Neutral Citation Number: [2025] EWHC 516 (KB)

Case No: QB-2022-000236

**IN THE HIGH COURT OF JUSTICE**
**KING'S BENCH DIVISION**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date:11 March 2025

**Before** :

**SENIOR MASTER COOK**

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**Between :**

**GARY JAMES WEBSTER & OTHERS**

**Applicants**

**- and -**

**TRELOARS TRUST**

**Respondent**

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**Andrew Goddard KC** (instructed by **Collins Solicitors**) for the Claimants
**Toby Riley-Smith KC** and **Celia Oldham** (instructed by **Veale Wasbrough Vizards LLP**) for the Defendants

Hearing date: 26 February 2025

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# Approved Judgment

This judgment was handed down remotely at 10.30am on 11 March 2025 by circulation to the parties or their representatives by e-mail and by release to the National Archives (see eg https://www.bailii.org/ew/cases/EWCA/Civ/2022/1169.html).

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SENIOR MASTER COOK

## Senior Master Cook:

## The application

1. This is the hearing of the Applicants' application for a Group Litigation Order [GLO]. The GLO is sought on behalf of a group of 63 prospective claimants who are either former pupils of Treloar's College who were infected with HIV and/or hepatitis by NHS blood products; or are people infected with such viruses by a former pupil; or are their estates or dependents.

2. The application is made by way of Part 23 application notice issued on 24 January 2022, at a point prior to the issue of any claim form, as is permitted by CPR 19.22 (1), which provides that a court may make a GLO where there are or are likely to be a number of claims giving rise to GLO issues.

3. The Court has been provided with the following evidence:

   (i) Witness statement of Desmond Collins (1) dated 21 January 2022 on behalf of the applicants.

   (ii) Witness statement of Natalie Wargent dated 17 February 2025 on behalf of the Respondent.

   (iii) Witness statement of Desmond Collins (2) dated 21 February 2025 on behalf of the applicants.

## The parties and the background to these potential claims

4. The Respondent is a charity which operates the Treloar School and College in Alton Hampshire [the College]. It is common ground that the College was established as the Lord Mayor Treloar Hospital and College in 1908. At its inception it was a hospital to treat children of both sexes up to the age of 12 who were suffering from tuberculosis disease of the bones or joints. The NHS took over running the hospital in 1948, acquiring 75% of the Trust's funds in the process. The institution continued until the hospital closed in 1994.

5. It is helpful at this stage to provide some context for what occurred at the college to give rise to these potential claims. The following is a summary of content from the final report of Sir Brian Langstaff Chairman of the Infected Blood Inquiry [the IBI Report] which was published on 20 May 2024, as set out in the Applicant's skeleton argument. This Inquiry was set up in 2018 to undertake a detailed investigation into the circumstances in which men, women and children treated by national Health Services in the United Kingdom were given infected blood and infected blood products, in particular since 1970.

> "(ii) By the 1960s the school had attracted a number of haemophiliacs children, which increased to the extent that, by the late 1970s, the school came to house a haemophilia centre. A distinguishing feature of this centre was that the pupil cohort could reside in the haemophilia centre whilst they received treatment.

(iii) The novel position of the haemophilia centre meant that pupils could be treated with blood product and observed in a controlled environment. The amalgamation of these factors provided the Lord Mayor Treloar Trust the opportunity to conduct research on its pupils. The Trust successfully applied for a research grant to enable this in 1967, which resulted in the appointment of Dr Rainsford specifically to conduct research in 1968.

(iv) From this date the pupil cohort was used for research into the treatment of haemophilia and the treatment's effects. As a result, the vast majority of pupils who attended Treloar's in the 1970s and 1980s were infected with hepatitis and/or HIV.

(v) A sizable volume of research projects were conducted. subsequently. From 1970 to 1973 Dr Rainsford studied the incidence of hepatitis. The objective of this study was to find any pattern in the way in which "*antibodies and antigens to hepatitis correlated with clinical illness, the frequency of transfusion and the presence of antigens in the blood products with which they were being treated*".

(vi) In 1975, this study was followed by "a prospective study of hepatitis associated with the use of Factor 8 concentrates". The objective of this particular study was to identify if commercial concentrates have a higher attack rate then domestic concentrates. To this end, pupils received injections drawn from one batch of product over a three-month period. The aim here was not to test how hepatitis infections could be limited, but rather to observe if one particular blood product caused more hepatitis than another.

(vii) As a result of this study, pupils were administered blood concentrates that infected them with hepatitis. Dr Kirk's conclusion was that there were no significant differences between treatments between the two products. Dr Craske encouraged further study into this. Dr Rainsford's research position was extended beyond 1975 and in each year if his tenure, further studies took place.

(viii) It is important to note at this juncture that the risk of hepatitis infection from treatment with blood plasma products was well known as early as 1968. Two significant and basic principles relating to the risk of blood products were known by the late 1960s:

a) It was understood that factor concentrates were manufactured from pools of plasma provided by a number of donors and that the larger the pool of plasma used for treatment, the greater the risk of contamination. To limit the risk of contamination, it was in the interests of the treating

clinician to limit the number of batches administered to their patient; and

b) It was understood that pools of plasma drawn from a populace with a lower incidence rate of infection would carry significantly less likelihood of being contaminated than pools of plasma drawn from a populace that had a high incidence rate of infection. To limit the risk of contamination, it was in the interest of the treating clinician to use NHS concentrates rather than blood products manufactured in America.

(ix) From the early 1970s, trials were also conducted into distinguishing if "*a level of Factor 8 sufficient to provide for effective clotting was maintained in the bloodstream of a pupil with haemophilia, they would not suffer from crippling bleeds*". These were known as trials of prophylactic therapy. One of the trials required the pupils to be split into two groups, one of which would be provided with a placebo dose (with a very limited clotting effect) to test the medication's effect and the other with a high dose. The UKHCDO considered this trial to be too "*ethically problematic to conduct*"; this is likely because it would deprive patients from blood products that would treat them. The views of the treating clinicians at Treloars were that it was "very doubtful that the trial would be ethically acceptable at a Haemophilia Centre", however the trial could be conducted on the school's pupils.

(x) Another trial from the 1970s tested which of three dosage regimes addressed bleeds into the knee, elbow and ankle joints most effectively. It was to identify what might be the lowest effective dose of Factor 8. The key reasons for this trial were that:

a) The cost of Factor 8 threatened its continued provision; and

b) The growing evidence that hepatitis was a common consequence of transfusion.

(xi) Each of the surviving former pupils who were treated as test subjects have each consistently maintained that neither they, nor their parents were ever provided meaningful consultation. The pupils, nor their parents, were never afforded the opportunity to consent to their treatment. Evidence provided by the Inquiry implies that Treloars went as far as to mislead parents on the treatment their children were receiving.

(xii) There was no set-procedure for informing the pupils at Treloars of their infections despite liver function tests being carried out at regular periods on blood samples taken at the time that infusions of concentrate were given to the pupils. They were

> either informed in the mid to late 1980s, or they were never told by the school."

6. It is important to note that the Inquiry considered evidence and looked at events which took place at the college in some detail. Sir Brian Langstaff referred to Treloar's as an exemplar which, "*both illustrates and highlights the nature of, and many of the reasons for, the national treatment disaster which was infected blood*". A full account of the evidence and findings can be found at Chapter 2.2 of the IBI report.

7. In October 2022 the parties agreed that this application would be adjourned to the first open date after 3 months from the date of publication of the final the IBI Report. This was an obvious and sensible step given the scope of the Inquiry and nature of the evidence it considered.

## Further Developments

8. There are further developments which it is important to record and which are referenced in Ms Wargent's witness statement. In July 2021 HM Government commissioned Sir Robert Francis KC to undertake a study into how to compensate victims of infected blood. His subsequent Report included recommendations that the Government should create a framework of tariff-based compensation for eligible infected and affected persons broadly reflective of comparable rates of common law damages. He recommended that compensation awards be made under various heads, including: impact awards, social impact awards, care awards, autonomy awards, and financial loss awards. The autonomy award was intended to meet "*the demand for aggravated damages*".

9. An Infected Blood Inquiry Response Expert Group was established to help design the proposed scheme. Its Final Report was published on 16 August 2024 and updated on 12 February 2025. The proposals took into account the Judicial College Guidelines and case law concerning comparable impacts, whilst disregarding some aspects of the law that limited certain claims. For example, the Supreme Court decision in **Paul v Wolverhampton NHST** [2024] UKSC 1, which limited the scope of secondary victim claims, was ignored, because it "*would exclude most affected persons claiming in their own right"*. Finally, no litigation-risk discounts were to be applied to the proposed tax-free awards.

10. The Infected Blood Compensation Scheme Regulations 2024 were made on 23 August 2024. They established the Infected Blood Compensation Authority [IBCA] which was empowered to make core compensation payments to eligible infected people in the categories identified by Sir Robert.

11. On 12 February 2025 the Infected Blood Compensation Scheme Regulations 2025, were laid before Parliament. These are currently expected to be made by 31 March 2025. They will provide for compensation to be paid to affected people (partners, parents, children, siblings and carers of infected people), and for the possibility to apply for Supplementary Awards in addition to the Core compensation.

12. The key features of the compensation scheme are explained at length in Ms Wargent's witness statement but I take its core features from Mr Riley-Smith KC's skeleton argument.

12.1 *Eligibility*: Compensation is available for "infected" and "affected" persons. Infected persons include directly and indirectly infected people. Those who were infected as a result of treatment which began or continued in specified periods (the end of which is determined by the introduction of screening for HIV, Hepatitis B and Hepatitis C) are automatically eligible; compensation will also be available to those who can show that they were infected by subsequent treatment with infected blood.

12.2 *Core Route*: Everyone eligible is entitled to "Core" compensation. They qualify for different types of awards depending on their circumstances:

(a) Injury impact awards, social impact awards, and autonomy awards are available to infected people (and their estates) and affected people.

(b) Care awards are available to infected people and their estates, and can be paid directly to affected people on the request of an infected person.

(c) Financial loss awards are available to infected people, their bereaved partners and children, and others established to be dependents.

(d) These tariff-based awards take into account the severity of infection, and fact of co-infection.

12.3 *Supplementary Route*: in addition to these core awards, "Supplementary" awards will be available to various groups. They include (a) victims of unethical research, (b) those with higher care costs, and/or (c) those who were high earners before infection.

12.4 *Quantum*: total awards are likely to be substantial. The Government has set aside £11.8 billion for the Scheme. Interim payments of up to £310,000 have already been made to infected people registered with an Infected Blood Support Scheme. The Government's published case studies give examples of total payments in excess of £1 million for living infected people and their estates.

13. I understand that core payments under the scheme are starting to be paid by the IBCA and it is expected that further payments to each group will be made through out 2025.

14. There is one further relevant matter that I should record. On 27 October 2017 my predecessor Senior Master Fontaine made a GLO in the case of **Jason Evans & Others v Secretary of State for Health**, see [2017] EWHC 3572 (QB). This GLO is known as the Contaminated Blood Products Litigation and the managing judge is Mr Justice Martin Spencer. The GLO issues contained in the GLO are:

> "1.1. Whether in exercise of its obligations pursuant to statute or otherwise to provide
>
> 1.1.1. a national blood transfusion service
> 1.1.2. a national blood products laboratory
> 1.1.3. a national epidemiology service the Defendant owed a

> duty to take reasonable care to prevent personal injury or loss to the Infected Claimants.
>
> 1.2. Whether in exercise of those obligations or otherwise the Defendant owed a duty to the Claimants to provide prompt and timely disclosure of the state of knowledge of the Defendant at all material times of the risk of infection from Contaminated Blood Products.
>
> 1.3. Whether in exercise of those obligations or otherwise the Defendant owed a duty to provide prompt and timely notification to the Infected Claimants of the information and/or knowledge which the Defendant held relating to the infection of the Infected Claimants with Hep C, and/or HIV.
>
> 1.4. Whether any undertakings given by the Claimants or any of them, directly or indirectly, to the Defendant at any time arising out of the HIV Haemophilia Litigation or otherwise are binding upon the Claimants, and in all the circumstances whether it is unconscionable for the Defendant to rely upon such undertaking.
>
> 1.5. Insofar as any of the Claimants may have discontinued a case brought within the HIV Haemophilia Litigation whether such discontinuance is binding upon those Claimants and/or their dependants, and in all the circumstances whether it is unconscionable for the Defendant to rely upon the said discontinuance.
>
> 1.6. Whether insofar as might be necessary the Court should exercise its discretion under Section 33.1 of the Limitation Act 1980 in favour of the Claimants.
>
> 1.7. In the event that the duty at 1.1 above was owed, whether the Defendant was in breach of that duty.
>
> 1.8. In the event that the duty at 1.2 above was owed, whether the Defendant failed to provide prompt and timely disclosure to the Claimants so as to be in breach of that duty and whether any such failure amounted, at any time, to misfeasance in public office.
>
> 1.9. In the event of breach of duty at 1.3 above, whether the Defendant failed to provide prompt and timely notification to the Claimants so as to be in breach of that duty and whether any such failure amounted, at any time, to misfeasance in public office."

14. This GLO was made prior to the establishment of Sir Brian Langstaff's Infected Blood Inquiry. Initial directions were made on 1 February 2018 requiring a generic particulars of claim and defence to be filed by November 2018. The proceedings were then stayed on 30 November 2018 to await the outcome of the Inquiry. By an order dated 25 October 2024 these proceedings are currently stayed until 25 October 2025 pending

awards to the Claimants under the Infected Blood Compensation Scheme. On this occasion Mr Justice Martin Spencer made the following observation:

> "Clearly, there is no point in the litigation if the claimants in the litigation are going to get everything which they seek from their misfortune from the statutory scheme."

**Submissions on behalf of the Applicant**

15. On behalf of the Applicants Mr Goddard KC submitted that the threshold requirements for making a GLO were met and that the court should in the exercise of its discretion make an order immediately without any further delay.

16. Mr Goddard KC referred to the GLO issues identified in the application notice which he said could be refined in due course and in conjunction with the manging judge;

> "1. Whether in exercise of its obligations pursuant to Statute Contract and or Tort, the Defendant had a duty to take reasonable care to prevent personal injury and loss to the Claimants and in the circumstances whether any duty was non delegable.
>
> 2. Whether any action taken by the Defendant was deliberate amounting to an assault or otherwise negligent, thus restricting the Defendants exposure to breach of duty.
>
> 3. Whether in so far as might be necessary the court should exercise its discretion under Section 33.1 of the Limitation Act 1980 in favour of the Claimants.
>
> 4. In the event that the duty at 1.1 above was owed, whether the Defendant was in breach of that duty and or otherwise the Defendant 's conduct amounted to an assault."

17. Mr Goddard KC acknowledged that resolution of these issues would not dispose of the claims, but he argued, they would be sufficient to establish that the school owed its pupils a duty of care. He referred to the degree of astonishment on the part of the potential claimants that the Respondent will apparently not accept that it owed the pupils a duty of care. He made the point that it is not understood by the potential claimants on what basis such duty is denied. Similarly, the potential claimants find it insulting that the Treloar Trust deny that there were any breaches of that duty. In the circumstances, he urged the court, not to underestimate the strength of feeling among the potential claimants generated by the fact that they are still to receive a proper apology for their treatment.

18. As to the need to make the GLO order without further delay Mr Goddard KC relied upon the evidence set out in Mr Collins' second witness statement at paragraph 43 onwards to the effect that the Applicants' firm position is that the compensation recommendations of Sir Robert and Sir Brian have not been fully implemented, that the current Scheme is based on the Report and recommendations from an Expert Group appointed by the Government without the involvement of the beneficiaries, and only as a result of the Governments defeat in the Victims and Prisoner Bill which became an

Act in the "wash up" following the announcement of a general election two days after the publication of the Infected Blood Inquiry's Final Report in May 2024.

19. Mr Goddard KC referred to widespread dissatisfaction among many of the intended beneficiaries of the compensation scheme that they had been left out of the consultation process and to the fact that proceedings had been commenced by Leigh Day acting on behalf of an unnamed claimant to challenge the amounts allowed under the tariffs.

20. Mr Goddard KC referred to a perception on behalf of the Applicants that the compensation provisions under the "supplementary route" in respect of unethical research practices performed on the pupils are manifestly inadequate for two main reasons. First, only claimants who attended Treloars between the years 1970-1983 will be eligible for the unethical research practices award provided for by s26 (1). Any claimants who attended outside of this date range while unethical research practices were continuing will need to look to litigation to recover for this head of loss. Second, such claimants will find that their recovery under the Scheme is capped at £15,000 which is less than they might expect to recover in civil proceedings. He acknowledged that the Compensation Schemes are intended to include an element of aggravated damages, but made the point that exemplary damages appear to be excluded, see 2nd Interim Report pp 46-47.

21. Mr Goddard KC drew my attention to the view of Lauren Palmer, one of the potential claimants, who wished her communication to be put before the court;

> "I write in response to the defendants statement, particularly addressing "the awards payable under that scheme are intended to reflect the damages that would be payable in comparable legal cases." I must strongly contest this assertion, as it fails to account for the extreme and unique circumstances surrounding my father's exposure to blood-borne viruses during his time at Treloar's School.
>
> There is clear evidence that my father was subjected to at least one unauthorised trial, during which he was deliberately exposed to life-threatening infections such as HIV and Hepatitis C. This was not a case of accidental medical negligence or misfortune—it was a deliberate and unauthorised act that violated his fundamental rights. The compensation currently awarded by the Infected Blood Compensation Authority does not reflect the legal damages that would be payable in cases involving such intentional and reckless disregard for human life."

22. Mr Goddard KC made it very clear to me that one of the potential claimant's most important motivations for wanting to pursue these claims is that they are concerned that if the School continues to reject any accountability for what happened to the pupils, or if the School is not otherwise held accountable, there is a risk that another Treloars-type disaster may occur in the future.

23. Lastly, Mr Goddard KC submitted that in the event his clients' proposal for a GLO was dismissed the result would be a multiplicity of claims, each of which will require the preliminary questions of whether the School owed a duty of care to that pupil and

whether it had breached that duty. This he suggested would inevitably lead to a significant increase in costs and use of court resources and also runs the risk of inconsistent findings between tribunals.

**Submissions on behalf of the Respondent**

24. On behalf of the Respondent Mr Riley-Smith KC submitted that the infected former pupils, and almost all of those affected thereby, are eligible for compensation under the Scheme. In the circumstances, the majority, if not all, of the Applicants can expect to receive awards that are intended to reflect the damages that would be payable in comparable civil claims. In the circumstances it is neither necessary nor proportionate for a GLO to be made (which necessarily triggers the commitment of significant resources to its establishment and management) at the very moment the Scheme is beginning to bear fruit.

25. In addition to his central point Mr Riley-Smith made a number of subsidiary submissions;

i) The Applicants have not established that a sufficient number of claims seriously intend to proceed: none of them have yet issued a claim; there are no generic pleadings; there has been inadequate investigation and vetting of the claims; the funding arrangements are unclear; and, in recent correspondence, they have indicated that they would want to "stay" any GLO as soon as it were made.

ii) Although common issues are likely to arise, this is not a homogenous group. The cohort is made up of a number of different sub-groups of types of claim. In each sub-group, the individual issues predominate.

iii) Such claims will give rise to a plethora of contested issues on both liability and quantum that will likely involve both the Trust and NHS entities. This will be complex and complicated litigation that is unlikely to be resolved by the time that these individuals receive their awards from the Scheme. None of these issues arise in a claim under the no-fault Scheme.

iv) It is clear that these claims have not been the subject of rigorous analysis by their own solicitors. Preliminary analysis suggests that many, if not all, will fail against the Trust on their individual facts. Such matters will not affect their entitlement to compensation under the Scheme.

v) GLOs take up the valuable resources of the court and lead to significant costs being incurred. The number and significance of the differences, and doubts over the numbers of viable claims, means that the economies of scale required to justify such costs are not established.

vi) If individual claimants wish to proceed they can issue claims which can be subject to collective case management under the court's existing case management powers.

**Decision and discussion.**

26. I have come to the very clear conclusion that this application for a GLO should be dismissed. It is important that it should be understood this does not mean the Court is preventing these potential claims from being progressed or is indicating any view upon the merits of the potential claims. In the event that any of the individual claimants wish to issue a claim, there is absolutely nothing to prevent them from doing so. My decision relates solely to the use of a GLO as the appropriate vehicle through which such claims should be progressed and is made as a matter of discretion under the court's powers of case management for reasons I will now elaborate.

27. The decision whether to make a GLO is primarily one of case management, see **Alyson Austin v Miller Argent (South Wales) Ltd** [2011] EWCA Civ 928. Lord Justice Jackson said:

> "The procedure contained in section III of Part 19 of the CPR enables group litigation to be managed by the parties and by the courts in an efficient and cost effective manner. Nevertheless the decision whether to make a GLO is a matter for the court's discretion. The making of a GLO commits both the parties and the court to the allocation of substantial resources to the conduct of group litigation. The court will not make a GLO before it is clear that there is a sufficient number of claimants, who seriously intend to proceed and whose claims raise common or related issues of fact and law."

28. Lord Justice Jackson's reference to an "efficient and cost effective manner" is rooted in the overriding objective to the Civil Procedure Rules which requires the court to deal with cases justly and at proportionate cost. CPR 1.1 (2) provides:

> "(2) Dealing with a case justly and at proportionate cost as includes, so far as is practicable:"
>
> (a) ensuring that the parties are on an equal footing and can participate fully in proceedings, and that parties and witnesses can give their best evidence;
>
> (b) saving expense;
>
> (c) dealing with the case in ways which are proportionate–
>
> (i) to the amount of money involved;
>
> (ii) to the importance of the case;
>
> (iii) to the complexity of the issues; and
>
> (iv) to the financial position of each party;
>
> (d) ensuring that it is dealt with expeditiously and fairly;
>
> (e) allotting to it an appropriate share of the court's resources, while taking into account the need to allot resources to other cases;

(f) promoting or using alternative dispute resolution;

(g) enforcing compliance with rules, practice directions and orders."

29. As Lord Justice Jackson recognised there can be no doubt that a GLO commits the parties and the court to the allocation of substantial resources to the conduct of the litigation that can only add to the overall costs of the litigation. There is no suggestion on the part of the Claimants that the GLO issues they propose will dispose of any of the potential claims. In his skeleton argument and oral submissions Mr Goddard KC suggested that the way forward following the making of a GLO would be for there to be a period of discussion and negotiation between the parties in order for appropriate criteria to be formulated for entry upon the Group Register. He maintained that the Respondent's criticisms of the detail provided in the letters of claim are irrelevant to the question of whether a GLO should be granted: I disagree. It is essential that a clear view of the GLO issues should be presented to the court by potential Claimants, preferably after discussion with the potential Defendants so that the court can properly understand the nature and extent of the resources which require to be committed to the operation of the GLO.

30. I accept that it would be possible to frame suitable GLO issues and I don't think Mr Riley-Smith KC disagreed, however the three issues put forward on behalf of the Applicants are far too simplistic in their current form and have not taken on board the valid criticisms made in the letters of response.

31. I also reject the submission made by Mr Goddard KC that a rejection of the GLO application would result in a multiplicity of claims which would require the issue of whether the school owed a duty of care to be determined and that this might lead to an increased use of court resources and inconsistent findings.

32. It is now clear that, as provided by CPR 19.1, any number of claimants or defendants may be joined as parties to a single claim form, see **Morris & others v Williams & Co Solicitors** [2024] EWCA Civ 376 and **Abbot v Ministry of Defence** [2023] EWHC 1475 (KB). As I pointed out in the case of **Hammon v University College London** [2024] EWHC 1744 (KB) at [41], with cooperation and creativity the court's standard case management powers can be used to replicate almost any feature of a GLO. In other words, if a significant number of claims were in fact issued by the current group of 63 potential claimants, there would be no bar to them being presented on a single claim form or being consolidated in a single claim or to them being managed together.

33. I am, however, far from satisfied that 63 claims will materialise having regard to the imminent approval and implementation of the Infected Blood Compensation Scheme. According to the Government's updated summary Policy Paper:

> "the Government hopes that the Scheme will enable victims of infected blood to receive due compensation without the need to go through a Court or tribunal process to seek redress" [page 38].

34. I accept the evidence that the Scheme has been designed to provide full compensation. Its architect Robert Francis KC made the following statement in August 2024:

> "…taken as a whole the figures and methods of calculating compensation generally fall within the range of what would be awarded in comparable legal cases. As a result, many will receive very substantial awards capable of making a real difference to their lives. Indeed, some proposed categories of award, particularly for people affected by their closeness to someone who was infected, allow for compensation for matters which might not even be recognised by the Courts. As such, some awards may even be in excess of what could be recovered in litigation."

35. In reaching this conclusion I have had regard to the policy papers prepared by the IBCA which set out case studies for the three groups of potential claimants; living infected persons, estates of deceased infected persons and affected people. These case studies set out clearly how compensation will be calculated under the Scheme. For present purposes I will set out one such example:

> "**Case Study 1: Application by an infected person living with HIV and chronic Hepatitis C who is a IBBS beneficiary**.
>
> Henry was born with a bleeding disorder in 1970. He received infected blood products as a child in January 1983 during an unethical research study,
>
> Henry currently lives with HIV and chronic Hepatitis C but has not developed liver cirrhosis. Henry currently received IBSS support payments for co0-infection with HIV and Hepatitis C Stage 1.
>
> As a person living with and HIV and Hepatitis C co-infection, Henry is eligible to for compensation through the Scheme. Henry is also eligible for an additional Autonomy award due his suffering caused by unethical research. As a living infected person, Henry has already received interim compensation payments of £100,000 and £210,00. Henry's application to the Scheme was assessed by IBCA in April 2025
>
> **Summary of Henry's application**
>
> Date of birth: 1 January 1970
>
> Date of treatment which lead to infection: 8 January 19883
>
> Date of first diagnosis (HIV): 1 May 1985
>
> Healthy life expectancy date: 2054 (based on version 8 Ogden tables)
>
> Infections severity band: HIV and Hepatitis C (chronic)
>
> The table below shows Henry's compensation award as an infected person.

| **Category of infected person award** | **Value of compensation** | **Calculation** |
|---|---|---|
| Injury | £195,000 | Award for infected person with HIV co-infection |
| Social impact | £70,000 | Award for infected person with HIV co-infection |
| Autonomy | £80,000 | Award for infected person with HIV co-infection plus £10,000 under the supplementary route as victim of unethical research. |
| Past financial loss | £1,042,807.17 | 43 years of financial loss at working age, plus flat rate award of £12,500 for miscellaneous costs |
| Past Care | £299,163.72 | Based on 14 years of past care for HIV and Hepatitis co-infection |
| Interim Payments Deduction | -£310,000 | Interim payments of £100,000 and £210,000 received |

| | | |
|---|---|---|
| Total (not including support scheme payments) | £1,376,970.89 | This is the amount Henry will receive as either a lump sum or a periodic payment |
| Support scheme payments | £48,622 per annum | This is the 2025/26 rate, updated for CPI every year. This includes winter fuel payment of (£670). He will receive these payments for life. |

36. It should be noted that if "Henry" had attended Treloar College between 1970 and 1983 his total Autonomy award would be £85,000. The flat rate additional award of £10,000 is to be paid to victims who were subjected to unethical research conducted by Dr Craske at various centres specified in the scheme.

37. The evidence before me supports the view that the proposed Scheme has a number of advantages for victims over litigation before the court. First, the eligibility criteria under the Scheme are wider and exclude the restriction on claims by secondary victims as a result of the case of **Paul v Wolverhampton** [2024] UKSC 1. Second, the Scheme is a no fault one where compensation will be paid without having to establish liability or incur costs in relation to issues such as breach of duty, causation and limitation.

38. One criticism of the Scheme strongly made on behalf of the Applicants is that the additional sum of £5,000 paid to those who attended Treloar School, over and above the £10,000 paid under the supplementary route for being a victim of unethical research, is derisory. I do not think it is helpful to look at that figure in isolation. As I have observed, in relation to the case study, the total Autonomy award for a victim who attended Treloar school would be £85,000. This sum is paid in addition to awards for injury and social impact. Unlike an award of damages in a traditional personal injury case, the heads of loss and levels of compensation available under the Scheme have been specifically tailored to meet the circumstances of the victims and based on the recommendations and principles put forward by the Infected Blood Inquiry. I do appreciate the strength of feeling expressed by Lauren Palmer and others, but in over forty years of experience of dealing with personal injury claims I have found such views to be a common reaction to the blunt and unsatisfactory remedy of compensating serious physical and mental injury with the award of a sum of money.

39. It is also said that the Scheme makes no provision for exemplary damages. Mr Collins seems to suggest that these factors will mean his clients will not receive full compensation under the Scheme.

40. However, in my judgment it is by no means clear that exemplary damages could be recovered in the circumstances giving rise to these claims. Exemplary damages are distinct from aggravated damages, and are not intended to be compensatory but are punitive. Lord Devlin's famous formulation in **Rookes v Barnard** [1964] AC 1129 stated that, other than where expressly authorised by statute, exemplary damages may only be awarded in two specific categories of case. First, those arising from oppressive, arbitrary or unconstitutional action by the servants of the government, or second, where the defendant's conduct has been calculated by him to make a profit for himself which may well exceed the compensation payable to the claimant. Further, there are other bars to their recovery in some of the proposed claims. Exemplary damages are not recoverable in any of the claims brought by the estate of a deceased pupil's estate, see **Shaw v Medtronic Corevalve LLC** [2017] EWHC 54, [28] and section 1(2)(a) of the Law Reform (Miscellaneous Provisions) Act 1934 which provides that any *"damages recoverable for the benefit of the estate… (a) shall not include- (i) any exemplary damages",* and exemplary damages are not among the types of statutory damages recoverable by dependants under the Fatal Accidents Act 1976..

41. Mr Goddard KC sought to argue, in relation to the School, that this was a clear case of a defendant whose conduct was calculated to make a profit. I express no view as to whether this argument would have any prospect of success other than to observe that the potential Claimants would have a heavy evidential burden to discharge.

42. More importantly, it seemed to me that Mr Collins had simply failed to produce evidence that any of his clients would be likely to recover less under the scheme than they would recover in the event of successful litigation. I pressed Mr Goddard KC to tell me if any comparative calculations had been carried out in relation the likelihood of a short fall in damages between the Scheme and Litigation in the case of any Applicant and he was commendably frank in his response, which was that this had not been done.

43. The court had no evidence relating to the funding of any potential claims. It is presumed that any potential claimant would have to enter into some form of conditional fee agreement. Indeed that is what is suggested in the letters of claim that have been provided so far. Mr Goddard KC, on instructions, informed me that no potential claimant would face a situation where in the event of success a portion of their damages would be retained as costs or a success fee.

44. I regard the Scheme as a form of alternative dispute resolution. The overriding objective of the CPR was modified, with effect from 1st October 2024 to give effect to Court of Appeal's decision in **Churchill v Merthyr Tydfil CBC** [2023] EWCA Civ 1416, to require the court to promote and use alternative dispute resolution. I would echo the words of Mr Justice Martin Spencer set out at paragraph 14 above. In my judgment it would not be an appropriate use of court's scarce resources to permit these claims to proceed let alone approve a GLO until the potential claimants have made claims in accordance with the Scheme.

45. In the event that any potential claimant were to be able to make out a case that they had not received proper compensation, such claims could procced efficiently and proportionately under court's ordinary powers of case management. A single firm of solicitors has been instructed and it is therefore unlikely that the additional apparatus attached to a GLO will be required.

46. I have gained the impression that an important motivation for obtaining the proposed GLO was to provide a vehicle whereby Treloar's would be forced to admit that it breached its duty of care to its pupils and thereby prevent a similar disaster happening again. I have already described this analysis as simplistic. As I understand the response, Treloar's accepts that it owed a duty of care to its pupils, what is in dispute is the extent of that duty of care and whether the acts of others were the effective cause of the damage suffered by its pupils and their families. The Inquiry's findings are now a matter of public record and have been accepted by the Government. In the circumstances, a reasonable bystander might conclude that the chances of such an incident reoccurring are minimal.

47. I realise that this decision will come as a great disappointment to the potential Claimants, however I urge them all to give the Scheme a chance and to take comfort in the fact that the Inquiry's findings are now public.