Witness Name: JAMES QUINAULT
Statement No: WITN7755006
Dated: 21 May 2025

INFECTED BLOOD INQUIRY

THIRD WRITTEN STATEMENT OF JAMES QUINAULT

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 12 May 2025.

I, JAMES QUINAULT, will say as follows:

Interim payments to estates

1. ***I am asked to confirm:***
   a. how many applications there have been for interim payments to estates;
   b. how many interim payments to estates have been made.

2. As of 9 May 2025, there had been 683 applications for interim payments to estates.

3. 92 applications were in progress; 21 applications had been approved and were awaiting payment; and 480 applications had been paid.

4. 90 applications had been rejected: in 31 cases, because the individual on behalf of whose estate the application was made was not known to the schemes; in

21 cases, because the individual making the application was not authorised to receive payment; and in 38 cases, because an interim payment had already been made.

Guidance to IBCA on interpreting the Regulations

5. ***I am asked to provide details of any advice which the Cabinet Office has provided to IBCA regarding the meaning of, or the approach to be taken to, specific regulations or specific parts of the regulations (whether under the 2024 or 2025 Regulations).***

6. The Cabinet Office has provided extensive advice to IBCA on the development and interpretation of the Regulations, on both specific regulations, and on the Regulations taken as a whole.

7. This has taken the following forms:

    a. briefing IBCA on the nature of the scheme and the regulations that implement it: for example, setting out the types of people that are eligible for compensation and the categories of award under the scheme;
    b. explaining to IBCA the intended operation of particular regulations that are complex and would benefit from explanation: for example, how to use the appropriate regulations to calculate a financial loss award;
    c. following from point b, collaborating with IBCA to help develop an engine for calculating claims and ensure that this engine is compliant with the Regulations. This involved explaining the intended operation of the Regulations and manually calculating hypothetical ‘case studies’ to assist in writing and testing the appropriate code;
    d. answering ad hoc queries from IBCA on the intended operation of regulations. This could involve “sense checking” IBCA’s interpretation in order to test whether it aligned with the intention behind the Regulations, providing advice on ambiguities, or seeking to outline the broader policy intention behind a particular regulation. This might be to respond to a

specific question from IBCA, or be part of their development of explanatory materials for IBCA staff or the community;

e. specifically on the steps that were needed in order to correct payments that had been made in accordance with an incorrect formula in the 2024 Regulations: the Cabinet Office produced a policy paper for IBCA that set out the error, how it had come to arise, how it was corrected in the second Regulations, and a proposed course of action on how to rectify the situation for those who had already been paid in accordance with the flawed regulation.

8. The above advice has been provided in a range of ways, including policy documents as noted above, presentations, email exchanges and verbal exchanges. Many of these interactions are informal and mostly not minuted. However, Cabinet Office officials can be invited to attend meetings of IBCA's Policy Group to provide input, and these events are minuted. A Cabinet Office official attended the Policy Group's meeting on 21 March, and the minute of this meeting has been provided to the Inquiry.

9. Advice to IBCA is limited to providing the Cabinet Office's understanding of the purpose behind the Regulations and of how the Regulations should be interpreted. IBCA is operationally independent and has the discretion to take a different interpretation. The Cabinet Office does not provide IBCA with guidance or instructions on what decisions to take in regard to individual claims.

10. For example, the Cabinet Office might set out its understanding of what the Regulations stipulate on how to decide whether a claimant has a Level 3 or Level 4 Hepatitis C infection. The Cabinet Office would not offer a view on how those provisions relate to a specific person's claim.

The Expert Group

11. ***I am asked to clarify how the Government saw the role and purpose of the Expert Group and provide copies of any instructions (beyond the Terms of Reference) provided to the Expert Group as to its role and remit.***

12. The Government saw the role of the Group as being to provide expert advice to the Government, to assist it in developing the detail of proposals for a compensation scheme.

13. The Expert Group's role was to support in particular with developing detailed proposals for severity bands and tariffs, and with the definition of eligibility criteria and evidence requirements.

14. The Group's instructions on its role and remit were set out in its terms of reference [RLIT0002487].

15. The terms of reference were supported by a suggested work programme, setting out in more detail what the Government was looking to the Expert Group to cover in its work. I have provided this document as exhibit [WITN7755007].

16. A further proposed work programme, for work up to December 2024 in support of the development of the second set of regulations, was shared with the Expert Group for discussion on 12 September. I provide this document as exhibit [WITN7755008].

17. ***In my oral evidence I said that the advice of the Expert Group on the SCM issue was "ambiguous" (transcript, INQY1000284 page 32, internal page 127). I am asked to identify the precise ambiguities that I was referring to in the report(s) of the Expert Group.***

18. The Expert Group's Final Report was ambiguous about whether all of the extra-hepatic effects of hepatitis and its treatment that are covered by the SCM or its equivalents should also qualify for the severe health impacts route; or whether instead the Expert Group meant that only some of them should qualify, since their Report identifies some effects as already reflected in core awards under the scheme.

19. Under the heading “Enhanced, Advanced and ‘Special Category’ bands”, the Expert Group’s Final Report said: “Some of these aspects [those recognised under the SCM and similar categories] of people’s experience have already been incorporated into core awards as the advice from the Expert Group is that they affect most people. This is the case in relation to chronic fatigue for all viruses.”

20. The Report also said of chronic viral hepatitis B and C: “There is likely to be a significant psychological impact that affects people’s ability to function, that should be reflected in the injury award for all beneficiaries in this category. Comparators have been taken from the National Blood Authority litigation (2001) and also from other personal injury cases involving liver damage, potential lifelong complications, stoma, and chronic fatigue. These comparators included compensation for the impact and side effects of treatment with interferon, where the awards ranged in 2001 from £17,000 to £45,000 (current updated values). We advise that an injury award of £60,000 would be appropriate”. The scheme as finalised includes an injury award of £60,000 for chronic hepatitis, as the Group recommended.

21. These sections of the Report are clear that, of the effects of hepatitis and its treatment for which SCM and equivalent payments are made, some (chronic fatigue, psychological impact that affects people’s ability to function) are already reflected in core awards under the scheme.

22. However, in listing the conditions that might qualify for the supplementary health impacts route, under Health Impact Group 5 (“Other Hepatitis C associated extra hepatic disorders resulting in long term severe disability”), the Group listed all the qualifying conditions for the SCM, including “suffering from significant mental health problems” and/or “persistent fatigue”. The Report went on to say “Those registered with SCM in the current support scheme would automatically be accepted”.

23. Read together these portions of the Report are ambiguous in that they imply that people might be automatically accepted into the supplementary route for things that the Report says are already compensated for under the core route.

24. The specific point of ambiguity is whether the Expert Group intended that those in the SCM for chronic fatigue for example should also qualify automatically for the severe health impacts route even though this is compensated for under the core route.

25. In the event the Expert Group in their Addendum Report clarified that some extra hepatic disorders recognised by the SCM resulting in long-term severe disability were not covered by the core route, and should be eligible for the supplementary route for health impacts; but that other less rare effects were already covered by the core route, and should therefore not qualify for the supplementary route, noting that everyone on the SCM will continue to receive higher support payments for life if they chose the IBSS option.

26. ***I suggested (transcript, INQY1000284 page 33, internal pages 130-131) that "I think the expert group themselves saw that their previous advice was ambiguous and was seeking to draw that out into something definite and clear". I am asked to set out the factual basis for the suggestion that the Expert Group themselves considered the previous advice to be ambiguous, and to provide copies of any communications from the Expert Group to that effect.***

27. Minutes have been provided of the Expert Group's meetings. Following the publication of their August Final Report the Expert Group discussed the severe health impacts supplementary route on the following occasions: 3 October, 17 October, 31 October and 7 November. The record of the discussion on 17 October shows the Group considering the interaction of conditions already covered in the core route and how that interacted with the conditions in the supplementary route, and discussing whether any conditions needed to be added or removed from the list. The record of the discussion on 31 October shows the Group noting in a discussion of how to set the criteria for psychiatric

disorders that a certain level of poor mental health was already considered under the core award.

28. On 8 November Ministers were asked for a decision on a proposal for the health impacts supplementary route, based on the Group's developed views. Thereafter, the Expert Group gave further detailed advice to assist with the drafting of regulations at its meetings on 21 November and 19 December. The Expert Group's Addendum Report sets out their final view of the issue.

29. ***The addendum report of the Expert Group [WITN7762015, page 5] states that "Following their acceptance of the recommendations made by Sir Robert Francis, we were invited by the Government to provide further detailed advice on three issues in order to assist with the drawing up of the Scheme". I am asked to:***
a. confirm when the Government invited the Expert Group to provide further detailed advice on the three issues.
b. provide a copy of the Government's invitation or request to the Expert Group for this further advice.

30. It was assumed from the beginning that the Expert Group might need to be retained beyond their initial three month contracts to provide further advice on further policy development. The original contracts provided for an extension of six months. Ministers agreed in April 2024 to extend contracts for this further six months.

31. From before the finalisation of their Report the Expert Group were expecting to be retained beyond this six month extension, given the need for expert advice on the drawing up of the second set of regulations. On 28 August, Ministerial approval was sought to extend the Expert Group's appointments to 31 December 2024 in order to provide advice on the further set of regulations.

32. A suggested work programme for work in support of the development of the second set of regulations was shared with the Expert Group for discussion on 12 September. I provide this as exhibit [WITN7755008]. This sets out the issues on

which it was expected that the Expert Group's advice would be needed, including the supplementary route for health impacts, where the task of the group is described as being to provide "any clarification required on definitions of health impact group".

33. ***Annex C of the 23 August 2024 paper (RLIT0002945, page 47) includes the following: "Where an eligible infected person has suffered one of the listed health impacts as a result of their infection, further compensation may be available for the associated care costs and financial loss experienced. Higher compensation available through the Health Impact supplementary sub-route will be calculated using the financial loss rates and care costs used in the Core Route. The amount of compensation awarded will depend on the duration of the health impact (or resultant treatment), as well as IBCA's assessment against the Scheme regulations. Further work will be undertaken on the Supplementary Route ahead of laying the second set of regulations." I am asked if I meant these parts of the August 2024 paper when I said (transcript, INQY1000284 page 33, internal page 130) that it referred to further work being undertaken. I am asked if the use of "may" was intended to suggest that individuals who qualified for the SCM/its equivalents might not qualify for the supplementary award, and if so, if that was consistent with candour/openness.***

34. I was referring to this part of the 23 August 2024 paper when I said that it referred to further work being undertaken. The relevant section of the body of the paper also said that "Further detail will be made available in due course".

35. I believe that "may" was intended to mean that the Government's plans for the supplementary route for health impacts were not yet confirmed, and were subject to the further work referred to.

The Special Category Mechanism and its equivalents

36. ***I am asked what information and advice were provided to the Minister between July 2024 and February 2025 with regard to the SCM/its equivalents. I am asked to provide copies of relevant submissions to ministers and/or internal policy papers which address or explain the Government's position.***

37. I am providing as an exhibit a copy of a submission to the Minister for the Cabinet Office of 8 November 2024 [WITN7755009] seeking decisions on the proposed health impacts supplementary route, and the readout of the Minister's decision dated 20 November [WITN7755010].

The role in the Scheme of date of diagnosis

38. ***I am asked to set out why the scheme as set out in the Regulations requires proof of date of diagnosis, and to describe how and why the date of diagnosis affects financial loss calculations (see further the discussion in the transcript, INQY1000284 page 36, at internal pages 141-143).***

39. For most elements of compensation under the scheme, the date of diagnosis for an infected person makes no difference. The level of compensation for injury, autonomy, social impact and care depend on the infected person's severity band, and are the same whenever a person was diagnosed.

40. However, the date of diagnosis does play a role in determining the level for a given year of the award for financial loss. The relevant regulation is Regulation 20.

41. In the case of those infected with HIV, financial loss is deemed to start from the date of infection. For this period financial loss is set at £14,829 a year, or 50% of national median earnings plus 5%, net of tax.
42. However, on diagnosis, compensation for annual financial loss rises to 100%, reflecting that most people previously in work would have been very likely to

have given it up at that point. The date of diagnosis therefore determines the year from which this higher rate of financial loss starts to be paid.

43. For hepatitis, similarly, financial loss is paid from the date of infection. For someone mono-infected with Hepatitis C, and born before 1953, financial loss in the chronic band is set at £11,863 each year from infection. This is 40% of the median national salary, plus 5%, net of tax.

44. However, people in the higher severity bands for hepatitis receive a higher rate of annual compensation for financial loss, reflecting that their ability to work will have been further reduced.

45. For someone with cirrhosis the calculation of annual financial loss rises to £23,726 a year, or 80% of the median national salary; and for someone with decompensated cirrhosis or liver cancer to £29,657, or 100%.

46. IBCA therefore need to identify the year when someone would have entered one or both of the higher bands, to ensure that they are paid the correct higher compensation for financial loss from that point.

47. The Regulations say that the level of severity of a person's infection in relation to a year is the level which has been established "to the IBCA's satisfaction".

48. Where a person has a diagnosis of cirrhosis, or of decompensated cirrhosis/liver cancer, IBCA will be able to take the date of that diagnosis as establishing the point at which a person entered that band, and therefore the point from which the higher rate of financial loss should be paid. Note that 'diagnosis' here means diagnosis of these severe conditions, rather than diagnosis of the original infection.

49. However, it is recognised that some claimants will not have received a diagnosis at all until liver damage was advanced. In other cases a diagnosis may have been received but a record of its date may no longer be available. In

the case of a claim on behalf of a deceased infected person, for example, there may be no records at all other than the death certificate.

50. IBCA will therefore accept for example, in place of a record of diagnosis, other medical records that suggest that this was likely on the balance of probabilities to be the point at which their infection progressed to the next level of severity.

51. If no records exist at all, the deeming provisions in Regulation 20(7) apply. In the case of a claim for example on behalf of a deceased person, where no records at all exist, other than a death certificate showing that they died of liver cancer, Regulation 20(7) allows IBCA to deem the point at which they would have developed decompensated cirrhosis/liver cancer to be four years before they died, and the point at which they would have developed cirrhosis to be six years before that.

52. These are the roles that date of diagnosis plays in the calculation of financial loss. For completeness, the date of diagnosis plays two other roles in the scheme:
    a. determining the "reference date". This will normally be March 31 2025, but for those who only become aware of their diagnosis after that date, the reference date becomes their date of diagnosis. The infected person's reference date is used when determining the eligibility of affected people. The relevant regulation is Regulation 4;
    b. determining how long an infected person has to apply to the scheme. Again, this will normally be six years from March 31 2025, but for those who only become aware of their diagnosis after that date, the date will be six years after their date of diagnosis. The relevant regulation is Regulation 14.

Co-infection with HIV and Hepatitis C and Hepatitis B

53. ***I am asked to explain why the scheme as set out in the Regulations does not contain provision for those co-infected with HIV, Hepatitis C and Hepatitis B (transcript, INQY1000284 page 37, internal pages 146-147).***

54. Someone who was co-infected with HIV and either Hepatitis C or B is already at the highest level of compensation for autonomy and social impact available under the scheme. The injury award for those with HIV and hepatitis co-infections is determined by the severity band of the hepatitis infection irrespective of whether this was caused by Hepatitis B or C or both.

Document DHOL0000003 on the 1982 date

55. ***I am asked what is the origin of the advice/position set out in DHOL0000003, and how it came to be transmitted to IBCA.***

56. I saw this document for the first time when it was brought to my attention by the Inquiry. I do not believe that the content of this e-mail was provided by the Cabinet Office policy team, and believe it is likely to have been written by IBCA staff themselves on the basis of their own understanding of the Regulations.

Deeming provisions for movement between Hepatitis severity bands

57. ***I am asked to provide further clarification with regard to the deeming provision in Regulation 20(7) and provide a response to the issues raised in the witness statement of Ben Harrison [WITN7759001 paras 103-106; WITN7759015 relating to Regulation 20(7) (transcript, INQY1000284 page 39, internal pages 153-154).***

58. As I say above, the date of diagnosis plays a role in determining, for a given year, the level of compensation for financial loss.

59. However, it is recognised that a record of the date of diagnosis may not be available, and so in the case of living applicants IBCA can accept other kinds

of evidence to show when a person is likely to have entered a higher severity band.

60. In the case of the deceased, however, there may be no records at all, other than a death certificate, and no way after the lapse of time of providing alternative evidence.

61. The 'deeming' provisions in Regulation 20(7) exist to ensure that where this is so, people are not undercompensated, so far as this is possible within a tariff-based scheme.

62. In the absence of any other evidence, Regulation 20(7) allows IBCA to assume for the purposes of calculating financial loss that someone who was at stage 4 at their death would have been at that stage for four years previously and at stage 3 for six years previous to that.

63. Mr Harrison in his statement [WITN7759001] raises the issue of what happens if a claimant can identify a likely year of infection, and has a date of diagnosis for the highest severity band, but nothing in between.

64. In the illustrative example Mr Harrison raises, 'Mr Smith' would receive the highest rate of financial loss from 2004. The deeming provisions would not apply as Mr Smith does have evidence of diagnosis.

65. Mr Harrison is correct that in the absence of any further evidence for when Mr Smith developed cirrhosis, the scheme would not be able to set a date for when he would have entered stage 3.

66. It could be argued that, relative to the assumption made in the case of a deceased person where no evidence can be provided at all, this means Mr Smith is losing the difference between six years of stage 3 financial loss and six years of stage 2.

67. This is a significant sum, but it is small in the context of the highest awards under the scheme - and the anomaly Mr Harrison identifies could only occur in the context of the highest awards, where someone is already in stage 4. In the example given by Mr Harrison, assuming Mr Smith was 16 in 1976, the difference would represent 3.5% of his total compensation under the core route.

68. The scheme could have assumed that everyone who is diagnosed at stage 4 would have been at stage 3 for six years prior to that. However, that would be unfair to those who could show evidence that they had been at stage 3 for longer than that.

69. Alternatively the scheme could have assumed that anyone who is diagnosed at stage 4 would have been at stage 3 for six years prior to that, *in the absence of evidence to the contrary*. However, this could be unfair to those who had evidence and produced it compared with those who had it and chose not to.

Cabinet Office understanding of 'the bulk of payments'

70. ***I am asked if the Cabinet Office understands "the bulk of payments to the infected are completed by no later than 2027, and the bulk of payments of the affected are completed by no later than 2029" to mean that all payments will be made to people infected by the end of 2027 apart from people who have yet to come forward and that all payments will be made to people affected by the end of 2029 apart from people who have yet come forward?***

71. I can confirm that the Cabinet Office understands "the bulk of payments" to mean that all payments to people infected and affected should have been made by the end of 2027 and 2029 respectively, apart from payments to people who have not yet come forward; or who have come forward only just before those dates, so that there has not yet been time for IBCA to process their claim or for the three months which claimants have to accept an offer to have elapsed.

Statement of Truth

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

Signed GRO-C

Dated 21 May 2025

Table of exhibits:

Date	Notes/ Description	Exhibit number
	Expert Group Terms of Reference	RLIT0002487
25 January 2024	Expert Group original proposed Work Programme	WITN7755007
12 September 2024	Expert Group further proposed Work Programme	WITN7755008
8 November 2024	Submission to Minister for the Cabinet Office on the supplementary route for health impacts	WITN7755009
20 November 2024	Readout from Minister's office on the submission on the supplementary route for health impacts	WITN7755010