

Aldwych House 5th Floor, 71-91 Aldwych London WC2B 4HN

The Rt Hon John Glen MP
Paymaster General and Minister for the Cabinet Office
70 Whitehall
London SW1A 2AS

20 May 2024

Dear Minister,

I enclose my Report under section 24(1) of the Inquiries Act 2005.

The first volume contains a summary which sets out some of the key failings, followed by an overview which provides a chapter-by-chapter summary. Lessons to be learned for the future are identified, and 12 recommendations made. The second volume covers people's experiences and a detailed account of what happened to children with haemophilia treated at Treloar's. The subsequent volumes explain what happened and why, and then examine the response of government and other public bodies.

As I say in the summary, it will be astonishing to anyone who reads the Report that these events could have happened in the UK. It will also be surprising that questions asking why so many deaths and infections occurred have not had answers before now. Those answers cannot be as complete as they might have been thirty years ago but I have no doubt that the conclusion that wrongs were done on individual, collective and systemic levels is fully justified by the Report.

A level of suffering which is difficult to comprehend, still less understand, has been caused, and this harm has been compounded by the reaction of successive governments, NHS bodies, other public bodies, the medical profession and others as described in the Report.

## **Infected Blood Inquiry**

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As I say in the Report, I fully expect that the government will wish to apologise in a meaningful way. My principal recommendation remains that a compensation scheme should be set up now. This Report does not add to the recommendations about compensation in the Inquiry's Second Interim Report of 5 April 2023.

I have been greatly assisted by the witness evidence and submissions I have received in addition to the documentary evidence. Almost 5,000 people gave evidence to the Inquiry, very nearly 4,000 of whom were people infected and affected; further evidence was gathered from over a hundred more who spoke to the Inquiry intermediaries. More than a quarter of this evidence from people infected and affected is cited in the Report. Time after time it tells a similar tale. Each account is compelling when viewed individually. Taken together the evidence is overwhelming as to the failures which are recounted. The evidence leads inexorably to the recommendations I have already made as to compensation, and is the foundation of the 12 recommendations I make.

I am not yet able to notify you under section 14(1a) of the Inquiries Act 2005 that the Inquiry has fulfilled its terms of reference. I hope to be able to say soon that the Inquiry's work is indeed complete.

In the meantime, I would like to record my thanks to the Cabinet Office for having provided the Inquiry with the resource and support it has needed for its work. It has fully honoured the promise made to me by your predecessor when I accepted the appointment as Chair.

Yours sincerely,

Sir Brian Langstaff

Brian Jy Langstoff

**Infected Blood Inquiry**