**Wednesday, 9 July 2025**

**SIR BRIAN LANGSTAFF:** That seemed like a Mexican wave! Thank you very much.

Just over a year ago, I presented the full Inquiry Report. I said this disaster was not an accident. Patient safety had not been put first. People put their trust in the NHS and doctors and that trust was betrayed. The NHS and successive governments compounded the agony by refusing to accept that wrong had been done -- for far too long.

On the same day as I stood before you, Rishi Sunak stood before Parliament and accepted the findings of the Inquiry. He described it as a day of shame for the British state and that whatever the cost of compensation, the state would pay it. This was now the time, finally, for national recognition of this disaster, for proper compensation and for vindication for all who had been so terribly wronged. It was years too long in coming.

Compensation needed to be rolled out quickly. Time has always been an enemy. Some time may have to be taken to get things right but time should never be allowed to become delay. Delay creates an injustice all on its own. At the hearings in May no-one quibbled when Counsel to the Inquiry said it was taking too long.

Well over 1,000 people had either come to London to hear the results of the decades-long battle for the truth or watched online. Some of them are no longer with us. One man spent his last days applying for compensation but died before the process was completed. His family don't know when they will receive the recognition that should have been his. A mother in her 80s whose two sons and husband were infected at the same hospital died before she was even allowed to start the process. Many, many fear they will not live to see the recognition which compensation brings.

You, you of all people, know the origins of today's report. You wrote to me from across the UK: individuals from all walks of life, campaign groups, charities, legal representatives, bereaved partners, parents, children and siblings, and parliamentarians. Many of you wrote to say how concerned you were about compensation, how desperate and how powerless you felt. You said that asking questions got formulaic responses, the suggestions were ignored, the challenge wasn't welcome, and that it was all taking too long.

The concerns grew and grew until I simply had to respond. The Inquiry set about gathering evidence informed by your questions and your concerns and more came to light that needed answers. So we held hearings. Still more came to light. Today, I present my additional report on compensation.

Many of you, I know, were worried that the fight for justice might not have ended with the publication of the Inquiry Report over a year ago. Yes, the Government announced a compensation scheme and, yes, it is properly funded. But just as you feared, this was not -- this is not -- the whole story.

The UK Government has known for years that compensation for thousands of people was inevitable and identified many who should have it. But only 460 have so far received compensation and many, many more have not even been allowed to start the process.

For decades, people who suffered because of infected blood have not been listened to. Once again, decisions have been made behind closed doors leading to obvious injustices.

It's not too late to get this right. We are calling for compensation to be made faster and, more than that, fairer. Let me explain.

In 2017, when Theresa May announced there would be an inquiry into infected blood, it was known that compensation might well be recommended. After all, it had been a central factor in the unwillingness of successive governments to establish a public inquiry until then.

No action was taken on compensation over the next three years but five years ago -- five years ago -- in July 2020, the then Paymaster General, Penny Mordaunt, wrote to the Chancellor to say she believed that compensation was inevitable.

No action was taken until March 2021 when she announced a Compensation Framework Study and Sir Robert Francis undertook it. He reported in March 2022 and you will remember the Government saying that they would publish the response with his report. They didn't.

I made my full recommendations on compensation in April 2023 over two years ago. Sir Robert Francis and I had both recommended that people infected and affected should have a central influence in the creative design of the scheme.

That autumn we now know Cabinet Office officials advised the Government -- the Government -- should take decisions about the design of the scheme and that an Expert Group should meet behind closed doors to provide advice.

The Expert Group was specifically forbidden by its terms of reference from talking to people infected and affected, the very people with the closest, most intimate knowledge and understanding of what the compensation scheme was supposed to compensate. It should have been unthinkable to design a scheme without properly involving people affected by the decisions being taken by Government. It seems even more inexplicable to prevent there being any involvement while the scheme was at a formative stage. Yet that is what happened and that is the source of many of the obvious injustices in the scheme. Let me describe how my recommendations may help to put that right.

The scheme as currently written compensates anyone infected with hepatitis B or C as a result of infected blood, blood products or tissue since 1952. Well, that was when the World Health Organisation identified how to reduce the risk of transmitting hepatitis through blood and blood products. It was well understood that when you addressed the risk of infection through blood, you were reducing the risk not only of known infections but also of future, as yet unknown, infections that could emerge -- just as HIV did. But the scheme, as currently written, makes anyone infected with HIV before 1982 ineligible.

A mother wrote to me to say that, and I quote:

"My daughter has now been 'invited' to claim compensation only to be told that she's likely to be ineligible because she was infected prior to 1982. The

relevant regulation appears to have no regard for the fact that she receives support payments and she was awarded both interim compensation payments without question. To reach this stage of proceedings to be faced with the unbearable possibility of her claim being declined is yet another nightmare to be somehow endured."

What she called a nightmare must end. I've recommended that an amendment be made to the regulations as soon as possible to address it.

For hepatitis, two things in particular stand out. First, the amount of compensation depends on levels of severity. Level 2 is chronic hepatitis B or C and Level 3 is cirrhosis (which should be understood to include serious fibrosis). Submissions have been made to the Inquiry that, as it stands, there is too large a gap between these two levels.

Now, this isn't a new concern. There was once a similar gap in the support schemes for hepatitis C. It became obvious over time that that gap needed to be bridged. Individuals and campaigners said so, medical experts agreed, justice required it, administrators took heed. They recognised that, as chronic hepatitis slowly progressed, as it always does unless successfully treated, disabilities slowly became worse even though

cirrhosis had not yet appeared. Those disabilities got to the stage where work, everyday activities, family life all became much more difficult.

So an intermediate category was recognised which came with additional financial support. In England, it was known as the Special Category Mechanism. I hope you will forgive me for referring to it as the "SCM". It's a bit less of a mouthful.

The national support schemes, each in their own way, introduced their own version and had no difficulty in satisfying themselves that a person qualified. When the compensation scheme was announced last May, there was nothing to bridge the gap between chronic infection and chronic/serious fibrosis. It took people responding to the limited engagement exercise undertaken in June 2024 by Sir Robert Francis to point out that the proposed scheme did not align with, or take account of, the SCM and its national variations. The Expert Group accepted, just as other experts had done before it, that the gap was too large. It recommended a supplementary award. Sir Robert Francis agreed. The Government, in turn, accepted that advice. So the position seemed clear.

You might have thought things were settled, but no. In January this year things changed again. Only a

small number of conditions were now to be eligible for the supplementary award. The lessons of the past were put to one side; the mistakes of the past were repeated. The apparent justification was that the SCM lacked an objective marker to prove entitlement.

The second thing that stands out about hepatitis is this. There is little evidence that the impact of interferon, an early treatment for hepatitis that devastated so many people's lives, has been properly recognised. Having had interferon treatment is easy to establish objectively if you're looking for a marker.

In respect of these two matters, I have recommended that anyone who received interferon should receive the same core award as someone with serious fibrosis or cirrhosis and that an SCM-type award should be available for those experiencing long-term severe disability, just as was accepted by all last August until it was reversed in January this year.

There is a compelling reality behind those recommendations. Consider a woman who was given a transfusion after birth which contained hepatitis C. Her health was never the same again. Her GP told her that it was because she had had children or because of her age, et cetera, et cetera, until eventually her liver deteriorated to the point that the GP had to work out what caused all her illnesses. She was diagnosed with hepatitis C and given a 48-week course of interferon. The side effects were close to unbearable and her life would never be the same again. Like most people, she went through that early treatment only to find after the 48 weeks that it hadn't worked.

She had a second course with ribavirin and that was even worse, giving her ribavirin rage that pushed away her family and meant she could not look after her children. Eventually, she cleared hepatitis with one of the modern treatments but she was ever able to go back to work. Money was a constant worry. When campaigners managed to get SCM, she got support payments that went some way towards helping. But when in January this year that changed (only a small number of conditions would now be eligible for the supplementary award), she would not be eligible despite her symptoms, despite interferon treatment. She could decide to keep getting her support payments but she really wanted to draw a line under all of this, take the lump sum compensation and not be left with constant reminders about what had happened.

If my recommendations are accepted, she could do that. Her core award would more appropriately reflect the severity of the impact on her life. She could apply for a supplementary award to recognise her long-term

severe disability. She wouldn't be forced into continuing support payments. And if my recommendations are accepted, those who have never been registered with a support scheme and who would be significantly disadvantaged by the Government's change of position on the SCM, will have an equivalent entitlement to compensation to those who had previously received SCM payments.

Well, you might wonder if this would increase the bill for compensation substantially. It wouldn't. I say that because, last November, Cabinet Office officials advised that the cost modelling they had treated everyone registered for the Special Category Mechanism -- there I said it -- and equivalence as receiving the higher levels of care and financial loss awards. The change they were making to the supplementary award would reduce the numbers eligible and the saving would be approximately 100 million. That saving wasn't justice.

Well, that sadly is not all I have to say about hepatitis. The regulations have further curiosities. Modern effective treatments introduced within recent years have enabled many people with hepatitis to have a greater earning capacity following successful treatment. But what if you're not one of those who's only received

these new drugs? What if you have the after-effects of earlier treatments to contend with? What if you have experienced decades of ill health that have prevented you from working as you would have wished? It doesn't logically follow that because someone else has had access to better treatment, your health should improve at the same time. Yet that is effectively what the regulations provide. Well, I recommend that the assumption that ability to work improved after new treatments came into use should not apply where there is evidence to show that you have real difficulties in returning to work, or to as much work as you did before.

The scheme sensibly takes some account of the problems there have been with medical records and late diagnoses, documented at length in the Inquiry Report. It allows the compensation authority, IBCA, to work out the likely severity of hepatitis in the past working back from the application date for someone with serious fibrosis or cirrhosis. That's because the disease naturally becomes worse and worse over time passing from chronic disease (Level 2) to cirrhosis (Level 3) to decompensated cirrhosis (Level 4).

The problem is that people who have been so seriously ill they needed a liver transplant will know when that happened but some of them may have no idea

when, before that, they had actually developed cirrhosis, which they inevitably would have done. Because the scheme doesn't work backwards from the date of transplant but from the date of application to the scheme, the effect of these deeming provisions is that they will be treated as if they never had cirrhosis but passed straight from the chronic disease stage (Level 2) to the stage of having a transplant (Level 4) jumping Level 3. They miss out on years of Level 3 compensation for cirrhosis which they would inevitably have suffered.

The effect of my recommendation would be to calculate back not from the date of application but, if it is known, from the date that a person's infection reached Level 3 or Level 4.

I've also recommended that the requirement in the regulations to provide evidence of the date of diagnosis of hepatitis is removed since it is not used in the calculation of compensation, and requiring people to prove something which serves no useful purpose is just likely to cause further delay.

People who currently receive support scheme payments have a choice as to how they deal with future costs and losses. They can go on receiving support scheme payments or they can opt for a lump sum to cover those losses. The oddity of the scheme is how past care costs and financial losses are compensated. A person who chooses to continue support scheme payments for the future will have that past loss reduced, whereas the person who decides not to continue support scheme payments for the future will receive the same sum for past loss but without any reduction.

Well, I have concluded the reasoning for this obvious inequality of treatment does not stand up to scrutiny and I recommend it ends.

The scheme's treatment of earnings losses assumes that if people had not been infected, they would have received statistically average earnings plus 5 per cent. There is, however, provision for people who would be very likely to have had higher earnings than that. They could be paid an exceptional reduced earnings award. Now, obviously there has to be some evidence of this. However, the evidential requirements are likely to prove a barrier for most people: the regulations set such a high bar that they may exclude people who have sufficient evidence that they would have been amongst the higher earners. Take the man who lost his business while he was undergoing treatment with interferon. He had no reason to retain full records for a compensation scheme decades in the future when there seemed no prospect of that at the time.

I recommend that the Cabinet Office consult on the evidence required for compensation for exceptional reduced earnings and consider whether the current requirements are unrealistically high.

One further point about the way in which this scheme is currently drafted. Entitlement to a supplemental Severe Health Condition Award arises if a person has, amongst other conditions, a severe psychiatric condition. At the moment, the evidence required by the regulations means that most people who should qualify will not. They need to have a diagnosis from a consultant psychiatrist and have had at least six months' consultant-led mental health treatment or been an in-patient. Now, the Clinical Lead of the new Infected Blood Psychological Service in England has recommended that this should be amended and I have adopted her recommendation. People who never had access to a psychiatrist should not have to provide an opinion from one, nor should it be necessary to demonstrate period of consultant-led secondary mental health treatment or in-patient treatment when consultant psychiatric services were not the norm across every part of the country and when getting access to them would involve disclosing the infection when stigma meant that most people would have to be careful about who they

told, if they told anyone at all.

I have three more recommendations to explain regarding the content of the scheme.

The first is where someone was subjected to unethical research. At the moment, the regulations provide list of haemophilia centres and studies of a specific date range. But unethical research wasn't necessarily limited to that list or that date range and the definition of research used by the Government in deciding which centres to include is too narrow.

A man was infected with hepatitis C as a result of treatment he had as a young child. His doctor wrote a letter saying that he hoped that since the boy had never had blood products before he would be suitable for a trial of a commercial blood product. That letter was copied to a pharmaceutical company. His mother was never told about this. She said that if she'd known, and I quote:

"I would have picked my child up and walked out of that hospital."

Yet the scheme does not provide an opportunity for him to satisfy IBCA that he was subject to unethical research practices because the hospital at which he was infected was not one of those specifically named in the regulations as a centre where unethical research took

place.

I recommend that where there is evidence that someone was the victim of unethical research practices they should receive the award. I have also recommended that the Minister consider whether the level of an award for unethical research accords with the general public's sense of justice and fairness.

It was not only the lives of people infected that were unalterably changed by the infections but also the lives of those closest to them. Some suffered serious psychological trauma. Many took on significant caring responsibilities with adverse impacts on health, education and careers.

There is currently no supplementary route for the people most severely affected. I recommended that the Minister involve parents, children, siblings, partners and carers in considering whether there should be.

I've also reflected on the submissions I have received about the deceased affected. I made by recommendations on compensation over two years ago and no-one affected has yet been able to start their claim, even though some are terminally ill and some are in their 80s and may not live to see justice.

The Government's expectation is that by the end of 2029 people affected who have come forward will have received compensation. The financial forecasts for the scheme have allowed for all those claims. But the end of 2029 will be more than six years after my recommendation. At the time, I made the recommendation I saw no reason why it would take anything like that long.

In view of the delays, I have recommended that where someone affected dies between the announcement of the compensation scheme on 21 May last year and 31 December 2029, their claim should not die with them but should become part of their estate.

I'm also concerned about the position of partners bereaved after 31 March this year. Whereas someone bereaved before or on 31 March continued to receive support payments, someone bereaved from or after 1 April does not.

Imagine a couple whose lives were turned upside down by the husband's infection. They both had to give up work. They could not get a mortgage or life insurance. They had to rely on support payments.

Until the rules changed in March, he knew that his wife would still be supported after his death. Now, all support will end when he dies because? Because eventually she will be able to apply for compensation. That will leave her financially desperate, at the worst

possible time, with no way of knowing when compensation will actually come.

I recommend that support payments continue to be available for bereaved partners until they receive compensation.

Let me turn from my recommendations to remedy injustices in the scheme to recommendations about the way in which the scheme is administered. I welcome the Government's announcement on Sunday that it has taken action to speed up the delivery of compensation.

(Child cries)

She or he does too!

But there is more than needs to be done. Over a year since the announcement of the compensation scheme, people should be able to apply. It's extraordinary that people can't even register for the scheme and that cannot help IBCA's ability to plan. The submissions to this Inquiry have called for registration to begin forthwith and I agree.

IBCA has the deciding role in compensation in the Regulations but it doesn't need itself to perform every preparatory step. Since time is not on anyone's side, I believe that the process of compensation should be viewed as a system in which enabling individuals to be more proactive where they wish, and making better use of

lawyers and third parties, will help speed the system.

I'm recommending that people are able to apply in three ways: the first is simple registration with a minimum of information; the second is completing a fuller application form for those who wish to do that, with the option (for those who already have, or whose lawyers already have, the relevant documents) of supplying an evidence pack; and the third, for those who wish to do so, is to include a calculation of their compensation. I have also recommended that, as an intermediate step, IBCA provides option to move straight to the declaration stage for people who provide all the necessary information. None of this would affect the order in which compensation is processed or favour one person over another, but it would mean that some claims can be processed faster and that benefits everyone.

I'm also advising that IBCA makes better use of the knowledge of lawyers who have built up a wealth of knowledge during the Inquiry about where medical records can be found or where they have concluded for good reason after their own efforts, that the records have been destroyed and that to try to obtain them now was likely to be a fruitless waste of time.

It is essential that people are aware of the legal support paid for by IBCA so that people new to all this

don't unwittingly sign up with lawyers offering support in return for part of someone's compensation. "No win, no fee" means if you win you pay a fee. That's difficult to justify where there is funding in place for lawyers who are signed up to do the necessary work at agreed rates. I have recommended that IBCA prominently refer to the availability of free legal support and that the Solicitors Regulation Authority reminds solicitors of their obligations.

Since it is known that some people are unlikely to live to receive compensation and that some people infected (such as those infected with hepatitis B or infected outside the cut-off dates for the support schemes) have never had compensation, it seems wrong to select claims at random. Though nothing I say in my report affects IBCA continuing with its work compensating people infected and registered with the schemes, since they expect to start all those claims by the end of this year, I recommend that IBCA updates the rest of its sequencing. I recommend that there are three cohorts: people infected and never compensated; the deceased infected, and people affected. I have said that IBCA should progress the cohorts in parallel, not sequentially, and with a system of prioritisation which considers age and state of health. It should be accepted as an overriding principle that prioritisation should aim to ensure that as many people as possible receive some compensation in their lifetime.

I've also made recommendations about IBCA's review process so that it works fairly. Many of the concerns about IBCA have related to transparency and the involvement of people infected and affected. The two are linked. If you, and others, don't know how the scheme is operating, you're likely to have unanswered questions and cannot share experience and knowledge that would help the scheme operate fairly for everyone.

There's no dispute about the principles of transparency and involvement. They must best fully reflected in practice. I have recommended that IBCA should now publish more guidance and documentation so that people can understand how the scheme is operating.

IBCA plans to have an advisory body consisting of people infected and affected, but I have recommended that IBCA should now put this in place and ensure that it has a formal role within IBCA.

I've also recommended that IBCA should now adopt a more structured response to contributions from people infected and affected so that you know they are actively listening.

This Additional Report and these recommendations

have been made after only 460 people have received compensation. Many more are yet to come and it is inevitable that some more issues will emerge. How do you deal with them? Well, I recommend that the Government and IBCA establish a mechanism through which your concerns can be raised and you can get a response and, if necessary, be considered by the advisory body or IBCA's board or the Cabinet Office and Minister.

It is a reflection of the lack of information and of response that further hearings and this additional report were necessary. The Inquiry stepped in because I could not in good conscience stand by when so many were raising concerns. I hope that going forward the approach will be that people affected by decisions are involved in them and need to be involved in them. That was one of the central lessons from the Inquiry Report published last year.

A significant cause of the infected blood scandal was the belief that authorities knew best and people didn't have to be consulted. Decisions were made behind closed doors and when things went wrong, people weren't listened to. It has happened again in the design of the compensation scheme. It will be a travesty to keep repeating these mistakes. People should not be kept at arm's length.

I hope that my Additional Report will help chart a constructive way forward, that the principles of transparency, involvement, listening rather than simply hearing, and recognising injustices and remedying them will underpin that response.

This last year has, as you know, brought further harm. No-one who watched the recent Inquiry hearings could doubt that. Now is the time to put that right. Now is the time for Government and IBCA to act so that you know that compensation -- the nation's recognition of the harm done to you -- will be faster and, more than that, fairer.

Thank you.

Thank you very much.

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