Much of the evidence heard on 7 and 8 May concerned the speed of delivery of compensation. The Inquiry has also received a large body of evidence that the uncertainty of not knowing when someone can expect to receive compensation, and the random way in which people have been selected for consideration, are damaging in themselves.

While changes of process may bring greater speed, not every case can be dealt with at once. Some applications will necessarily be determined before others. If the majority of these were likely to be concluded within a handful of months, people whose cases were amongst the last to be determined might nonetheless accept the position. However, the evidence heard suggests that it will take longer than that. The need to prioritise claims in an acceptable manner, which all can understand and most would accept as being fair, has been there from the moment that complex Regulations about compensation were put in place. IBCA is now prioritising the claims of people who have been told they have less than 12 months to live. However, there is no other scheme of prioritisation currently in place, nor any other transparent basis on which one claim will be determined in advance of another except random selection.

The Inquiry is inviting submissions on a proposal to help establish the most appropriate way of achieving a scheme of prioritisation which both is fair and commands the greatest trust.[1]

There are different ways in which a clear, transparent, system for deciding which claims are to be assessed first could be adopted. IBCA's current approach is to give priority to people who have been told they have less than 12 months to live but otherwise to select people at random. Selection at random can be understood but seems arbitrary. If people infected and affected were able to register their interest with IBCA then, after separating out people who have been told they have less than 12 months to live for first consideration, those applications could be dealt with in the order they were received. That would arguably be less random, but it would feel

[1] The Inquiry is aware that some of the evidence it received was critical of IBCA's consultation on prioritisation (see Counsel Presentation on Evidence Concerning Compensation 29 April 2025 para 16 INQY0000464). However, the Inquiry believes that it would be helped by having submissions on the issues set out in this document.

similarly arbitrary. Alternatively, a score could be assigned to each case based on a number of factors, but any weightings applied to arrive at the score could feel arbitrary too, and the application of a weighting system might be complex and seem lacking in clarity.

Accordingly, it may be that a better solution would be to separate out those applications which it is commonly accepted should be dealt with before those that remain e.g. those where the applicant is within the last 12 months of life; then to separate out another set of applicants from the pool of those who remain by using the next most significant factor, and continuing to do so by applying different factors in turn to the remaining group of applications. The process would continue until all the relevant factors had been used to filter through the applications. Within each group the less significant factors (for these purposes) are used to rank applications. This system (ranking applications by the serial application of factors, each of lesser significance for these purposes than the previously applied factor), allows everyone to understand why one application is processed ahead of another, and gives confidence that their place in the queue is the result of transparent ranking. However, it requires a general measure of agreement as to which features are more important than others for the purpose of deciding “who’s next?”

It must be emphasised that every claim matters, that justice will not be achieved until every person infected (alive or deceased) and affected receives compensation, and that any system of prioritisation emphatically does not mean that any claim, or any individual whose claim it is, is less important than any other. A proper system of prioritisation recognises however that justice is long overdue and that, as all understand, people will die before receiving the recognition of compensation.

The principles underpinning such a system in this proposal are that the order in which applications are processed should minimise the number of people who die before receiving recognition through compensation, maximise the number who live to receive some benefit from compensation, and take into account whether the infection has yet been recognised through interim compensation.

To minimise the number of people who die before receiving recognition, maximise the number who live to receive some benefit from compensation and recognise that some people infected have yet to receive any recognition through interim compensation, applications ***by people infected*** could be filtered according to the following list of factors ranked in descending order:

- have been told she/he has less than 12 months to live
- is 80 or over
- has advanced liver disease or a liver transplant *and* lives with the consequences of AIDS
- has advanced liver disease or a liver transplant
- is 60 or over
- lives with the consequences of AIDS
- is coinfected (i.e. has been infected with more than one virus)
- has never had interim compensation
- had interferon treatment (with or without ribavirin)
- age

Similarly, applications ***by people affected*** could be considered according to the following list of factors:

- has been told she/he has less than 12 months to live
- is 70 or over
- the infection has never been recognised by interim compensation to the person infected, the estate of the person deceased or a bereaved partner
- personally never had interim compensation (directly or through a payment to the estate of the person deceased)
- age

Applications to recognise ***the compensation for people deceased*** through estates could be considered according to the following list of factors:

- any beneficiary of the estate has been told she/he has less than 12 months to live
- any beneficiary of the estate is 70 or over
- never had interim compensation
- age of the oldest beneficiary of the estate

On this model IBCA would work through the three lists and where an applicant has more than one claim related to the same infection (e.g. as a person affected and the losses of a deceased person through the estate) they would be processed together. Working through the three lists in parallel would mean that for all three groups the number of people who die before receiving recognition through compensation is minimised.

The lists should be responsive to new applications, to changes in people's health and should be continually updated for age. The lists should also be updated if adjustment of the factors or their relative priority is needed in the light of feedback. People should be given the best available information as to where they stand in the lists, and this should be updated on a regular basis.

Worked example

To illustrate this approach with a fictitious sample of people infected:

Adam 85 advanced liver disease
Bella 55 chronic Hepatitis C and had interferon
Chris 44 chronic Hepatitis B so never had interim compensation
Daisy 60 lives with the consequences of AIDS
Edgar 56 advanced liver disease and lives with the consequences of AIDS and is coinfected with Hepatitis B, C and HIV and has been told he has less than 12 months to live
Florence 50 advanced liver disease and coinfected with Hepatitis B and C
George 55 advanced liver disease from Hepatitis B so never had interim compensation
Harriet 58 advanced liver disease
Imran 62 advanced liver disease and lives with the consequences of AIDS and coinfected with Hepatitis B, C and HIV
Jane 82 chronic Hepatitis C
Ken 46 chronic Hepatitis C and had interferon
Lucy 54 chronic Hepatitis C

To construct the list manually[2] from the bottom upwards:

Sort by age
Sort by had interferon treatment (with or without ribavirin)
Sort by never had interim compensation
Sort by coinfection with more than one virus
Sort by lives with the consequences of AIDS

[2] In practice, the process would easily be computerised and should thus not itself give rise to further delay.

Sort by 60 or over
Sort by advanced liver disease
Sort by has had AIDS *and* advanced liver disease
Sort by 80 or over
Sort by has been told has left than 12 months to live

This process results in a list taking all of these factors into account in the prioritised order.

The order becomes:

Edgar 56 advanced liver disease, lives with the consequences of AIDS, coinfected with Hepatitis B, C and HIV and has been told he has less than 12 months to live
Adam 85 advanced liver disease
Jane 82 chronic Hepatitis C
Imran 62 advanced liver disease, lives with the consequences of AIDS and coinfected with Hepatitis B, C and HIV
Florence 50 advanced liver disease and coinfected with Hepatitis B and C
George 55 advanced liver disease from Hepatitis B so never had interim compensation
Harriet 58 advanced liver disease
Daisy 60 lives with the consequences of AIDS
Chris 44 chronic Hepatitis B so never had interim compensation
Bella 55 chronic Hepatitis C and had interferon
Ken 46 chronic Hepatitis C and had interferon
Lucy 54 chronic Hepatitis C

This suggested approach is designed to ensure that as many people as possible live to see their suffering recognised by the State, to maximise the number who live long enough to receive some benefit from compensation, to minimise the wait for people who have yet to receive any compensation and to enable everyone to have confidence that the order in which recognition is received is transparent. In other words, it is aimed at achieving a measure of broad fairness in the order in which claims are assessed, whilst acknowledging that every claim must be determined as soon as possible.

The Inquiry invites submissions on this approach and in particular:

A. whether the outcomes to be prioritised should be:
    i. as many people as possible live to see their suffering recognised by the State

ii. the number of people who live long enough to receive some benefit from compensation is maximised

iii. the wait for people who have yet to receive any compensation is minimised

B. whether this proposal achieves those outcomes

C. whether there are alternative ways to achieve these outcomes or alternative factors or approaches that you believe the Inquiry should consider.

The Inquiry emphasises that what is set out above is simply a proposal and that no decision has been taken by the Chair to make a recommendation along the above lines.

Any submissions should be filed by the deadline of **4pm on 23 May 2025**, and can be filed as part of any Recognised Legal Representative's or unrepresented Core Participant's main submissions or as a separate submission.

Submissions should be provided to submissions@infectedbloodinquiry.org.uk by recognised legal representatives on behalf of the clients they represent.