proposals to engage with the infected blood community. This will enable us to finalise our advice with the benefit of that engagement and knowledge of the responses to the consultation.

Recommendation 4a: Recognition of the impacts of interferon treatment

The impacts of interferon treatment are currently recognised within the compensation scheme in the quantification of injury awards and in the Severe Health Condition (SHC) supplementary awards relating to some rare but very significant adverse effects (e.g. the development of autoimmune thyroid disease following interferon treatment). Having considered the observations of the Inquiry in its Additional Report, reviewed again evidence presented to the Inquiry and reflected on community feedback on the earlier proposals, we offer the following initial advice.

1. The injury award levels for chronic hepatitis were fixed by comparison with judicial awards (as recommended by Sir Brian Langstaff in his interim report on compensation). These included cases brought by infected persons against

the National Blood Authority in 2001 where interferon treatment had been received. However, they may have involved less severe impacts than the Inquiry has found is normal. It is difficult to be confident of how more severe impacts would be considered. Even so, we advise that the injury awards should be uplifted by £10,000 for those who were treated with interferon as recognition of the impact of interferon treatment. That amount is in excess of the component of judicial awards in 2001 (uprated for inflation) that were stated to relate to interferon in a case where the impacts of treatment were considerable and seems to us broadly consistent with likely court awards.

2. We believe that during treatment for interferon it is likely that care needs arose that are inadequately compensated in the current core awards. Our advice is that this could be addressed by uplifting the care award for any year in which interferon treatment was received to cover 16.5 hours care per week. No specific evidence of receipt of care should be required as this can be reasonably inferred from the impact of treatment.
3. We consider it likely that people's ability to work would have been reduced while being treated with interferon and for a year afterwards. We suggest that a reduction of 80% in earning capacity should be recognised in the financial loss awards for this period. Some people will have managed to work while undergoing treatment but most would not and it would be disproportionate to seek specific evidence of loss of earnings. Rather this can be taken to be likely if there was a course of interferon treatment and no further evidence should be required.

We have deliberated whether these impacts would be experienced by everyone who was treated with interferon and consider that there will be some cases where the treatment was quickly abandoned and the impacts were therefore only short-lived. As a result, we advise that eligibility should arise where there has been a course of treatment, such as 12 weeks. However, we recognise that this may be difficult to evidence and believe it is best to err on the side of inclusion if this is the case. It would be useful to consult on the availability of such evidence.

Recommendation 4b Recognition of Special Category Mechanism (SCM)

Extensive TEG discussions have led us to conclude that it would be advisable to create an additional category of Severe Health Condition to cover any gaps with the current SCM (and equivalent categories in the Scottish, Northern Irish and Welsh schemes) rather than make amendments to existing categories.

We recommend that the English scheme's assessment criteria are used as the basis for determining eligibility for the additional Severe Health Condition award. This is the scheme under which most beneficiaries are receiving additional payments, with equivalent criteria in Wales and Northern Ireland.

In respect of the quantification of awards for those eligible for the new SHC category, we offer our initial advice below but intend to deliberate further on the comparisons of support schemes' approach with the Compensation Scheme's provisions as we do

not find these straightforward. For example, SCM Payments were designed to address current support needs and not lifetime impacts. In addition, it was envisaged that beneficiaries might return to the lower support payments if adverse impacts on their lives reduced, although it is not clear to the TEG whether this did in fact happen. Further, the value of SCM payments were not calculated by reference to care costs or financial loss, although the description of the impacts that were considered in assessing eligibility includes elements that would be compensated under these headings in the statutory compensation scheme. So that we can provide more detailed and better informed advice in due course, we intend to draw together material on these and other issues relating to SCM to inform engagement with members of the infected communities over the next few months . This will be independent of the Government's consultation process and limited to improving our expert advice, which you will want to consider alongside the consultation responses.

In advance of this, we offer our advice on a number of issues that we consider should be fed into the proposals on which you will consult.

1. Our discussions with EIBSS assessors and review of documentation confirm that eligibility for SCM was determined after the submission of evidence about current impacts of infection and treatment. Such evidence was considered against detailed criteria by medical assessors. For those who have already been assessed by existing support schemes, we consider that they should qualify for the new category of SHC from the date of any such assessment. However, when there has been no such assessment, we think it likely that this approach can only be adopted in respect of living beneficiaries. This is in contrast to the existing SHC categories where it is likely that the records relating to deceased victims will contain evidence including the relevant clinical markers, enabling eligibility to be established. We intend to explore the issue of deceased beneficiaries further when we engage with the community.
2. We note that the existing support schemes were not open to people who contracted Hepatitis B. We have yet to give detailed consideration to the need for revision to the current eligibility criteria for SCM to accommodate the impacts of HBV but will do so over the next few weeks. This is an area where engagement with the community will be of great assistance.
3. The diversity of impacts that are recognised by the SCM Award make it difficult to quantify the care and financial loss awards. We wish to give further consideration to this issue as we continue our review of the criteria. The TEG considers that it would be reasonable for the Government to base its consultation on equivalence between the new category of SHC based on SCM categories with the existing long-term severe disability category of SHC. Our understanding of the Inquiry's Additional Report is that it expressed a concern that this category was insufficiently comprehensive rather than set at an inappropriate value. This leads us to suggest that financial loss should be set at 70% reduction in earnings for years when treatments had limited effects and 60% when they improved. On the same basis, care awards should cover additional compensation for 6 hours per week domestic support and ad hoc care.

Recommendation 5a Severe psychological harm

The TEG has reviewed the ways in which psychological harm is currently recognised in the compensation scheme. This includes the quantification of injury, autonomy and social impact awards, using legal comparators where compensation was awarded for mental ill health, emotional distress, stigma and social isolation. These were included in the core awards because they will have been widely experienced. The assumptions made in the tariff-based system for financial loss was that both psychological and physical impacts would impair people's capacity to work.

Having explored the issues with leaders from the Infected Blood Psychological Service, our initial advice is that the suggestion made by the Inquiry's Additional Report to create a severe health condition based on a formulation-based opinion of a qualified psychological professional is not compatible with the structure of the compensation scheme. This is because formulation-based opinions are co-created with patients in order to guide therapeutic plans and are not a guide to the severity of psychological harm. To use formulation-based opinion would require, more often than not, a new expert assessment. Even with an agreed battery of psychometric measures, it is not clear that severity could be diagnosed retrospectively as these measures would assess current levels of impairment. This would be inconsistent with the principles on which the compensation scheme has been developed. It is also unclear how assessments would reliably correlate to people's ability to earn or care for themselves, which are the categories of award that would be increased through a SHC.

Our initial advice is that it might be best to approach compensation of those whose mental health has been particularly severely impacted as part of the new SHC addressing the SCM category. We reach this view noting that the majority of SCM beneficiaries are eligible by reason of their mental health. We consider that this approach is more likely to lead to inclusion of all those that the Inquiry felt were wrongly excluded than would a separate category of severe psychological harm. We anticipate that we will revisit this conclusion in the light of the consultation responses and the TEG engagement with the community before giving final advice.

Recommendation 6b Exceptional financial loss

The TEG has considered the legal advisors' explanations of the approach that judges take to make awards that they consider fair, based on reviewing all the evidence put before them by the parties and taking into account a wide range of factors. This is not compatible with a tariff-based approach, which is why judicial tariff guidelines limit themselves to general damages (covered in the compensation scheme by injury, social impact and autonomy awards).

As the Inquiry's Additional Report noted, it is unusual for there to be any evidence which will show on balance of probabilities that earnings would have been higher than UK median earnings. We have considered whether provision could be made for those who had secured professional qualifications; for example as lawyers, accountants, or medical doctors. However, we noted that these professions had

significant drop-out rates and also a wide range of lifetime earnings. It would be possible to examine median salaries and to seek to create a profile that would take into account years of training when earnings were lower than provided for in the compensation scheme (which assumes an even earning level across every year of working age life). However, we do not think this would lead us to conclude that it was probable that people would achieve higher lifetime earnings than already allowed within the scheme. We also noted that if eligibility were expanded to cover some groups with defined career tracks it may create inequity between those who can benefit and those who cannot. Our advice is therefore that future earnings of potential high earners are too speculative to be accommodated in the tariff-based compensation scheme. We note that those individuals who consider that they have compelling evidence will be free to put the issues before a court.

Recommendation 8a Affected supplementary route

Given our current view (prior to consultation) that a new SHC addressing severe psychological harm is not workable for infected people we further conclude this approach cannot be the way forward for the affected.

We consider that rather than seeking to define eligibility by requiring evidence of particular harm, it may be more helpful to describe those who are likely to have suffered particularly badly. This approach could lead to an increase in injury awards. We have not yet considered how such groups might be determined. Understanding the views of the community on this point is important and we would like to see these elicited as part of the consultation. The TEG will consider this further in the light of consultation findings and feedback from the community.

Yours sincerely,

A handwritten signature in blue ink, appearing to read 'Jonathan Montgomery', with a long horizontal line underneath it.

Professor Sir Jonathan Montgomery FMedSci
On behalf of the Technical Expert Group