

Witness Name: David Foley  
Statement No.: WITN7757011  
Exhibits: WITN7757012 -  
WITN7757020  
Dated: 20 May 2025

## INFECTED BLOOD INQUIRY

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### THIRD WRITTEN STATEMENT OF DAVID FOLEY

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I provide this, my third witness statement, in response to further requests for disclosure under Rule 9 of the Inquiry Rules 2006 dated 12 and 13 May 2025.

I, David Foley, will say as follows:

#### Introduction and overview

1. This statement should be read alongside my first two witness statements and oral evidence given to the Inquiry at the hearing on 8 May 2025. This information builds on the evidence already given to the Inquiry and provides further detail, as requested by the Inquiry, on the areas identified in the Rule 9 requests.
2. In **Section 1**, paragraphs 1-9, I respond to questions regarding IBCA's Clinical Advisors including specialisms, recruitment and processes. This addresses questions 1-5, and 13 in the Rule 9.

3. In **Section 2**, paragraphs 10 to 11, I set out the training provided for Claim Managers and how this is kept up-to-date. This addresses question 7 in the Rule 9.
4. In **Section 3**, paragraphs 12 to 17, I provide further explanation of IBCA's approach to Infection Severity Levels for Hepatitis B and C. This addresses question 9 in the Rule 9 as well as further questions 2-6 addressed via the Rule 9 of 13 May.
5. In **Section 4**, paragraph 18, I describe IBCA's current policy team, addressing question 1 of the 13 May Rule 9.
6. In **Section 5**, paragraph 19, I explain how Claim Managers tell those making claims about legal and financial support in response to question 10 of the 12 May Rule 9.
7. In **Section 6**, paragraphs 20-31 I provide further detail on IBCA's processes including changes made through the test-and-learn process, options for further proposed changes to the process and review processes. This addresses questions 6, 8, 11-12 and 20-23.
8. In **Section 7**, paragraphs 32-34, I explain the background behind the claims manager letter (DHOL0000003) in response to question 17.
9. In **Section 8**, paragraphs 35-36, I set out IBCA's view that it does not have the power to make interim payments addressing question 18.
10. In **Section 9**, paragraphs 37-41, I discuss current understandings around the onboarding of future cohorts and timelines addressing questions 14-16 and 19.

## Section 1: Clinical Advisors

1. I have been asked about the experience and qualifications of IBCA's current Clinical Advisor.
2. IBCA's current Clinical Advisor has substantial experience in treating infectious diseases with a specialism in HIV and in travel and tropical illnesses. They have spent many years working in Hepatitis B and C clinics. Since 2020 they have been a medical assessor for the England Infected Blood Support Scheme (EIBSS). We recognise that additional advisors with a range of experiences and backgrounds are needed as claim numbers increase, and more detail on this recruitment is provided later in this section.
3. Both from the current advisor's experience on EIBSS and wider review they have a detailed understanding of the history of the scandal, the clinical practices of the time and the associated medical conditions. The Clinical Advisor has also been provided with information on the Victims and Prisoners Act ("the Act") and the Infected Blood Compensation Scheme Regulations 2025 ("the Regulations")<sup>1</sup>, the role and training of Claim Managers and how IBCA supports claims so that the Clinical Advisor understands the support that may be required to help Claim Managers ensure that eligible people making a claim receive all the compensation due to them.
4. Currently the Clinical Advisor is working part-time as needed, typically working 2-3 hours per week providing direct support on claims. In addition to the provision of advice on individual cases, the Clinical Advisor will also provide training<sup>1</sup> for Claim Managers where requested including on particular diseases and their impacts on individuals and may be asked to sit on Appeal Panels where appropriate.
5. In practical terms the Clinical Advisor leads calls in which Claim Managers can discuss any claims on which they work, and would like support. At

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<sup>1</sup> For the avoidance of doubt, any reference to the Regulations refers to the 2025 Regulations and any previous guidance or training based on the 2024 Regulations has been updated where necessary.

present, the calls take place generally twice a week, though this can be increased at need. In advance, Claim Managers provide the Clinical Advisor with an anonymised synopsis of the case and the information to be considered. The Claim Manager documents the information and advice they receive from the Clinical Advisor within their Decision Log and also discusses this with the person making the claim. If the person making the claim has any questions or would like anything additional to be provided to the Clinical Advisor, the Claim Manager will facilitate that. It is then the responsibility of the Claim Manager to use this information to make a decision on the claim.

6. As mentioned above, we have been seeking to bring on more Clinical Advisors and as of 14 May we have a contract with a healthcare resourcing company to provide approximately 10 Clinical Advisors including those with specialisms in Haematology, Hepatology and Gastroenterology. Clinical Advisors will be provided with a full history of the scandal including the impact on record keeping and the need to make judgements based on the available evidence which may be historic and partial. The number of Clinical Advisors will be kept under continual review. The Service Specification is exhibited at WITN7757012.
7. In keeping with our 'test and learn' approach, and based on the experience of working with our current Clinical Advisor, we have developed Decision-Making forms in which the Claim Manager can provide the Clinical Advisor with the (anonymised) information that they have, including that provided verbally or in writing by the individual, and indicating the area in which they need advice to support a balance of probabilities assessment. These areas will include: advice on the infection diagnosis; advice on the diagnosis date; advice on the likely infection context; and advice on the likely infection severity history. The Claim Manager and Clinical Advisor will then discuss the case and the clinical advice and this will, as currently, be recorded in the Claim Manager's Decision Log and the person making the claim will be told about the advice received. This process will also apply as we work with an increased number of Clinical Advisors as claim numbers continue to increase, and will help to ensure that a Clinical Advisor with appropriate experience reviews each case that requires

clinical advice. Where the advice provided is applicable to other cases this will be incorporated into guidance and training for all Claim Managers, to ensure consistency in decision-making.

8. At present we do not track how often decisions are made 'on the basis of the balance of probabilities' rather than there being sufficient evidence to determine the outcome; neither is information separately collated of when clinical advice has been sought, but we are considering if and how this can be captured in future. The person making the claim is always made aware of the basis on which the Claim Manager has made their decision, including where they have sought clinical advice and what that advice has said.
9. Further, IBCA is in the process of setting up a Clinical Panel. This will be an experienced group of leading clinical and medical practitioners. This will be a further source of expertise to ensure that the clinical elements of our work are of the highest standards, including, where needed any decisions of "policy" on clinical matters.

## **Section 2: Claim Manager Guidance**

10. I have been asked about the guidance given to Claim Managers on the Regulations. As set out in my first witness statement, *"every claims manager receives a minimum of 3 weeks classroom training with ongoing consolidation following the classroom. This training includes both technical information on the scheme and trauma-informed learning. There is specific provision in the training that supports Claim Managers to identify and respond to any safeguarding concerns."*
11. If an issue arises on the interpretation of the Regulations or through the test-and-learn process, the Claim Manager will raise this with the Service Design team who will take this for discussion to IBCA's Policy Forum. This group meets regularly to discuss issues that have arisen and to agree an approach. I have exhibited the Terms of Reference and minutes of the Policy Forum and WITN7757013-WITN7757016. This is incorporated into guidance and shared



with all Claim Managers; consequently, that part of the guidance that includes any aspect of 'policy' is liable to constant changes. IBCA has considered publication of internal guidance but has determined that this is unnecessary where assistance can be given directly to any who require it and publication poses an unacceptable risk of impacting IBCA's work through the increase in fraudulent claims and their sophistication. Nevertheless, however pressing the need to safeguard against fraud and prevent the system being overloaded by fraudulent claims diverting resources from genuine claims, this will not prevent IBCA from continuing to publish information wherever possible on our approaches and seek views on IBCA's policies with community groups and legal representatives.

### **Section 3: Level 3 Severity**

12. I have been asked about how Claim Managers approach severity levels as it appears in Level 3 in Schedule 1 to the Regulations, and in particular the part of the definition which refers to "*Cirrhosis, characterised by serious scarring (fibrosis) of the liver caused by long-term liver damage caused by infection*". Claim Managers are asked to look for information that confirms cirrhosis or serious scarring or serious fibrosis (as well as any evidence of B-cell non-Hodgkin's lymphoma and Type 2 or 3 cryoglobulinemia caused by infection accompanied by membranoproliferative glomerulonephritis which also provide evidence of Level 3 severity in the Regulations).

13. This evidence could be a medical opinion from a clinician stating that their patient had cirrhosis or had a liver that was cirrhotic, a diagnosis of severe fibrosis or severe scarring, or a Fibroscan score of above, for example, 13, then the Claim Manager is likely to determine this is evidence of Level 3 severity.

14. Where the language is ambiguous with no indication of severity - or where test scores are ambiguous based on clinical advice - then Claim Managers are expected to assemble all the relevant information needed for the Clinical Advisor to be able to provide informed advice. This is because diagnosing

cirrhosis at the borderline between the two (our Clinical Advisor indicated 10-12) requires the case details to be considered in the round. This is consistent with the Expert Group's advice to the Cabinet Office that 12.5kPa would be an appropriate cut-off. An example of the relevant medical indices, to which I referred in my evidence on 8 May, are exhibited at WITN7757017.

15. When a Claim Manager asks for Clinical Advisor advice for a cirrhosis issue, they are briefed and told to provide evidence of the earliest mention of key words, symptoms, tests and treatments relating to Level 2 and Level 3, with context, for the Clinical Advisor to consider. The processes are as set out above in paragraphs 7-9. This does not require a diagnosis of cirrhosis to be assessed as Level 3 severity. The Clinical Advisor will consider the case in the round with all the evidence that can be provided in order to inform their advice to the Claim Manager. The Claim Manager will then make a decision taking account of all the information available within the regulatory parameters.

16. We are in the process of reviewing all cases where severity was assessed at Level 2 and there was a query over whether something was chronic or cirrhotic and where Fibroscan scores were above 10. All these cases had been referred to the Clinical Advisor for expert input. The individual determinations made in each case would depend on the specifics of the case. The person making the claim would, of course, be able to request an internal review if they were not satisfied with the determination.

17. IBCA has not discussed this issue with the Cabinet Office.

#### **Section 4: Policy Team**

18. I have been asked about IBCA's policy team. IBCA is in the process of recruiting for a permanent operational policy team which will report to the Service Owner (IBCA's Director of Digital and Service). An interim policy team is currently staffed by temporary resource, reporting to the Service Owner, and supported by staff from the Programme Delivery Team. Ultimately

matters of operational policy are for decision by the senior leadership team of IBCA who are responsible and accountable for delivery of the regulatory obligations; matters of law will be the subject of legal advice where they arise.

## **Section 5: Legal and Financial Support**

19. I have been asked about how Claim Managers provide information about legal and financial support. Information about this support is provided to those making claims from the beginning of the process. The Claim Manager will discuss this with the claimant and, if they receive no response to the email with details of the support available, then discuss it at their next conversation. The same process is followed for the provision of financial advice. I have exhibited the letter template at WITN7757018 (it should be noted the template is only a starting point that may be amended if, for example, the person making the claim has already informed us they wish to use a lawyer who has previously supported them). Those making claims are then reminded of this support when provided with their offer as per the example exhibited at WITN7757019. At any point during the claim process, a person claiming can ask for details of this support.

## **Section 6: Processes**

20. I have been asked about the test-and-learn process and what we have learnt. IBCA has, and is still, learning a significant amount which we use to constantly improve our support to people making claims. To respond with some examples in the limited time available I have exhibited a document as WITN7757020 which sets out some of this learning which includes:

- the 2024 Regulations prevented us from paying infected bereaved partners' infected claims. This is because the 2024 Regulations disallowed partial deregistration - if someone were to be paid their Core compensation as an infected person, they would have to stop receiving their bereaved partner payments too. The 2025 Regulations has slightly different language within it, and the IBSS have made changes to scheme rules and processes on their side, so that we can now pay



infected bereaved partners their infected payments alongside all other registered infected claims.

- we adjusted our approach to the initial call between people making a claim and Claim Managers to ensure we were meeting the needs of those making claims. In particular we observed the value of offering video calls for those who choose it to support with building a relationship and those who benefit from visual aids for their memory. This allowed us to build video calling requirements into our telephony platform.
- we found that the standard requirement for a consultant signature was adding time to the processing of claims when the work to gather the evidence has already been done by a nurse practitioner who is familiar with the patient and their history. As a result we adapted the form to include the signature of other registered healthcare professionals such as Advanced Nurse Practitioners, to speed up the time in which evidence could be returned to us.

21. I have been asked about the information provided to people making a claim when they are made an offer. When a Claim Manager makes an offer they first, at declaration stage, review the information with the person making the claim, to confirm they are confident that all the relevant information has been considered. The offer letter then sets out how the compensation amount has been calculated, reminds the person claiming about the support available including legal and financial advice, and sets out options for having the offer reviewed. I have exhibited an example offer letter at WITN7757019.

22. I have been asked to set out if IBCA would see any disadvantages to a system in which people have the option to provide to IBCA with a completed application form with/without calculation of compensation that either they or a funded legal representative has completed.

23. We are always considering and seeking ways to make the process more efficient while ensuring we are supporting those claiming. If individuals already have all the necessary information, that is welcome and we can

certainly use this to speed up the information and evidence gathering stages of the claim journey. In many cases, we do see this already when claims are started. As a result, we are already exploring how we can provide the option to move straight to the declaration stage for individuals where we hold all the necessary information and we will explore how we can continue to work with claimants and legal representatives to support the provision of the information that they hold in this process.

24. On the question of prioritising any group, for example those with legal support where all their information may have been gathered, wider issues arise around overall fairness. Inevitably, if claims are being dealt with as a priority, other claims that would otherwise have been considered on a straightforward system will be pushed back. To prioritise those who have full information pushes back those who, for no fault of their own, do not have full information. Using the instruction of legal advisers as a basis for prioritisation raises other issues. Accordingly, it would be incorrect to see this as an obvious 'win/win' matter.

25. One of the disadvantages, or risks, that we are trying to manage of an application form process is that this may lead individuals, or their representatives, to seek evidence and information from clinicians and centres before their claim has begun. We are working with those providers to minimise any delays in the provision of evidence. Multiple requests from individuals for different records could create significant delays across all claims which we naturally want to avoid.

26. In any event, IBCA will still need to complete a calculation as set out in the Regulations. This calculation will be based on the provided information and evidence in order to be assured of the accuracy in making an offer.

27. I have been asked which data points or evidence are proving problematic or causing claims to take longer to process. Currently we don't have any identifiable common causes for which evidence proves particularly problematic as this can vary case by case. As I have said above, we are

working with information providers on how we can make all processes more efficient. If evidence does emerge around any particular evidence gaps, we will work with them specifically to tackle that issue.

28. I was asked to consider whether IBCA would be able to do its work more quickly and effectively if instead of looking for a date of diagnosis, it was required to look for a date of exposure. We are still considering this; our initial assessment is that this may in some cases speed up the process, but it is difficult to be certain as we have not tested this through any real cases.

29. I have been asked whether there has been a change in the information provided to those making claims from their IBSS information. IBCA shares with the person making the claim, and their representatives, all the information that is used to calculate the offer. This has been IBCA's consistent process at the declaration stage. We are aware that in some cases representatives have asked to see wider information including that not used to calculate the claims and we are discussing how IBCA might approach that.

30. I have also been asked to confirm the position in terms of requests to haemophilia centres and clinicians for records. When we start a claim, we review the claim file made of evidence that we received from the IBSS scheme and archived materials from the Skipton Trust. Where there are gaps, we discuss with the person seeking compensation how best to bridge those gaps, as in some cases the individual has evidence themselves that can be used, and which they can provide to IBCA to progress. In cases where we need to seek additional information, we will discuss with the person seeking to claim compensation what we need to demonstrate and routes to access that evidence. Commonly this is either where one needs to ascertain an infection date, or a change in the severity of an infection.

31. As regards the process for reviewing claims before offers are made, once the Claim Manager has agreed the evidence on which the claim should be based with the person making the claim (the Declaration), a 'buddy' Claim Manager will perform the same calculation in parallel to assure the calculation. This is

then passed to a Finance Checker who confirms that all relevant information is in place and that the calculation has been properly performed. At the point of payment, once the offer is accepted, further checks are also undertaken by a fraud checker to ensure that the payment account is not fraudulent and to ensure bank details are properly entered. In addition, there are regular assurance checks undertaken by Team Leaders by means of 'sampling' that all processes are being followed both technically and compassionately, so that those making claims are being sensitively and appropriately supported.

#### **Section 7: Letter from Claim Manager (DHOL0000003)**

32. I have been asked about the email which has been shared by the Inquiry as DHOL0000003. This email was written to support a Claim Manager who was engaging with a solicitor acting on behalf of a claimant. The solicitor had asked for an explanation of why the claimant's HIV infection date could not be placed before 1 January 1982, despite them having multiple treatments prior to this date and their belief that the infection likely occurred earlier. The intent was to help the solicitor better explain the rationale to their client, with clarity and compassion, and for this reason set out an understanding of the reasoning in the Regulations.

33. The specific scenario involved a claimant without a single, known infection event. In such cases - where the infection date cannot be directly attributed to a single treatment - we apply the earliest possible date that falls within the liability window, in line with the Scheme Regulations.

34. The email was drafted by a member of IBCA's Operations Team and was discussed with IBCA's Operational Policy Team before it was sent. The Cabinet Office was not consulted on the email before it was sent.

#### **Section 8: Interim Payments**

35. I have been asked whether IBCA considers that it has the power to make interim payments. IBCA's powers are set out in the Act and the Regulations. There is no power granted by either for IBCA to make interim payments.

36. I would observe that a practical consideration around any decision to award interim payments, were it possible, would be the need to determine eligibility for those not already registered on a scheme. IBCA is currently developing the processes and approach for assessing eligibility. As noted, once these are available it is likely that the time taken to assess eligibility for any interim payment will be a substantial part of the time taken to assess the whole claim. Once eligibility has been assessed it may therefore be more suitable to assess the whole claim rather than to make an interim payment.

#### **Section 9: Cohort Size and Timelines**

37. I have been asked to confirm IBCA's understanding of the size of the cohort of the living registered infected. My understanding is that there are 3,524 individuals who are living with infection and registered with a support scheme. That number may increase as the schemes continue to assess those that registered before 31 March 31, 2025.

38. I have also been asked about how IBCA is considering approaching the claims of those who are infected but who have never been registered with a scheme. We are speaking with representatives from this part of the community to work with them to design a suitable approach including where there may be gaps in information and how IBCA can best go about seeking that information. We will publish details of the approach on our website and through community newsletters and other fora once we have a proposed approach, taking into account the views and suggestions of community representatives.

39. I have been asked about timelines for expanding the service and my understanding of the meaning of the statements in the Framework that "*the bulk of payments to the infected are completed by no later than 2027*" and



*"the bulk of payments of the affected are completed by no later than 2029".* As I set out in my evidence, both IBCA and the Cabinet Office are clear that these dates are not targets and that IBCA is aiming to process claims more quickly than this. We have already begun by setting out that we have committed to begin an average of 100 claims a week.

40. In my evidence of 8 May I also said that I was in ongoing discussions with the Cabinet Office about how we could ensure that IBCA has the resources it needs and how I, as Accounting Officer, could have agreement to take on more risk so that IBCA could move even faster. This will require IBCA to go beyond our currently agreed budgets. These discussions are ongoing but my discussions to-date with the Principal Accounting Officer have made clear that IBCA will have the resources and agreements necessary to take the appropriate steps to go faster. With this assurance I believe, based on how we have been able to build and scale up to date, that we should have begun claims for all those who are living registered infected this year. We will seek to open claims routes for all other groups as soon as possible, continuing to use a test-and-learn approach, including beginning to process affected claims this year.

41. As I set out in my previous witness statements and in my evidence at the hearing on 8 May 2025, I along with everyone at IBCA absolutely understands and respects that for those due compensation we simply cannot progress quickly enough. As Sir Robert said: *"any time taken to receive and process claims and to pay awards is too long for those who have waited decades for justice and, in far too many cases have died before receiving it"*. We will not rest until everybody who is owed compensation has received it, and we will continue to take every opportunity within our power to go faster while always ensuring we always act with propriety, fairness and compassion.

### **Statement of Truth**

I believe that the facts stated in this witness statement are true.

Signed  GRO-C

Dated 21/05/25

### **Table of exhibits:**

Date	Notes/ Description	Exhibit number
Undated	Service Specification – IBCA – Clinical Advisors	WITN7757012
Undated	IBCA – Policy Forum Terms of Reference	WITN7757013
21.03.2025	IBCA Policy Forum Minutes	WITN7757014
22.04.2025	IBCA Policy Forum Minutes	WITN7757015
02.05.2025	IBCA Policy Forum Minutes	WITN7757016
Undated	Fibrosan Chart	WITN7757017
Undated	Example Template Support Letter	WITN7757018
Undated	Example Offer Letter	WITN7757019
02.05.2025	IBCA – Lessons Learned from early compensation claims	WITN7757020