

INFECTED BLOOD INQUIRY

SUBMISSIONS ON BEHALF OF THOSE REPRESENTED BY MILNERS SOLICITORS

1. On 16 April 2025, Counsel to the Inquiry produced a very helpful note setting out the purpose and scope of the hearings held on 7 and 8 May. As to the purpose of the hearings, Ms Richards KC quoted the Chair; his words are worth repeating here:

“The decision to hold hearings has not been taken lightly. It reflects the gravity of the concerns expressed consistently and repeatedly, to the Inquiry. These merit exploration in public. People infected and affected do not have time on their side. Our goal is to be constructive and to identify what actions can be taken by the Government and Infected Blood Compensation Authority to address the concerns, and help them gain the trust of those who have had to wait many decades for recognition and compensation.”

2. Ms Richards then went on to outline the anticipated scope of the Inquiry's hearings; she listed twenty areas of concern which the Inquiry intended to explore with witnesses, and which fell within the Inquiry's remit to examine the nature, adequacy and timeliness of Government's response to the Infected Blood Scandal.
3. In making this submission, we therefore understand that the Inquiry will be best assisted by concise submissions which point to direct issues with the Infected Blood Compensation Scheme Regulations (2025) (“the Regulations”) and the manner in which they are being interpreted and applied by the Infected Blood Compensation Authority (“IBCA”) together with suggestions as to how the Regulations and their application might be altered to better serve infected and affected people.
4. It goes without saying that the backdrop and context for the hearings on 7 and 8 May was the anger, anguish and despair expressed by infected and affected people to the Inquiry over a period of months. In our submission, Counsel to the Inquiry captured the essence of the community's emotion in her powerful presentation of 29 April 2025¹ and whilst there can be no substitute for reading the witness statements provided by infected and affected people (and indeed, viewing the oral evidence of the panel on 7 May), we can do no better job in

¹ INQY0000464

summarising their feelings towards Government and the IBCA than that which has already been prepared by Ms Richards.

5. In the written evidence of Mr Harrison on behalf of Milners Solicitors² an approach was adopted of separating the various issues into two broad categories which he labelled policy and operational – the former to be taken up with the Government, the latter to be taken up both with the IBCA and the Government.
6. During the course of the recent hearings, it became apparent that whilst the IBCA certainly has no control over the content of the Regulations, their interpretation of the Regulations is at times, of critical importance. As such, in this submission, we have taken a different approach and will proceed in the following manner:
 - i) The Regulations – taking each problematic regulation in turn, identifying the problem with that regulation and/or the manner in which it has been interpreted, and then suggesting alterations which might alleviate some of the concerns expressed by infected and affected people.
 - ii) The operation of the IBCA – examining the changes which could be made to how the IBCA goes about administering the Infected Blood Compensation Scheme (“IBCS”) in order to better serve those it is tasked with compensating.
 - iii) Miscellaneous issues – matters which arose during the course of the hearings or more generally through the conduct of the Government since the Inquiry’s Report of May 2024.
 - iv) Suggested Recommendations

The Regulations

Regulation 3

7. Regulation 3 defines an eligible infected person for the purposes of the Scheme; paragraph 4 of that regulation provides dates during which a person must have received treatment in order to be eligible for the Scheme. The date range within which a person infected with HIV must have received treatment, is set, at Regulation 3(4)(a) as between 1 January 1982 and 1 November 1985.
8. In the first instance, we recall the Chair’s comments in the Inquiry’s Second Interim Report, where it is written:

“In my view, eligibility should be dependent on whether a given infection was caused by a suspected transfusion, blood product or tissue transfer. The critical question is not one of date, but one of cause and effect.”³

² WITN7759001

³ 05/04/2023, Second Interim Report, Pg33

9. In making this comment, the Chair was predominantly concerned with the 1985 end-date for eligibility and Regulation 3(6) attempts to deal with this concern, providing the IBCA with discretion to determine that a person infected after 1985 is nevertheless eligible to claim from the Scheme. The regulation does not however, allow for a person infected before 1982 to establish their eligibility irrespective of the strength of evidence they might have.
10. In the context of a compensation scheme founded on the Government's acceptance of its moral responsibility to pay compensation rather than any concept of liability, this is plainly wrong. On a literal interpretation of the Regulation, any person infected with HIV prior to 1982 is entirely excluded from the Scheme.
11. The issue was taken up with the IBCA by Collins Solicitors who received in response, what is in our submission, a deeply troubling reply⁴. For ease of reference, we set out the relevant parts of that reply below:

"The HIV liability window under the Infected Blood Compensation Scheme begins on 1 January 1982, even though there is evidence that some individuals may have contracted HIV from blood or blood products prior to this date.

This cut-off is not a reflection of whether infections happened before 1982 we fully acknowledge that they did. Rather, it reflects the point at which, based on current legal advice, it is considered that the UK Government and health authorities should reasonably have foreseen the risk of HIV transmission through blood and blood products and taken precautionary action.

Legal Basis for 1982 Start Date

- *The year 1981 saw the first published cases in the United States of what was later understood to be AIDS, but at the time, the cause was unknown.*
- *By early 1982, there was emerging international evidence linking a new transmissible virus to blood and blood product use — particularly in haemophiliacs in the United States.*
- *This included reports suggesting that a blood -borne agent was likely responsible, raising red flags about the safety of the blood supply and commercial clotting factor products.*
- *From this point onward, the Government is considered to have had a duty to investigate and act, given the growing scientific concern and international awareness.*

The legal test for liability focuses on what the Government knew or ought to have known, and whether it failed to act on that knowledge in a way that could have prevented harm. Therefore, infections that occurred before 1 January 1982 fall outside the liability window because — based on current legal advice — it is not accepted that the risk was reasonably foreseeable by UK authorities

⁴ DHOL0000003

prior to that date, nor that they were under a legal duty to act differently at that point.

We recognise that for those infected before 1982 - and for their families – this distinction can feel deeply unfair. Their suffering is no less significant, and many understandably feel that they were failed by the system. We also acknowledge that campaigners are continuing to challenge these legal boundaries, and such challenges may, shape future decisions or legislative changes. However, at present, the Scheme is required to operate within the legal framework set by the Infected Blood Compensation Scheme Regulations 2024, and those regulations currently do not allow discretion or flexibility to extend liability outside the dates set out.

12. In his evidence on 7 May, the Minister confirmed that this position had been given to the IBCA by the Cabinet Office and indeed, that it was the position of the Cabinet Office⁵ albeit the following day, Mr Quinault did appear to distance the Government's position from that expressed above⁶.
13. In his third written statement⁷ Mr Quinault goes further and says that he does not believe the position had been given to the IBCA by the Cabinet Office – he suggests that the position is a reflection of the IBCA's interpretation of the Regulations. Mr Quinault stops short of describing any steps which the Cabinet Office might have taken to disabuse the IBCA of their apparent belief that any concept of liability has any bearing on the Scheme – we can only presume that the Cabinet Office has taken no such step.
14. In our submission, the position set out in the email to Collins Solicitors of 22 April 2025 is so outrageous that it is worthy of careful and detailed scrutiny:
 - i) The Government accepted Recommendation 1 of Sir Robert Francis' Compensation Study which itself, recommended that the Government accept that irrespective of the findings of the Inquiry, there was a strong moral case for compensating victims. Where the Scheme is founded on a moral responsibility to compensate, it is bizarre and illogical for the Government to then seek to limit eligibility based on concepts of liability and foreseeability.
 - ii) Whilst been deeply conscious of the statutory prohibition on the Inquiry ruling upon or determining civil or criminal liability⁸, some examination of concepts of liability is, in our submission, necessary in order to demonstrate that the Government has not had proper regard to the content of the Inquiry's Report – this goes to the nature and adequacy of Government response which is squarely within the Inquiry's Terms of Reference.

⁵ Transcript 07/05/2025, Pg150 L21 to Pg151 L9

⁶ Transcript 08/05/2025, Pg 145 L24

⁷ WITN7755006_0012

⁸ S.2 Inquiries Act 2005

- iii) The content of the email of 22 April proceeds on the false premise that because the Government could not reasonably have known about AIDS before 1982 (itself a questionable assertion), it cannot be liable for infections which arose prior to a period when it could have reasonably been expected to act.
- iv) In the Inquiry Report, Sir Brian wrote: *"For centuries, humanity has struggled with strange disease and found ways of warding it off. It has done so without needing precisely to understand how precisely it was caused. Knowledge is elusive: there is almost always more of it we do not yet know. What is important in ensuring public health is having enough knowledge to understand that there is a risk (and therefore to begin to search for ways which prove effective in warding it off) rather than to have certainty of the precise cause and effect. An effective public health system does not demand certainty before responding..."*⁹
- v) Volume 3 of the Inquiry's Report carefully describes how from the earliest days of transfusion medicine, it became known that transfusion carried with it the inherent risk of disease transmission. Sir Brian quoted Sir Colin Walker who wrote *"Our blood supply is amongst the safest in the world but even so, medical advice is always likely to be that the best transfusion is no transfusion"*.¹⁰
- vi) In spite of clear knowledge of the risks of transfusions (whether that be whole blood or blood products), the United Kingdom persisted with a multitude of practices which served to increase rather than decrease risk – we will not rehearse them all here – they are well recorded throughout the Inquiry's Report – but they included collecting blood from prisons, deriving blood products from large pools of plasma, failing to introduce surrogate screening, being tardy in introducing screening tests; the list goes on.
- vii) The position as to liability then, is far more complicated than the communication of 22 April sets out; in our submission, the Government knew throughout the mid-20th Century, that there were risks associated with transfusion, and it knew that some of those risks were known and some of them were unknown. The State failed to mitigate and minimise those risks.
- viii) Whilst it might be correct to say that AIDS was a novel condition in 1981 or 1982, this does nothing to mitigate the State's responsibility to ensure that transfusion medicine was administered in the safest possible way. It might not have been possible in 1981 to say that a person could be infected with AIDS as a result of a blood transfusion, but it was reasonably foreseeable at that time, that a person could be infected with pathogens (both known and unknown) as a result of a transfusion.

15. In our submission, whoever prepared the legal advice which made its way into the communication of 22 April was not only wrong in law but also demonstrated

⁹ Inquiry Report, Volume 3, Pg144

¹⁰ NHBT0000028_0005

quite clearly that they had had no regard whatsoever to the Inquiry's numerous findings in its Report, about the litany of failures on the part of the State to ensure the safest possible blood supply.

- 16. The Inquiry should recommend that Regulation 3(4)(a) be amended to remove the reference to 1 January 1982 and provide for the automatic eligibility of any person infected with HIV prior to 1 November 1985.**

Regulation 7

17. In our submission, Regulation 7 and the application of an equation to a person's total additional financial losses in order to arrive at their past financial losses is problematic. Mr Harrison explained in his written statement¹¹ how the equation serves to reduce a person's past financial losses in the event that choose to remain registered with the Infected Blood Support Schemes ("IBSS"); Mr Harrison said that he considered this to be the *"clear breaking of a promise made to the infected community because the application of the past financial loss equation results in a deduction from a past financial loss award..."*

18. The promise referred to was contained in the Government's response to the August 2024 recommendations of Sir Robert Francis KC, where they said:

"Support scheme payments will not be taken into account when assessing an applicant's 'injury', 'social impact', or 'autonomy' awards, or in relation to past financial loss or care awards. Applicants will be able to access these parts of their compensation as a lump sum or periodical payment."

19. On 8 May, the point was put to Mr Quinault and he provided the following by way of response:

"I understand the point the recognised legal representatives are making, which is that if you do as the calculation does and take an average across the whole of that period, you are arguably under-representing the past loss because that average also includes some years where people will be getting a pension rather than full earnings, and I think that is a fair point to make.

But what I would say is, I do not believe that, overall, this approach is disadvantaging people or is, you know, not fulfilling the Government's promise to make sure that people's past compensation is not affected if they take the support payments route.

The care award, which is cut in the same way, broadly speaking most people's most expensive years of care are in the future rather than in the past, but this calculation approaches those both in the same way so that, arguably, there -- you know, there is a -- compensation is weighted towards the past.

¹¹ WITN7759001_0027

And, of course, the calculation of financial loss begins at 60 as well. It assumes full earning power at the national average plus 5 per cent from 16 rather than a later point. So for those reasons, I think it is not under-compensating people.

It would be possible to do as the -- it would have been possible for the regulations to do as the RLRs suggest and to take a different approach and to build up the financial loss award kind of year by year, but I think while that might have looked more precise, I don't think it would actually be more accurate.”¹²

20. We submit that there are two points to take with this response:

- a) Firstly, the application of the equation at Regulation 7 is not an “arguable” under-representation of a person’s past loss, it is a clear and unambiguous one which is made all the more blatant by the fact that one is necessarily obliged to calculate the accurate figure in order to then apply the equation.
- b) Secondly, the Government accepted Sir Robert’s August 2024 recommendation to retain the support schemes and count payments from them, only against future financial losses and care costs. It’s commitment on 16 August (quoted above) is also clear and unambiguous.

The Government did not say words to the effect of “we will retain the support schemes and largely leave your past financial losses intact”. The Government has not made, at least until Mr Quinault gave his evidence, any argument to the effect that some credit has to be given from their past losses, by claimants, for other areas where the scheme is more generous.

Nevertheless, in his evidence, Mr Quinault sought to balance the clear reduction being applied to past financial losses against the fact that loss calculations can begin to run from the age of 16 and therefore may be generous in earlier years.

21. In our submission, Mr Quinault’s response was entirely unsatisfactory. It was open to the Government, in August 2024, to qualify their acceptance of Sir Robert’s recommendation – they did not do so and still now maintain that despite the obvious, they are not undercompensating past financial losses for those electing to remain registered with the IBSS.
22. Mr Quinault’s bald assertion that building up financial losses year by year may appear to be more precise but wouldn’t actually prove more accurate, defies reason: it is plain even to a fool in a hurry that a deduction is being applied to a person’s past financial losses.
23. The Inquiry should find that the application of the equation at Regulation 7, serves to take away from the past financial losses of a claimant who elects to remain registered with the IBSS. The Inquiry should further find that by applying

¹² Transcript 8 May 2025, Pgs 150-151

this equation to establish a claimant's past financial losses, the Government has failed to honour the commitment it gave, on 16 August 2024, to only credit IBSS payments against a person's forward looking financial losses and care costs.

24. The Inquiry should recommend that the Regulations be amended with the removal of the application of the equation at Regulation 7 to establish past financial losses and new provision made for a simple count up of a person's past financial losses by applying the appropriate loss amount to each year that they have been infected.

25. With further regard to Regulation 7, Mr Harrison expressed some concern in his written statement, that the further 25% reduction applied to past care costs by the equation risked failing to reflect the actual care requirements that an infected person had experienced. Mr Harrison wrote:

*"...I think that the equation which has been arrived at weights too much of the award to future care costs and is not generous enough in relation to past care costs. In my experience, the equation typically yields past care awards of less than 50% of what the total award would be. To my mind, this is unlikely to reflect the reality for many and I think particularly here of people who have suffered HIV infections and who had lengthy periods of extreme ill health prior to the advent of effective treatments to control their infections. I also think of people who endured the first treatments for HCV and who told the Inquiry about the severe impact of these treatments on their ability to carry out the simplest daily tasks."*¹³

26. Mr Quinault addressed the care costs provisions of the Regulations at various parts of his evidence. Returning first to the passage of his evidence cited above, where Mr Quinault intimated that the Government had worked on an assumption that a claimant's care requirements would typically be greater in the future rather than the past; Mr Quinault sought to make the argument that the Scheme was if anything, generous in its calculation of past care costs.

27. In relation to Hepatitis C, Mr Quinault's presumption of greater future care costs for infected people, is illogical in the context of a scheme which assumes an effective treatment date of 2016 and then reduces an infected person's financial losses by 50% following that date.

28. By way of explanation, the Scheme on the one hand, appears to assume that following the introduction of effective HCV treatments, little or no further damage was caused to a person infected with Hepatitis C yet on the other hand, it nevertheless weights the majority of their care requirements to the future. The Scheme does this in spite of the evidence heard by the Inquiry of the horrors of the first rudimentary HCV treatments which dramatically impacted people's lives, evidence which was summarised concisely by the Inquiry in its Report¹⁴.

¹³ WITN7759001_0028

¹⁴ 20.05.2025, IBI Report, Volume 2, page 79 onwards.

29. In our submission, there is no justifiable or rational reason for the reduction of past care awards by the additional 25% which Regulation 7(4)(b)(i) provides for; the reduction not only defies the experiences which people have described to the Inquiry of being entirely dependent upon others during the earlier years of their illnesses, it also apparently contradicts at least some of the logic underpinning other parts of the Scheme itself.
30. In addition to the removal of the equation at Regulation 7 for the calculation of past financial losses, **the Inquiry should recommend that the equation at Regulation 7(2) should be modified, insofar as it concerns past care awards, to read $((Y2+0.25) \div Y1) \times T$; thereby removing the additional 25% reduction to the calculation.**

Regulation 14

31. Regulation 14(2)(c) requires that an application for core route compensation must be supported by evidence of the date on which a person was diagnosed with their infection (as opposed to the date they were infected), irrespective of the type of infection that they have.
32. Regulation 20(4)(a) is the only other regulation which requires the date of diagnosis in order to calculate a person's core route compensation entitlement; this regulation relates solely to HIV Infections.
33. The apparently unnecessary requirement to produce a diagnosis date in HCV and HBV claims was an issue raised by Counsel to the Inquiry with Mr Quinault on 8 May, the following exchange took place:

"Q. I can turn to a completely different aspect of the regulations now. The regulations require, and again for anyone who wants to know, it is Regulation 14(2)(c), that the application must be accompanied by evidence which establishes the date on which the diagnosis of the infection was made. Now as I understand the scheme, that does have some relevance for some of the HIV calculations. But the position of those infected with hepatitis C and this is the case whether it's transfusion or blood products, many were not informed of their diagnosis for years, some were tested without their knowledge and not informed of their diagnosis. What's the relevance of asking for evidence of date of the diagnosis, particularly as it may well slow down that the process of assessment of their claims because it's a search for a chimera which won't exist in the records?"

A. It's not relevant to the determination of a lot of the claim. It doesn't affect what happens to the injury or social impact or autonomy award or the award for care. Those are the same. They just depend on severity band under the same whenever you were diagnosed.

Where it does make a difference under the scheme is for financial loss. So as we've just discussed, the scheme pays higher rates of financial loss for people in the higher severity bands for hepatitis and obviously you want that financial

-- that higher financial loss paid, you know, from when it's probably reflective of people's circumstances that's to say, you know, as far back as they were suffering those extra impacts and diagnosis is the attempt to capture a kind of marker for that.

Now, I acknowledge that there will be many people who don't have that information. If they do have it, great, and the scheme can work on that. If they do not, this is where IBCA's ability to look at the balance of probabilities and other evidence comes in. There might be something in medical records that on the balance of probabilities makes it likely that that was the moment, or if there's nothing at a station, that that was the moment that someone, you know, started to feel so particular impacts would do.

Where this is particularly relevant I think is in claims from people, from estates where it could well be there is just no records of any kind at all, only a death certificate, sadly, and that is where the deeming provisions come in. If no other evidence exists for those estate claims the scheme will assume that they would have -- if they died of their infection that they would have been in the top band for four years before that, and in the band below for six years before that.

34. It appears from his answer, that Mr Quinault was conflating the diagnosis of the relevant infection (required by Regulation 14(2)(c)) with the diagnosis of other conditions which move a claimant from one severity banding to the next (such as a diagnosis of cirrhosis to move to Level 3 or liver cancer to move to Level 4).
35. Having now had sight of Mr Quinault's third statement¹⁵, it is abundantly clear that he is conflating the diagnosis of infection (which has no relevance to the calculation of hepatitis claims and which is clearly defined at Regulation 14(2)(a)) with the date of diagnosis of a condition (other than the hepatitis infection itself) which has resulted in a change of severity. The date of change of severity is clearly of relevance and is defined separately in the Regulations at Regulation 20(6)(b).
36. Whilst it must be right that some evidence must be relied upon in relation to establishing a claimant's severity banding, the requirement that a claimant must produce the date of diagnosis of their hepatitis infection serves no utility whatsoever. To the contrary, it is a waste of time and resource for the IBCA to seek to establish such a date when it has no bearing on the compensation calculation at all.
37. **The Inquiry should recommend that the text of Regulation 14(2)(c) should be modified to read: "Where the diagnosis mentioned in sub-paragraph (a) is one of HIV, the date on which it was given."**

Regulation 20

¹⁵ WITN7755006_0010

38. In his written statement, Mr Harrison set out an issue with the drafting of Regulation 20¹⁶. Regulation 20(6)(b) first provides that:

“(b) “the severity of P’s infection”, in relation to a year, is—

(i) the level of severity of P’s infection which has been established in relation to that year to the IBCA’s satisfaction;

(ii) where insufficient evidence has been provided to establish the level of severity of P’s infection in relation to that year, to be determined in accordance with paragraph (8);”

39. The reference at 20(6)(b)(ii) to paragraph 8 is presumably intended to be a reference instead to paragraph 7 where the substance of the Scheme’s ‘deeming’ provisions are contained. Paragraph 7 provides:

“(7) For the purposes of paragraph (6)(b)(ii), where on the relevant date the severity of P’s infection is—

(a) level 2, the severity of P’s infection is deemed to be level 2 for each year of P’s infection;

(b) level 3, the severity of P’s infection is deemed to be—

(i) level 3 for the 6-year period which ends with the final year;

(ii) level 2 for every other year of P’s infection which is before the final year;

(c) level 4, the severity of P’s infection is deemed to be—

(i) level 4 for the 4-year period which ends with the final year,

(ii) level 3 for the year 6-year period which ends with the year which is 5 years before the final year, and

(iii) level 2 for every other year of P’s infection which is before the final year.”

40. The final year is then defined at paragraph 8 as the year in which the relevant date falls; the relevant date is in turn defined at Regulation 2 as the date of a person’s application for compensation.

41. The effect of the deeming provisions as drafted, is that they serve only to deem periods of severity from the date of a person’s application for compensation and have no use to any claimant who has some information about their severity changes but not enough to establish all of their changes of severity.

42. In the first instance, the text of the Regulation appears contradictory within itself. Regulation 20(6)(b)(ii) appears to intend that the deeming provisions will

¹⁶ WITN7759001_0028 onwards

- operate in any year where “insufficient evidence has been provided to establish the level of severity of P’s infection”. The use of the “relevant date” at paragraph 7 then serves to negate that apparent intention.
43. This is a point that does not appear to have been appreciated by Mr Quinault when, in his oral evidence, he was asked about the case of someone who had a liver transplant in 2005 and whether the deeming provisions should apply to that person from 2005.
44. Mr Quinault responded *“So where evidence exists, the scheme takes what evidence there is and the point of the deeming provisions is to kind of step in if there is no evidence at all.”*¹⁷
45. In our submission, this interpretation of Regulation 20(6)(b) is wrong. The point of the deeming provisions as expressed at subparagraph (ii) is to deem a level of severity to any year in which there is insufficient evidence to establish a severity level.
46. Applying the deeming provisions only from the date of a person’s application for compensation is irrational because the deemed periods are founded on advice from an expert clinical panel about the ordinary progression of a hepatitis infection towards liver failure. By denying access to the deeming provisions to those who for instance, know that they had a liver transplant in 2005 but don’t know when they developed cirrhosis, is to undercompensate such a person in spite of the Government’s own expert advice about when that person likely progressed from chronic infection to cirrhosis and then onwards to liver failure.
47. When the point was put to Mr Quinault in his oral evidence, the following exchange took place:
- “Q. Doesn't that disadvantage people?”*
- A. So I think where they have the evidence it shouldn't do, no.*
- Q. Forgive me, I don't understand the answer. It's not an easy provision to understand, but if the only piece of evidence is the liver transplant in 2005 –*
- A. If there's no evidence at all then the deeming provisions apply. The sort of anomalous situation is where you do have some evidence, you have got evidence that people were at the highest -- someone was at the highest severity band and you have a definite date of infection or a deemed -- an assumed date of infection I think then there possibly is an anomaly in that the deeming provision can't -- that's the way the regulations work, can't provide for the kind of middle stage, if you like, as it would in the case of someone who -- for an estate claim.*
- Q. That could potentially make a big difference?*

¹⁷ Transcript 08/05/2025 Pg152, L19

A. It would make a difference but, of course, it only applies in the case of the highest awards when people are already at the top end of what the scheme can provide. So I think there is an issue there but it's not -- you know, it's small in the context of those larger awards. I think -- I looked at the issue that Mr Harrison pointed out, I think in that case what we're talking about here is a significant sum of money, but it's about 3.5 per cent of the total award

48. Mr Quinault's evidence in this regard was plainly unsatisfactory for the following reasons:

- a) It is wrong to describe the scenario advanced by Mr Harrison as "anomalous". In our submission, there are likely to be a number of people (thinking particularly of whole blood transfusion recipients) who did not know that they had an infection until they became seriously ill and who will not have records to show the deteriorating state of their health because they were not being monitored because, in turn, they did not know that they were infected.
- b) It is wrong to say that the deeming provisions would only fail to operate in the most serious cases where people already are at the top end of what the Scheme can provide. Paragraph (7)(b) of the Regulation provides deemed periods for people with level three infections, that is to say cirrhosis. The awards for a level three infection are certainly more generous than for a level two infection but they come nowhere close to the top end of what the Scheme can provide. To the extent that it is even relevant what proportionate difference the failure of the Regulation to engage yields, it is a significant sum of money which people ought to be receiving but which they will not.
- c) By our calculations, the failure of the deeming provisions to engage makes the following differences in cash terms:
 - i. To a person who in 2005, attended hospital with abdominal pain and was told that they had cirrhosis, was diagnosed with HCV and treated for their infection and whose cirrhosis never progressed any further: **£59,315** being 5 x £11,863; £11,863 being the difference between level two and level 3 financial losses per year for the period when the person ought to be deemed to have been at level three.
 - ii. To a person who in 2005, attended hospital with liver failure, was fortunate in swiftly receiving a transplant and who survived their ordeal: **£124,560** being 6 x £11,863 (the difference between level two and level three payments over the six year deemed period at which they ought to have been level three) PLUS 3 x £17,794 (being the three year period during which the person ought to have their losses calculated at level four instead of level two, £17,794 being the difference between the two levels)

49. In both cases, these are significant sums of money which ought to be paid to infected people but which, contrary to the Government's own expert advice, are being denied.
50. In his third written statement¹⁸, Mr Quinault doubles down on his assertion that the example given to him by this firm and put to him in his oral evidence, is an anomaly which would result in *only* a 3.5% difference to the value of the claim. In our submission, whether it makes a 3.5% or a 35% difference is not the point – the point is that the additional sum should be paid to the infected person.
51. **The Inquiry should recommend that Regulation 20 be amended to allow for the application of the deeming provisions from any known date of severity change.**

Regulation 26

52. Regulation 26 defines unethical research practices within the Scheme and draws eligibility for a further award to infected people who:
- a) Attended Lord Mayor Treloar College between 1970 and 1983; or
 - b) Were treated for a bleeding disorder at any of the nine listed haemophilia centres between 1974 and 1984; or
 - c) Were subject to research led by Dr John Craske between 1974 and 1984.
53. We accept the utility in automatically qualifying those at Treloar's for an award and we understand the intended utility in providing a date range within which people will automatically qualify for the unethical research award if they were treated at certain institutions.
54. However, in our submission, it would be difficult to locate an infected haemophiliac who did not consider that (and in large part, could not evidence that) they had been subject to unethical research practices.
55. The Government acknowledges, in Regulation 26(2)(b) that the research of Dr John Craske was unethical; that research drew upon the annual returns of all haemophilia centres and accordingly all infected haemophiliacs have an argument that they were subject to research by Dr Craske. The difficulty in establishing this on an individual basis places a cumbersome and unnecessary burden both on the applicant and on the IBCA; particularly when one considers that the sum awarded under Regulation 27 is, with the utmost respect, a relatively nominal figure.
56. **The Inquiry should recommend that Regulation 26(2) be amended to simply read "An eligible infected person was also subject to unethical research practices if they received treatment for a bleeding disorder between 1974 and 1984."**

¹⁸ WITN7756006_0013-14

Regulation 82

57. Regulation 82 concerns the internal review process which is open to applicants who disagree with a decision taken by the IBCA. Regulation 82(7) sets out that the IBCA must *"take reasonable steps to ensure that the review is carried out by a member of the IBCA's staff who had no involvement in the making of the original determination."*
58. In practice, this has been interpreted into policy by the IBCA as meaning that where an internal review is requested, the claim will be moved to a new claim manager to take a fresh decision.¹⁹
59. In his third written statement, Mr Foley discusses borderline level two/three severity cases and how they are assessed; at paragraph 16²⁰, Mr Foley says:
- "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."*
60. This highlights a lacuna within the Regulations (or at least, their interpretation). It is of course right that someone previously unconnected with the claim conducts the review, but if the decision is contingent upon the advice of the clinical advisor, then the review process is rendered redundant unless a clinical adviser who is also unconnected to the first decision is consulted.
61. Elsewhere, at paragraph six of his third statement, Mr Foley notes that the IBCA has recently contracted with a healthcare resourcing company to provide 10 clinical advisers. As such, there appears to be no reason why, where an internal review is requested of a decision which is made on the basis of clinical advice, the IBCA cannot also direct that a previously unconnected clinical adviser will also be consulted.
- 62. The Inquiry should recommend that where an internal review is requested of a decision taken by the IBCA which involved the input of a clinical advisor, the review should involve taking further and separate advice from a different clinical advisor, unconnected with the first decision.**

Schedule 1

63. Schedule 1 to the Regulations provides the definitions for each level of severity of hepatitis infection. Level three is defined, *inter-alia* as *"Cirrhosis,*

¹⁹ 08/05/2025 Transcript, Pg74, L17 onwards

²⁰ WITN7757011_0007

characterised by serious scarring (fibrosis) of the liver caused by long-term liver damage caused by infection”

64. Firstly, we submit that the only definition of cirrhosis which the IBCA must concern itself with, is that given to it by Parliament in the Regulations, as set out above. Any clinical definition of cirrhosis which deviates from this statutory definition may have some relevance insofar as it establishes that a person has cirrhosis and therefore level three eligibility, but only insofar as it does not detract from or otherwise restrict, the statutory definition.
65. Put simply, it is entirely appropriate that the IBCA should accept a clinical diagnosis of cirrhosis as rendering the subject of that diagnosis eligible for a level three award. However, it is entirely inappropriate for the IBCA to overlay a clinical definition on top of the statutory definition in order to restrict the eligibility of people who the Regulations define as being eligible for a level three award.
66. As a matter of construction, the statutory definition provides, in our submission, that serious scarring of the liver is synonymous with fibrosis – insofar as the Regulations are concerned, they are one and the same thing. The Regulations further provide that cirrhosis is characterised by such serious scarring or fibrosis.
67. On any proper reading of this definition, one can therefore say that serious scarring or fibrosis of the liver is the identifying factor by which the Scheme will consider that a person has cirrhosis in the absence of a clinical diagnosis (the definition could simply have stopped at “Cirrhosis” if a clinical diagnosis was what was required and what follows would be rendered superfluous.)
68. The statutory definition does not provide a requisite level of fibrosis and therefore the Regulations provide (put at its simplest) that for the purposes of establishing level three entitlement, fibrosis equals cirrhosis.
69. The IBCA appears to have gone about, at the direction of the Cabinet Office, seeking to interpret Schedule 1 in a restrictive way which is simply not provided for in the Regulations.
70. At an early stage of his evidence, Mr Foley addressed the definition of cirrhosis within Schedule 1, he said:
- “There are parts in there where there are decisions that have to be made that require clinical expertise in particular, for example, thinking about the degree of severity of fibrosis and that would be an example of where a clinical assessor would provide some expert advice that a claims manager simply wouldn't have.”²¹*
71. With the utmost respect, in our submission Mr Foley is wrong; in taking advice from a clinical assessor in relation to the level of fibrosis required to qualify for a level three award, the IBCA is seeking evidence beyond that which is required

²¹ 08/05/2025 Transcript, Pg18, L19 onwards

- by the Regulations. In doing so, the IBCA has interpreted the Regulations in a way which requires a claimant to prove more to access their level three award than the Regulations themselves require. The Regulations simply require a claimant to evidence fibrosis in order to qualify for that level three award.
72. Moreover, the IBCA is wrong to effectively seek interpretation of a statutory instrument from a clinical assessor. To do so conflates, as we note above, the statutory definition of cirrhosis provided by the Regulations with a (potentially more restrictive) clinical definition of cirrhosis.
73. In our submission, the role of a clinical advisor in assessing whether a case meets a level three threshold, is limited to those elements of the assessment which fall outside of the text of the Regulations. That is to say that if a person does not have record of a clinical diagnosis of cirrhosis or fibrosis, the clinical assessor might consider what other conditions they can evidence and advise as to whether those conditions might, on the balance of probabilities, be suggestive of cirrhosis.
- 74. The Inquiry should find that the proper interpretation of the definition of cirrhosis within Schedule 1 to the Regulations, includes any claimant who can evidence that (a) they have a clinical diagnosis of cirrhosis; or (b) they have fibrosis as a result of their infection with hepatitis B or C.**

Schedule 2.

75. In his August 2024 Report, Sir Robert Francis wrote:

"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 the fairest way to reflect the purpose of the SCM as being to support particular needs rather than because their infection or 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."

[...]

*I recommend that the advice of the expert group is followed with regard to the recognition of SCM eligibility."*²²

76. The Infected Blood Inquiry Response Expert Group published their Final Report on 16 August, they wrote:

²² RLIT0002466_0031-32

“...The Expert Group therefore proposes that there should be six groups of circumstances where the calculations of care needs and financial loss should be adjusted to recognise the increased impact that some beneficiaries experience from their disease. This should take the form of a supplementary route application and have the adjustments set out below. Those who have already been recognised under the Support Schemes would not need to produce further evidence to qualify...”²³

[...]

Health impact Group	Infection	Amendment to care award	Amendment to financial award	Notes
<p>5) Other Hepatitis C associated extra hepatic disorders resulting in long term severe disability.</p> <p>This includes those currently assessed as the following category on IBSS:</p> <p>Hepatitis Special Category Mechanism (EIBSS) Severely affected Hepatitis C (SIBSS) Stage 1 Plus (WIBSS) Hepatitis C Stage 1 Enhanced Payments (NIIBSS)</p>	<p>Hepatitis B</p> <p>Hepatitis C</p>	<p>Lifetime Domestic Support</p> <p>6 hours per week (Support with heavier domestic tasks, attendance of medical appointments and household maintenance.)</p>	<p>Financial loss: Match to cirrhosis b.</p>	<p>Those registered SCM in the current support schemes would automatically be accepted</p> <p>New applicants would need to provide evidence supporting their diagnosis impact.²⁴</p>

²³ RLIT0002474_0027

²⁴ RLIT0002474_0030

[...]				
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77. The Government response Sir Robert's August 2024 recommendations included the following text:

*"Following the recommendations of Sir Robert and advice from the Infected Blood Inquiry Response Expert Group, the Scheme will now include a 'health impact' supplementary route to compensation. This will provide more financial support for infected people with health conditions not recognised within the core route that could impact an applicant's care requirements and capacity to earn. This will include impacts currently recognised under the Infected Blood Support Scheme payment band 'Hepatitis Special Category Mechanism' (or equivalent UK wide bands)."*²⁵

78. As at 16 August 2024, the Government had purportedly accepted Sir Robert Francis' recommendation for an SCM equivalency within the Scheme; that recommendation itself (as set out above) was that the expert group's advice should be followed as to the recognition of the SCM. In turn, the expert group had recommended an automatic eligibility for current IBSS SCM registrants which would provide them with an enhanced care award and financial losses uplifted to the cirrhosis level.

79. None of this made its way into the Regulations.

80. Instead, Schedule 2 provides a list of rare conditions which is far more restrictive than the more expansive qualification criteria of the IBSS. Psychological and psychiatric conditions were a major route to SCM qualification in the IBSS; in Schedule 2, paragraph 5(c), there is a requirement that anybody attempting to access the severe health impact award on psychiatric grounds must either have been under consultant-led mental health treatment for at least 6 months or have been sectioned.

81. On 29 April 2025, Dr Sarah Helps, the Interim Professional Clinical Lead of the Infected Blood Psychology Service wrote to the Inquiry²⁶ with her concerns about the overly restrictive qualification criteria for the severe health impact award, she concluded by saying:

"To summarise, the IBPS strongly recommends that the supplementary regulations are operationalised to allow for evidence from any qualified doctor, counsellor or mental health professional to support an application for the supplementary award related to severe mental distress."

82. We endorse her comments entirely in relation to claimants who are not currently registered with the IBSS. In relation to those who are currently registered with the IBSS and SCM qualified, we say that the Government should do what it

²⁵ WITN7760006_0006

²⁶ NTHT0000059

said it would do in August 2024 and make those people automatically eligible for a supplementary award.

83. In his oral evidence on 7 May, the following exchange took place with the Minister:

“Q Minister, forgive me, it's not that what was set out in August didn't make clear what is now the position; it's that what is set out in August is fundamentally different from what is now the position?”

A And the difference is that there were conditions under the Special Category Mechanism that are accounted for in the core route. I'm just explaining the difference and that is I gave the example of someone with chronic fatigue, for example. That would be taken into account in the core route and that is this reason behind that. But I accept entirely your point about the clarity of the communication.

Q But if that's right why did the expert group and Sir Robert recommend what they recommended in August of last year, and why did you accept it?

A Well, obviously you have to ask them the reason for why they recommended things. What has happened, though, is that there has been that look at the scheme at what is included in the core route and what is included in the supplemental route which is what has happened.”²⁷

84. The Minister seeks to explain the difference between what was promised by Government in August 2024 and what made its way into the Regulations on the basis that some further consideration was given to conditions already accounted for under the core route. With the utmost respect to the Minister, this is nonsense. The expert group's 16 August report makes clear (in the extract cited above) that their recommendations were made having given consideration to the fact that some elements of the SCM within the support schemes may already be reflected in core route awards.

85. In his evidence, on 8 May, Mr Quinault built on the Minister's position by asserting that there was ambiguity in the expert groups report – he relied on the fact that the expert group had noted that some elements of SCM entitlement were already accounted for in the core route but had nevertheless recommended automatic entitlement for current SCM registrants²⁸.

86. Where Mr Quinault finds ambiguity, we find absolute clarity. The expert group had, in their 16 August report, acknowledged aspects of commonality between the SCM and the core route and nevertheless recommended that all those currently admitted to the SCM should be eligible for a supplementary award.

87. Aside from any issues of commonality between the SCM and core route awards, the Minister also sought to explain that clinical markers were a

²⁷ Transcript 07/05/2025, Pg161, L10 onwards

²⁸ Transcript 08/05/2025, Pg127, L10 onwards

necessary requirement to access the severe health impact award to ensure fairness between those currently registered on the support schemes and those unregistered; he said:

*"...But, you know, the point here is that the broad point is around the clinical markers point and that is because there are obviously the group of victims who are receiving money under the Special Category Mechanism but there's also another group of victims who wouldn't have been part of the support schemes but who would also qualify for this. So my recollection of this is that the clinical markers point was for fairness across both those groups and for the integrity of the scheme."*²⁹

88. The Minister's rationale here makes no sense – firstly, the expert group had said within their report that people who were not currently registered with the schemes could demonstrate their eligibility for a severe health impact award by showing diagnosis of one of the conditions now listed at Paragraph 7 of Schedule 2. Sir Robert suggested in his August 2024 recommendations that unregistered people might prove their eligibility by meeting the SCM criteria for the support scheme within their home nation³⁰.
89. The Government had here, two clear proposals as to how the severe health impact might be made available to unregistered applicants without removing an automatic entitlement for those currently admitted to the SCM of the IBSS. In our submission, the only plausible reason why the Government would remove automatic eligibility for current SCM registrants is to reduce the number of people who are able to access the severe health impact award.
90. Secondly, the Minister's comments about fairness between registered and unregistered applicants are made in the context of a scheme which already distinguishes significantly between those two groups in the following ways:
- a) IBSS registered applicants are automatically accepted as being eligible to claim from the Scheme;
 - b) IBSS registered applicants are prioritised in terms of the order in which they can make their claim, over and above unregistered applicants; and
 - c) IBSS registered applicants are given a choice of whether to accept a core route lump sum offer or an IBSS route offer – unregistered applicants are not given the same option.
91. The point here is that the Scheme already has 'baked-in' additional evidence requirements for unregistered applicants so we fail to understand how requiring additional evidence to access the severe health impact award places any additional burden on unregistered applicants which is of a sufficient magnitude to justify requiring registered applicants to re-prove the additional impacts of their infections.

²⁹ Transcript 07/05/2025, Pg164, L20 onwards

³⁰ RLIT0002466_0032

92. **The Inquiry should recommend that all those currently registered with the IBSS and admitted to the SCM should automatically be eligible for a severe health impact award as envisaged by the expert group in their 16 August 2024 report.**

The Operation of the IBCA

Interpretation of the Regulations

93. As to the interpretation of the Regulations, Mr Foley said, in his oral evidence:

*"Where there is an interpretation about the regulations, we are always interested in being able to interpret it properly and understanding what the Government's intent in the regulation were and that does mean that we work in a multidisciplinary team on those issues. There's usually somebody from the Cabinet Office, if they feel they need legal advice they will get from the Government legal department advice. There will be IBCA policy officials and there will be IBCA operational officials and where we have something that defines how they should be interpreted or is the key part about interpreting them, we will convey that as an explanation for why that has been the decision."*³¹

94. In his third written statement³² Mr Quinault gives some idea of the of the "extensive advice" which the Cabinet Office has provided to the IBCA on the "Cabinet Office's understanding of the purpose behind the Regulations and of how the Regulations should be interpreted".

95. We submit that this evidence is quite concerning, for the following reasons:

- a) Whilst it is clearly the case that the Regulations were drafted to instructions from the Government and tabled by the Government in Parliament, the Regulations as enacted are not necessarily an expression of the Government's intention, they are an expression of Parliament's intent.
- b) Parliament is sovereign and the Government's interpretation of a statutory instrument passed by Parliament carries no greater weight than the interpretation applied to those regulations by a claimant to the Scheme. Where discrepancies in interpretation arise and cannot be resolved, the Courts are the ultimate arbiters.
- c) It is therefore inappropriate in our submission, for the IBCA to consult solely with the Cabinet Office about interpretation of the Regulations and to take advice on interpretation points (whether first or second hand) from the Government Legal Department. At the very least, this is a demonstration of the lack of independence and autonomy which those we represent, feared.

³¹ Transcript 08/05/2025, Pg83, L4 onwards

³² WITN7755006_0002

- d) More seriously, it builds an institutional unfairness into the Scheme whereby the Government will always, absent Judicial Review, be able to dictate how the IBCA interprets the Regulations and will likely always tend towards a restrictive interpretation.
96. In our submission the IBCA has erred in its understanding of the basic constitutional principle that the Regulations are an expression of the intention of Parliament and not of the Government. In doing so, it has interpreted the Regulations at the direction of the Government and without any regard for the operational independence which it is said to possess.
97. It is one thing for the IBCA to take account of the Government's view on interpretation together with the views of infected and affected people (or their representatives) and then reach a decision of its own; it is quite another thing for the IBCA to devise policies and procedures based on the Government's desired interpretation of the Regulations, alone.
98. The IBCA has its own general counsel and its own solicitors, it has the legal resources to take the views of Government and applicants and reach its own decisions as to the interpretation of the Regulations; we submit that a truly independent organisation would adopt this approach.
99. We further submit that some of the policies and procedures devised so far by the IBCA in conjunction with the Cabinet Office, are unlikely to be an accurate reflection of Parliament's intentions – we think particularly here of the definition of severity level three within Schedule 1 of the Regulations. This being the case, it is all the more important that the Inquiry, in its further report, offers guidance and clarity as to how aspects of the Regulations ought properly, to be interpreted.

Improving the efficiency of the Claims process

100. Arguably, the single greatest issue with the operation of the IBCA which gave rise to the need for the Inquiry to first take further evidence and then hold further hearings, was the speed at which claims were being accepted by the IBCA.
101. Mr Harrison set out in his written statement³³ that it wasn't simply the pace which was causing concern, it was the lack of communication about anticipated timescales for increasing capacity and processing claims, and the damage that this information vacuum was causing.
102. In our submission, the Inquiry's actions in taking further evidence and holding hearings has already yielded progress on both of these fronts in that:
- a) Shortly prior to the hearing on 7 May, the IBCA issued notices to begin claims to 200 people and committed to issuing a further 100 per week from that point forward, increasing as the number of claims managers increased.

³³ WITN7759001_0023

- b) In his evidence on 8 May, David Foley said that he had confidence that all living, infected, IBSS registrants will have started their claims by the end of 2025³⁴.
103. Whatever the motivating factor for the sizeable uptick in the rate at which claims are being started, it is clearly positive that significantly more claims are now being started, and Mr Foley's evidence has at least reassured a number of those we represent that they will be able to begin their claims this year.
104. That is not to say that more cannot be done.
105. An obvious limiting factor in the rate at which capacity can be increased is the rate at which the IBCA can recruit more staff – largely claim managers but also clinical assessors and support staff. Mr Foley set out in his evidence that the IBCA currently has 100 claim managers, and they intend to increase at a rate of 40 per fortnight until they have 500 claim managers in total.³⁵
106. If the IBCA's ambition and timescale is met, then by the end of September, the IBCA should have completed its recruitment and, allowing for two weeks of classroom training and four weeks of working at reduced capacity, with a buddy³⁶ in that final intake, should be at full capacity to accept claims by mid-November this year.
107. Bearing in mind the importance of ensuring that IBCA staff are adequately trained, it is, in our submission, perhaps unlikely that a great deal can be done to accelerate the recruitment timescales that Mr Foley outlined.
108. With that in mind, it becomes all the more important to ensure that what resources are available, are used as efficiently as possible; as matters currently stand, we fear that this is not the case.
109. In our submission, the IBCA appears to have taken an overly principled view on two points which are captured in the oral evidence of Mr Foley when he said:

"So we've taken the approach of, as I described earlier, of supporting people to get the compensation that they are due. And we've also -- when we did early engagement from user research, one of the things that came through quite clearly was being able to do as much of the heavy lifting for people as possible would be helpful and advantageous. So instead of sending out an application form, what we've instead done is said: we will start the claim for you, we will gather as much information as we can to avoid you having to do it, we will accept anything that you provide and want to add or change in there, and that allows us to have a smoother, faster and less burdensome journey. So it's the -

³⁴ 08/05/2025 Transcript, Pg42, L8

³⁵ 08/05/2025 Transcript, Pg42, L22

³⁶ WITN7757001_0011 & 08/05/2025 Transcript, Pg74, L1

- it ends up being the equivalent of an application form, but it isn't an application form that we are issuing or sending out to people."³⁷

110. The first point is that the IBCA holds the view that it is solely responsible for collecting relevant evidence and preparing a person's claim; to a degree this is true, but the IBCA should not accept that this is the default position in every case. There will of course be cases where the IBCA needs to exercise its powers to compel documents and information, but there are many more cases where the evidence exists and where the claim manager needs to do little more than record that evidence in a declaration form.

111. The second point is that the IBCA appears to hold a principled, inflexible and at times, protective view of the position of claim managers. We do not suggest that the role as envisaged (i.e. one of preparing the claim and guiding a person through their compensation claim as a single point of contact) is not appropriate in some cases. In other cases, however, the extent to which a claims manager becomes involved in a pre-prepared case is a waste of that claim manager's time which might have been better spent processing other claims. It would seem far more efficient, where possible, for a person (whether or not legally represented) to file a pre-completed declaration form together with the supporting evidence behind it – assuming that the evidence is accepted by the claim manager/IBCA then the claim could immediately progress to an offer stage.

112. In an exchange between Counsel to the Inquiry and Sir Robert, the issue of filing pre-prepared claims to the IBCA was raised, Sir Robert said:

*"Well, you could do that, but it would still mean that those who didn't have the advantage of legal representation of the type you describe would be disadvantaged. And, at the moment, people are brought forward on the basis, random basis, that you have described."*³⁸

113. We do not accept that taking pre-prepared applications necessarily involves disadvantaging people without legal representation and even if it does, those people could remedy any disadvantage by instructing solicitors.

114. By way of further explanation, the IBCA could publish its precedent declaration form on its website along with a guide as to what evidence they will accept in connection with each data requirement within that form. An unrepresented person who felt able to do so, could download the form, complete it and file it with the corresponding evidence in just the same way that a represented person could.

115. In our submission, the IBCA and/or Government's objection to accepting claims in this manner is not that it is unfair, it is that it would encourage unrepresented people to seek legal support at a pre-claim stage and thereby potentially partially undermine the role of claim managers.

³⁷ 08/05/2025 Transcript, Pg, 58, L6 onwards

³⁸ 08/05/2025 Transcript, Pg 62, L12

116. A further point where efficiency could be improved, tangentially related to what has already been said, is the manner in which referrals of unrepresented people are made by the IBCA to the law firms contracted to provide that support.
117. To the IBCA's credit, it has already moved from a position of notifying people of their entitlement to legal support after initial calls had taken place, to notifying them in their first communication with a claimant – this has tended to mean that lawyers are involved from the earliest stages when a previously unrepresented person avails themselves of the legal support on offer.
118. The effect of this has been that lawyers can speak with claimants before the initial IBCA call which has then in turn meant that where documents are readily available, an evidence pack can be produced ahead of the initial IBCA call. The cumulative effect of all of this is that the length of time from claim commencement to declaration form signature has been, in some cases at least, heavily truncated.
119. The result is that the person making their claim is happy that their claim proceeds extremely quickly and that the claim manager should have more time to progress more claims at once.
120. Where this system falls down, and where inefficiency creeps back in, is in the level of exchange which occurs between claims managers and lawyers from the point of referral. By way of explanation:
- a) Whenever a referral is made to advise a previously unrepresented person, a document is sent across from the claim manager to the solicitor which contains the person's name, claim number, postal address and date of birth. This document is signed by the solicitor and returned to the IBCA as confirmation that the solicitor can act.
 - b) At this point, the solicitor will typically need to contact the claim manager and ask for contact details (to avoid having to onboard the client via post), ask what stage the claim is at, and ask for copies of any documents collected so far/the IBSS records. Email addresses and telephone numbers tend to be given fairly quickly, the time which it takes to transmit available records varies amongst claim managers and some will not release them without a "data request".
 - c) For the reasons already set out above, it would be in everyone's interests if the return of the engagement document triggered an automatic release of information to the lawyer whereby, they would receive the claimant's email address, telephone number, IBSS records and any declaration form and/or offer which had already been prepared.
 - d) This would enable the lawyer to, where possible, prepare an evidence bundle for the claim and, in the absence of any necessary evidence, identify what it is and where best to find it.

121. Taking all of this together, **the Inquiry should recommend that the IBCA begins to:**

- i) **Accept pre-prepared declarations forms supported by evidence bundles for living, infected, IBSS registrants whether represented or unrepresented;**
- ii) **In the case of previously unrepresented people who have requested legal support, provide the referred lawyer with full contact details and all copy evidence at the point at which that lawyer accepts the instruction.**

The role of the Clinical Assessor(s)

122. Mr Foley was first asked in his evidence whether the current clinical assessor and those that the IBCA was looking to recruit would be hepatologists; he replied that the IBCA was looking for a range of medical experience including understanding about, in particular, hepatitis and HIV.³⁹

123. Mr Foley was later asked more directly, what the specialism of the current clinical assessor was, he replied *"I would need to find out. I'll write to you"*.⁴⁰

124. Whilst we await Mr Foley's written response, it might be (fairly or otherwise) inferred from the responses in his oral evidence that the current clinical assessor is not a hepatologist. If they are not a hepatologist then it would seem a curious appointment on the IBCA's part given that of the claims currently being processed, the only advice likely to be required is in relation to the severity of someone's hepatitis infection.

125. We recognise that in due course, there might be call for a wider range of specialties when severe health impact awards are being considered or as and when people return to the Scheme as a result of deterioration in their health, but as matters stand, the only possible call for clinical assessment is in relation to the severity of someone's hepatitis infection.

126. The remainder of this submission proceeds:

- a) Without prejudice to our earlier submission on the interpretation of Schedule 1 to the Regulations and the definition of "Cirrhosis"; and
- b) On the assumption that the current sole clinical assessor appointed by the IBCA, is not a specialist hepatologist.

127. If (which is not accepted) there is a role for a clinical assessor in deciding whether a fibrosis level is sufficient to qualify a person for a level three award,

³⁹ 08/05/2025 Transcript, Pg19, L16

⁴⁰ 08/05/2025 Transcript Pg93, L25

that clinical assessor should be a specialist. The risk in having a clinical assessor who is not specialist, and who is perhaps a general practitioner, is that they are likely to rely on textbook reference points from scan results or biochemical markers. This in turn will inevitably result in a 'computer-says-no' assessment for borderline cases.

128. In our submission, there is a risk that whilst only one clinical assessor is in position and whilst their specialty is unknown, claims currently being processed will be subject to different and perhaps more stringent criteria in establishing severity levels than may have been the case prior to the appointment of the clinical assessor, or which may yet prove to be the case following the appointment of clinical assessors with other specialties.

129. NOTE – After this submission was drafted, David Foley's third written statement was published where he sets out that the current clinical advisor is specialist in infectious and tropical diseases and has worked on the England Infected Blood Support Scheme for the last five years. Without disparaging the experience of that adviser at all, nor calling into question her expertise, we consider that our initial submission still stands because whilst ever the Scheme's only questions of a medical nature are concerned with the severity of a hepatitis infection (defined by reference to liver damage and associated health conditions), the most appropriate expertise to seek is that of a hepatologist.

IBCA Communications and Transparency

130. In his written evidence to the Inquiry, Mr Harrison said:

"My own perception is that the IBCA is deliberately ambiguous about certain points; I suspect this is born of well-meaning intentions and that the IBCA does not, for example, want to raise expectations on a certain issue until it is certain. Nevertheless, the impact of the IBCA not acting frankly is that seeds of mistrust, anger and fear are sown. The following examples spring to mind:

a) The IBCA's line about starting small and working up capacity to accept claims is a line which has been used for a number of months now and one which is wearing extremely thin with those I represent. I do not accept that the IBCA is aimlessly sending out invitations without any plan or timescale as to how those numbers of invitations might be increased.

My view is that the community would be far more understanding of delays if the IBCA were to say "this is our plan and anticipated timescale for working up to accepting applications without invitation." Where delays occur, if the IBCA explains the reasons for those delays and what remedial action is being taken, I think that the community would be far more accepting.

*The present position, of being given the same line for months whilst being updated only about the relatively small numbers of claims which are being progressed, is intolerable for many...*⁴¹

131. In their written statement on behalf of the Birchgrove Group, Alan Burgess and an anonymous witness said:

*"Be frank and transparent with the community; we refuse to believe that the IBCA has no assessment of how long it will take to process the claims of all those currently registered with the IBSS. Tell us what that assessment is and manage expectations – telling us that you are working as quickly as possible without actually telling us what you are doing to increase capacity, does nothing to alleviate anyone's concerns."*⁴²

132. In his oral evidence, Sir Robert said:

*"Throughout, we have been open with the community and conducted continuous dialogue with them about how we are processing claims. We do listen to the concerns, and what we do is always informed by them. We cannot always satisfy those concerns, but we will be honest about what we're doing and will avoid the risk of raising expectations we cannot fulfil."*⁴³

133. We submit that Sir Robert is wrong to attach too much weight to the risk of raising expectations which then go unfulfilled and that the IBCA ought to be as frank as possible with infected and affected people about their plans for the development of the Scheme.

134. The Inquiry has heard and seen a large volume of evidence from infected and affected people about the psychological toll which being left in the dark about when their claim might be dealt with, has taken. The IBCA would be better placed to build trust with the Scheme's beneficiaries if it adopted a franker approach in its communications. It is of course right that the IBCA should do so in a manner which tempers expectations and makes clear that no promises are being made but, in our submission, the damage done by leaving people in the dark outweighs the risk of dashing people's expectations if unexpected delays or hurdles arise in the future.

135. In his oral evidence, David Foley said:

"On the cohort that we have built so far, which is those who are living have been infected and have been registered with the existing support schemes, you know, on that basis I can be pretty confident that for the living registered infected we should have started all of their claims this calendar year which gives an idea of the -- you know, the acceleration that we have talked about and also illustrates, you know, our commitment to as the minister said yesterday, those dates are the backstops and our ambition is to do everything much faster and

⁴¹ WITN7759001_0023

⁴² WITN7752001_0020

⁴³ 08/05/2025 Transcript, Pg106, L8 onwards

that starts, I think, now that we know a bit more, to paint a bit more light on that commitment."⁴⁴

136. This was an important piece of evidence to many of the infected people whom we represent; it gave them a timescale within which they could frame their expectations and dispelled their fears that they might yet be waiting years for their claim to be addressed.

137. **The Inquiry should recommend that the IBCA communicates its plans and anticipated timescales for opening up the Scheme to all cohorts as soon as those plans and timescales are settled upon (to the extent that they have not already been settled upon).**

Publication of IBCA guidance and policies

138. As we note in the later sections of this submission, IBCA guidance and policy is, in light of the evidence heard and seen by the Inquiry, being directed by the Cabinet Office, particularly on points of interpretation⁴⁵.

139. It is therefore a matter of fairness, both procedurally and more generally, that applicants to the Scheme have access to the guidance and policy which reflects the IBCA's (which is to say the Cabinet Office's) interpretation of the Regulations. Only the most serious considerations should negate against a position of absolute transparency when it comes to that guidance and policy.

140. Mr Foley was asked about such guidance and whether it could be published, he replied, in his third written statement⁴⁶:

"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 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."

141. We consider that there are a number of things to unpack in this response:

⁴⁴ 08/05/2025 Transcript, Pg42, L5 onwards

⁴⁵ WITN7755006_0002

⁴⁶ WITN7757011_0005-6

- a) Where Mr Foley says that it is unnecessary to publish guidance because assistance can be given directly to any who require it, this is plainly unsatisfactory and requires an applicant to trust the interpretation of the Regulations contained within that guidance to the IBCA, without being able to see the guidance itself or understand how the interpretation is formulated.
- b) Mr Foley cites the risk of fraud as a reason why guidance and policy might not be published but does not explain how the publication of this guidance could, of itself, increase the risk of fraud. We do not understand Mr Foley's fears or how the publication of guidance could lead to an increased risk of fraud. If the fear is that someone might fraudulently produce documents to enhance their claim, then they are just as likely to do that at whatever point they become aware of the Scheme's requirements.
- c) As a matter of fact, the IBCA has not consulted with community groups or legal representatives on any policy or guidance which concerns the material interpretation of Regulations.

142. The prime example of where policy uncertainty for Scheme applicants is causing difficulties is with the interpretation of Schedule 1 of the Regulations and particularly, how the IBCA is interpreting the definition of cirrhosis. The IBCA has clearly prepared some fixed parameters for what they will accept, without further evidence, as an eligibility for level three entitlement. Scheme applicants should know what those parameters are and should have an understanding of how they came to be set. Without this information, Scheme applicants do not have sufficient information to challenge the interpretation of the Regulations which the IBCA is employing.

143. The Inquiry should note that it has seen no compelling evidence that the publication of IBCA policy and guidance could lead to an increased risk in fraud and should recommend that all such policy and guidance, insofar as it concerns the interpretation of Regulations which will impact upon the eligibility of a claimant or the quantum of their claim, be published by the IBCA.

Sequencing/Prioritising the Order of Claims

144. There are two issues when it comes to sequencing; the first and broader issue is the order in which different cohorts will be accepted into the Scheme; this can be taken in relatively short order. The second and far more difficult issue, is the order in which claims at an individual level should be processed.

145. As to the order in which different cohorts should be brought into the Scheme to make their claims, we are conscious of Mr Foley's evidence, where he said there was not an anticipated timescale at the moment for bringing

deceased infected claims⁴⁷. Nevertheless, the Minister and the IBCA committed in their combined evidence, to their target of starting the first affected claims by the end of this calendar year.

146. Whilst it is right that a deceased infected claim should not be considered an “affected claim” and, as Carolyn Challis pointed out in her evidence⁴⁸, those claims are a recognition of an infected person whose life was lost, there is nevertheless an interplay between those claims and some affected claims.

147. The Regulations permit the assignment of an infected person’s care award and there are several reasons why the personal representative of an estate might elect to make such an assignment. If an assignment is made then, as we understand the regulations, the assigned amount would move into a caregiver’s affected claim.

148. We submit that this situation is most likely to arise in the affected claims to be made by bereaved (i) partners; (ii) parents; and (iii) children and we foresee a difficulty in processing these affected claims unless those claimants are able to simultaneously progress the deceased infected claim. Many will consider that these types of claimants hold some of the most serious and pressing affected claims.

149. In this regard, we submit that the IBCA must proceed with caution when it decides the order in which different cohorts will be brought into the Scheme to make their claims; it must avoid at all costs, taking the very simplest affected claims at the end of this year for the mere purpose of meeting a target. That is not to say that every claim is not deserving of attention, it is simply to say that there is an objective view that the parent of a deceased child who has never received any recognition for their loss, is a very pressing case.

150. Turning to the order in which individual claims should be sequenced or prioritised, we have had regard to the Inquiry’s proposals of 12 May 2025 into which it is clear, a great degree of thought has been placed.

151. Attempting to create a system of prioritisation, particularly one which would operate across all cohorts rather than within individual cohorts, is a vexed issue because it necessarily involves comparing the circumstances and suffering of different people and then ordering them in degrees.

152. Whilst there is a relatively broad consensus that people within the last year of their life ought to be brought forward to make their claim, beyond that we see very little consensus; this makes it extremely difficult to rank the factors for consideration.

153. Moreover, we are unsure as to how administratively burdensome it would be to rank all people in the manner which is suggested but logically, it would seem that it would be more difficult to include currently unrecognised people

⁴⁷ Ibid, Pg56, L14

⁴⁸ 07/05/2025 Transcript, Pg80, L7

because their eligibility to claim must first be established. That is not to say that those people are not deserving of prioritisation; the point is simply that a detailed and considered approach to prioritisation such as the Inquiry suggests, would likely come at an administrative cost.

154. We refer back to our previous submissions on the importance of efficiency, particularly at a time when the IBCA is yet to reach its anticipated full capacity in terms of staffing levels. We would be cautious of any proposal which would prevent the IBCA from processing the maximum number of claims at any given time.

155. Whilst the intention of a system of priority may be to ensure that the maximum number of people see recognition for what has happened to them, or see their immediate suffering alleviated, it may be that this goal is best achieved by maximising the efficiency of the Scheme that we already have in place.

156. Finally, it is worthy of consideration that a prioritisation system may well offer some peace of mind to those placed to the front; it may well also have negative effects on those who know that they are now at the back.

General/Miscellaneous Issues

Test & Learn

157. Mr Foley spoke in some detail about the methodology of the test and learn approach and why it had been embraced by the IBCA⁴⁹ he set out the advantages of building a system in the real world which could evolve as it was built and rapidly increase its capacity after that initial learning had been done.

158. There was, in our submission, some force in Mr Foley's evidence and even if there might not be a consensus that a test and learn approach was appropriate for the Scheme, a clear explanation of why that approach was taken has been given.

159. Nevertheless, we submit that there is a clear drawback to the test and learn approach and that is what to do about claims which have taken part in the test phases but then the Scheme has evolved, and they would have perhaps received a greater financial benefit had they not been within the first intake.

160. This situation arose earlier this year when the current regulations replaced the first regulations and adjusted or clarified the equation for calculating past financial losses and care awards⁵⁰.

161. On this occasion, the IBCA initiated internal reviews under Regulation 83 which empowers the IBCA to commence an internal review in three circumstances:

⁴⁹ 08/05/2025 Transcript, Pg 22, L23 onwards (by way of example)

⁵⁰ WITN7755003_0030

“(a)whether fraudulently or otherwise, any person has misrepresented or failed to disclose a material fact and the original determination was made in consequence of the misrepresentation or failure,

(b)the original determination was based on a mistake as to a material fact, or

(c)there was an error or omission which affected the substance of the original determination, including as to the amount of any payment made under the IBCS.”

162. The right to commence an internal review after an offer of compensation has been accepted resides solely with the IBCA. Whilst Regulation 82 enables a person making a claim to request an in internal review, paragraph 3 of that regulation prevents them from doing so if an offer of compensation has been accepted.

163. We have no reason to doubt that the IBCA would commence internal reviews wherever an error was identified or the Regulations were amended or interpreted differently and indeed, Recognised Legal Representatives have received assurances from the IBCA to this effect.

164. Nevertheless, there is, in our submission, something of a lacuna in terms of how an internal review can be assured in circumstances where there is disagreement between the IBCA and a claimant, about whether a change has impacted their claim. By the letter of the Regulations, a claimant is to a degree, always reliant on the goodwill of the IBCA to commence an internal review.

165. It is conceivable that a number of changes may occur to the Scheme and to the Regulations over the coming months:

- a) The Minister undertook to revisit several aspects of the Scheme in his oral evidence⁵¹; changes could be made to the Regulations and/or their interpretation as a result of his review.
- b) The Inquiry may make recommendations about the content and/or interpretation of the Regulations, the Government may accept those recommendations and change would result.
- c) As a natural consequence of a test and learn approach, the IBCA's interpretation of the Regulations may adapt into more comprehensive policies over time: this may mean that claims are assessed under different criteria as time progresses.

166. Whilst not questioning the IBCA's integrity, there ought to be a recorded mechanism whereby people who have been the subject of either a mistake or a change in regulation/interpretation/policy can independently request (and have heard) an internal review.

⁵¹ As summarised by the Chair at 07/05/2025 Transcript, Pg195, L9 onwards.

167. In our submission, **the Inquiry should recommend that Regulation 82 be amended to empower claimants to seek an internal review at any time after they have accepted an offer of compensation if (a) a change has been made to the Regulations and/or their interpretation; or (b) a change has been made to IBCA policy, AND any such change could result in the Claimant's offer of compensation being changed.**

The Future of the Infected Blood Inquiry

168. In our August 2023 submissions to the Inquiry⁵², we encouraged the Chair to refrain from providing the sponsoring minister with notice that the Inquiry's terms of reference had been fulfilled.

169. In a submission which was endorsed by a number of the other Recognised Legal Representatives acting for infected and affected people, we said that the Inquiry still had an important function in monitoring the implementation of its recommendations, by virtue of the fact that one of the Inquiry's terms of reference is to *"examine the nature, adequacy and timeliness of the response of Government."*

170. In the Inquiry's Report, this submission was accepted, and the Chair wrote:

*"In the context of this Inquiry, perhaps beyond all other, it is unconscionable to allow a state of affairs to exist in which these fears [of assurances being given and not kept and of a dragging of feet on the part of Government] are realised. I am satisfied that I must do what I properly can within my powers to try to ensure this does not happen."*⁵³

171. Before saying:

*"...before the end of this year, the Government should report back to Parliament as to the progress made on considering and implementing the recommendations. I anticipate that at that stage, I should be able to tell the Minister that the Inquiry has fulfilled its terms of reference. But I shall do so only if I am satisfied that there is no further role I can usefully play in preventing delay."*⁵⁴

172. Regrettably, at precisely the time at which the Chair anticipated that he might be able to notify the Minister that the Inquiry's terms of reference had been fulfilled, he finds himself in receipt of a number of submissions, following two days of further hearings, and about to prepare a further Report.

173. In our submission, the events of the last twelve months and particularly, the events of the last two months, have demonstrated clearly that there is still

⁵² SUBS0000070_0003

⁵³ Inquiry Report, Volume 1, Pg282

⁵⁴ Ibid

a further role which the Chair can usefully play in preventing delay. We say this for two reasons:

- a) As matters currently stand, only one cohort of potential claimants has begun to have their claims processed by the IBCA. Whilst we can assume that one way or another, the IBCA will meet its target to begin the first affected claim by the end of this year, we have no idea when the various different cohorts (deceased infected, bereaved partners/parents/children, unregistered infected, unregistered affected) will be able to begin their claims. It is far from satisfactory that so many people do not yet know when they will be able to commence their claims and whilst we hope that it will not prove necessary, it is not inconceivable that the Inquiry might in the future receive significant volumes of correspondence from those people expressing their concerns.
- b) The very act of taking further evidence and holding hearings has, in our submission, already brought about a reduction in delay. It is more than mere coincidence that the IBCA accepted 200 claims shortly before the commencement of the hearings on 7 May and committed to taking an average of at least 100 claims per week going forward.

We can say this because the Minister told the Inquiry during his evidence that he made no apology for using deadlines such as the hearing dates to “drive the system”.⁵⁵

174. We say that the Chair’s decision to refrain from notifying the Minister in May 2024, that the Inquiry’s terms of reference had been fulfilled has been vindicated. Indeed, it is difficult to imagine that the Inquiry’s terms of reference could be fulfilled whilst so much uncertainty still remains about how and when people will receive their compensation.

175. In our submission, **the Chair should satisfy himself that the Infected Blood Compensation Scheme is working tolerably well for all cohorts of claimant before providing the Minister with notice that the Inquiry’s terms of reference have been fulfilled.**

176. We suggest that the Chair might provide a date within 2026, advised by the anticipated timescales of the IBCA, whereby he will take stock of the progress of the Scheme and hopefully, at that point, consider that the Inquiry’s terms of reference have been fulfilled.

Whilst reserving our position as to making further submissions in relations to the documents published on 21 May 2023, unless we are able to assist the Inquiry any further, these are our submissions.

**BEN HARRISON
MILNERS SOLICITORS**

⁵⁵ 07/05/2025 Transcript Pg 73, L22 onwards

APPENDIX

Suggested Recommendations.

In our submission, the Inquiry should make the following recommendations:

- i) that Regulation 3(4)(a) be amended to remove the reference to 1 January 1982 and provide for the automatic eligibility of any person infected with HIV prior to 1 November 1985.
- ii) that the equation at Regulation 7(2) should be modified, insofar as it concerns past care awards, to read $((Y2+0.25) \div Y1) \times T$; thereby removing the additional 25% reduction to the calculation.
- iii) that the text of Regulation 14(2)(c) should be modified to read: "Where the diagnosis mentioned in sub-paragraph (a) is one of HIV, the date on which it was given."
- iv) that Regulation 20 be amended to allow for the application of the deeming provisions from any known date of severity change.
- v) that Regulation 26(2) be amended to simply read "An eligible infected person was also subject to unethical research practices if they received treatment for a bleeding disorder between 1974 and 1984."
- vi) that where an internal review is requested of a decision taken by the IBCA which involved the input of a clinical advisor, the review should involve taking further and separate advice from a different clinical advisor, unconnected with the first decision.
- vii) that all those currently registered with the IBSS and admitted to the SCM should automatically be eligible for a severe health impact award as envisaged by the expert group in their 16 August 2024 report.
- viii) that the IBCA begins to:
 - a) Accept pre-prepared declarations forms supported by evidence bundles for living, infected, IBSS registrants whether represented or unrepresented;

- b) In the case of previously unrepresented people who have requested legal support, provide the referred lawyer with full contact details and all copy evidence at the point at which that lawyer accepts the instruction.
- ix) that the IBCA communicates its plans and anticipated timescales for opening up the Scheme to all cohorts as soon as those plans and timescales are settled upon (to the extent that they have not already been settled upon).
- x) Find that it has seen no compelling evidence that the publication of IBCA policy and guidance could lead to an increased risk in fraud and should recommend that all such policy and guidance, insofar as it concerns the interpretation of Regulations which will impact upon the eligibility of a claimant or the quantum of their claim, be published by the IBCA.

AND the Inquiry should:

- xi) find that the proper interpretation of the definition of cirrhosis within Schedule 1 to the Regulations, includes any claimant who can evidence that (a) they have a clinical diagnosis of cirrhosis; or (b) they have fibrosis as a result of their infection with hepatitis B or C.

AND

- xii) the Chair should satisfy himself that the Infected Blood Compensation Scheme is working tolerably well for all cohorts of claimant before providing the Minister with notice that the Inquiry's terms of reference have been fulfilled.