

Research Briefing

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Infected Blood Inquiry: recommendations for recognition, healthcare and patient safety



Summary

- 1 Background to the public inquiry
- 2 Recommendations of the inquiry
- 3 Response to the inquiry report
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Summary

During the 1970s and 1980s, thousands of UK patients contracted HIV, hepatitis viruses, or both, from contaminated blood or blood products. The [Infected Blood Inquiry](#), which investigated the use of contaminated blood products, made several recommendations focused on improving safety and patient care in its final report. This briefing examines these recommendations.

The inquiry's primary recommendation was that a compensation scheme for those "infected and affected" should be established immediately. The Library briefing [infected Blood Inquiry: compensation](#) provides more information.

The Infected Blood Inquiry

The Infected Blood Inquiry examined the circumstances in which NHS patients were given infected blood and blood products and the impact of these infections. It also scrutinised the response of the government, health services and professionals, and aimed to identify the organisations and individuals responsible.

The [final report of the inquiry](#) was published on 20 May 2024.

Recognition and ongoing care

The inquiry report included recommendations to ensure that the harm caused by infected blood is appropriately recognised and remembered. These include creating a national memorial and providing funding for the infected blood community to maintain their network via regular meetings or events.

Other recommendations focus on the ongoing care and regular monitoring of those who contracted hepatitis C from infected blood or blood products. The report asks health service commissioners to consider how their services meet the needs of these patients. It also recommends that patients are routinely asked about their history of blood transfusions to help identify anyone who has been infected but not yet diagnosed.

Patient safety and voice

The inquiry report says that patient safety must be the “paramount consideration” and a guiding principle for health services and the government. It therefore makes several recommendations that aim to improve patient safety in the NHS. They include specific proposals to improve the safety of blood transfusions and the care of patients with haemophilia (a condition that prevents the blood clotting properly).

Wider recommendations to improve patient safety include:

- A review of the existing statutory [duty of candour](#) in England, Wales and Scotland, which requires NHS organisations to be open and transparent about mistakes and harm in patient care, and the introduction of a statutory duty in Northern Ireland.
- Extending the duty of candour to cover individuals in leadership positions in NHS organisations, and making these leaders personally accountable for responding to concerns about patient safety.
- Reviewing and simplifying health care regulation in the UK and considering the introduction of “safety management systems”, following the example of other industries, such as aviation and defence.
- Auditing and progressing work to digitise patient records to ensure that they are complete and accessible to patients.

The report also recommends strengthening the voice of patients by including measures of patient satisfaction in the evaluation of health services, funding charities that represent and support patients affected by infected blood or blood disorders, and raising awareness of the [Yellow Card](#) system for reporting side effects and safety concerns about medicines (including blood and blood products).

Government response to the inquiry report

The government published an [initial response](#) to the infected blood inquiry report in December 2024, followed by a [full response](#) on 14 May 2025. These responses say that the UK Government and the devolved administrations in Scotland, Wales and Northern Ireland “have accepted the Inquiry’s recommendations in full or accept them in principle”.

The inquiry’s recommendations about compensation, memorials and incorporating lessons from infected blood into healthcare professionals’ training were all accepted in full by the UK Government and the devolved administrations. In other areas, some recommendations or parts of

recommendations are accepted in full, and others in principle, and the response varies across the UK.

When a recommendation has been accepted in principle, the government says that it accepts the inquiry's rationale for change, but that further work must be conducted to "fully understand the implications of implementing complex recommendations", including [costs and different ways of achieving recommended outcomes](#).

For example, the inquiry's recommendations about reviewing the statutory duty of candour in healthcare in England, Scotland and Wales were accepted in full. Its recommendations about extending this duty to NHS leaders and civil servants were accepted in principle. The government said it was considering how these proposals would interact with other initiatives, including a [consultation on the regulation of NHS managers](#) and the [proposed 'Hillsborough Law'](#).

1

Background to the public inquiry

During the 1970s and 1980s, thousands of UK patients contracted HIV, hepatitis viruses, or both, from contaminated blood or blood products. In July 2017, the then Prime Minister, Theresa May, announced a public inquiry to examine how contaminated blood and blood products came to be used in the UK.¹

The [House of Lords Library briefing on the infected blood scandal](#) provides a useful overview of the background to the Infected Blood Inquiry, its final report and the initial government response.² Brief background information is provided below.

1.1

What was infected blood?

During the 1970s and 1980s, some donated blood and blood products (medical treatments made from human blood) were contaminated with viruses. Many patients who received blood transfusions or treatment with blood products were infected with hepatitis, HIV, or both.

Infected blood affected many different groups of patients, including people who received blood transfusions after childbirth, surgery or major trauma. People with haemophilia and other bleeding disorders were particularly affected, as they received more blood transfusions and, from the 1970s, new treatments known as [factor concentrates or clotting factors](#) to help their blood to clot. These products were produced by pooling the blood plasma of large numbers of donors.

To meet demand, the UK imported factor concentrates from the United States, where donors were paid for blood donations, increasing the numbers of donors from populations more likely to be infected with hepatitis or HIV, such as prisoners and drug users. As a result, imported factor concentrates were more likely to be contaminated with these viruses.³

An expert report commissioned by the inquiry produced statistics to estimate the numbers of people infected with HIV and hepatitis viruses between 1970 and 1991. The report notes that there is uncertainty about some of the available data but estimates that 1,250 people with bleeding disorders were

¹ Prime Minister's Office, [PM statement on contaminated blood inquiry](#), 11 July 2017

² Lords Library research briefing, [Infected blood scandal: Background, impacts, interim compensation and inquiry outcomes](#), 22 May 2024

³ Infected Blood Inquiry, [The Report: What happened and why?](#) 20 May 2024, p447-448

infected with HIV and between 2,400 and 5000 people were infected with hepatitis C.⁴ At least 79 people were infected with HIV, and 26,800 people were infected with hepatitis C via a blood transfusion.⁵

1.2

The Infected Blood Inquiry

On 11 July 2017, following pressure from campaign groups and parliamentarians, the then Prime Minister, Theresa May, announced a public inquiry to examine the circumstances that led to individuals being given contaminated blood and blood products in the UK.⁶

The Infected Blood Inquiry was chaired by Sir Brian Langstaff, a former High Court judge, and [terms of reference for the inquiry](#) were announced in summer 2018.⁷ Hearings began shortly afterwards.

- Evidence submitted to the inquiry, together with the transcripts of the hearings, can be accessed on [the inquiry's website](#).
- [The inquiry also has its own YouTube channel](#) where its hearings can be viewed.

The inquiry finished taking evidence in July 2023.

Interim reports of the inquiry

The inquiry published two interim reports before publishing its final report. In July 2022, the first interim report recommended that interim compensation payments of at least £100,000 should be made to those infected and their bereaved partners.⁸

In April 2023, the second interim report recommended that a compensation scheme should be set up and begin work that year.⁹

The second interim report also drew attention to the lack of specialist psychological support for the infected blood community in England.¹⁰ Specialist services were established in Scotland, Wales and Northern Ireland in 2016.¹¹

⁴ Infected Blood Inquiry, [Expert Report to the Infected Blood Inquiry: Statistics](#), 16 September 2022, p 1-2

⁵ Infected Blood Inquiry, [Expert Report to the Infected Blood Inquiry: Statistics](#), 16 September 2022, p3-4

⁶ Prime Minister's Office, [PM statement on contaminated blood inquiry](#), 11 July 2017

⁷ Infected Blood Inquiry, [Terms of Reference](#), accessed 23 May 2024

⁸ Infected Blood Inquiry, [First Interim Report](#), 29 July 2022

⁹ Infected Blood Inquiry, [Second Interim Report](#), 5 April 2023

¹⁰ Infected Blood Inquiry, [Second Interim Report](#), 5 April 2023, p62-78

¹¹ Infected Blood Inquiry, [Letter from Sir Brian Langstaff to Rt Hon David Lidington CBE MP](#), 15 October 2018

In August 2022, the Department of Health and Social Care (DHSC) commissioned research on the need for support. The research team published its findings in August 2023, recommending the development of an inclusive, flexible and compassionate service that should be embedded within the wider support system for the infected blood community.¹²

In a letter responding to the publication of the inquiry report, NHS England announced that DHSC will provide £19 million over five years to provide an Infected Blood Psychological Support Service, which was expected to be set up in summer 2024.¹³

Final report of the inquiry

The final report of the infected blood inquiry was published on 20 May 2024.¹⁴ It comprises seven volumes, detailing the experience of those infected and affected, the history of the use of blood and blood products in the UK, understanding of the risk of infection, and the response of the health service and government.

The report concluded that there had been “systematic, collective and individual failures” in identifying and managing the risk of infections in blood and blood products and in the response of health services and government.¹⁵

Additional report of the inquiry

In March 2025, the inquiry announced that it would publish a further report, to “consider the timeliness and adequacy of the Government’s response on compensation”.¹⁶ On 7 and 8 May 2025, the inquiry held two additional days of hearings to consider this issue.¹⁷ The scope of these hearings was described in a Note from Counsel, published on 16 April.¹⁸ The inquiry heard from a panel of infected and affected people, together with the Cabinet Office Minister, senior civil servants and the Chair and Chief Executive of the Infected Blood Compensation Authority.

Following the hearings, the inquiry said that it was collecting additional evidence and submissions on a proposal to establish a “scheme of prioritisation” for the compensation scheme.¹⁹

¹² Eva Cyhlarova and others, [Psychological support for individuals historically infected with HIV and/or hepatitis C as a result of NHS-supplied blood transfusions and blood products, and for affected families](#), August 2023

¹³ NHS England, [Publication of the Infected Blood Inquiry final report](#) [Letter], 20 May 2024

¹⁴ Infected Blood Inquiry, [The Inquiry Report](#), 20 May 2024

¹⁵ Infected Blood Inquiry, [The Report Volume 1 Overview and Recommendations](#), 20 May 2024, p2

¹⁶ Infected Blood Inquiry, [Infected Blood Inquiry to Publish Additional Report](#), 13 March 2025

¹⁷ Infected Blood Inquiry, [Inquiry to hold hearings in May](#), 9 April 2025

¹⁸ Infected Blood Inquiry, [Inquiry publishes Note from Counsel](#), 16 April 2025

¹⁹ Infected Blood Inquiry, [Inquiry’s work after the hearings](#), 13 May 2025

More information is provided in the Library briefing [Infected Blood Inquiry: compensation](#).²⁰

²⁰ Commons Library research briefing CBP-10099, [Infected Blood Inquiry: compensation](#)

2

Recommendations of the inquiry

The inquiry's final report made 12 recommendations and set out a series of "lessons to be learned" from infected blood. As in its interim reports, the inquiry's primary recommendation was that a compensation scheme should be established immediately. The Library briefing [Infected Blood Inquiry: compensation](#) provides more information about these recommendations and the implementation of the compensation scheme.²¹

This briefing paper explains the report's other recommendations and the government's response to these. The recommendations focus on recognition and support for infected and affected people, and improving patient safety.

2.1

Recognition and remembrance

The report's second recommendation aims to ensure appropriate recognition of the harms caused by infected blood, and to create "a tangible reminder for future generations".²² In addition to a formal, meaningful apology, the report calls for the creation of several memorials:

- A permanent national memorial, with the design and location determined by a steering committee comprised of those infected and affected, and representatives of the UK's devolved administrations.
- Consideration of additional memorials in Northern Ireland, Wales and Scotland.
- A memorial dedicated to the children who were infected while pupils at Treloar's school. This school had an NHS haemophilia treatment centre on site and many of its pupils were infected during research studies into treatments for their condition in the 1970s and 1980s.²³

The report also asks the government to fund at least three events for infected and affected people, to ensure that they can meet and maintain contact with each other.²⁴

²¹ Commons Library research briefing CBP-10099, [Infected Blood Inquiry: compensation](#)

²² Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p221

²³ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p223

²⁴ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p223

2.2

Healthcare for infected patients

The report makes two specific recommendations about the ongoing care of patients who have contracted hepatitis C through contaminated blood.

Monitoring patients infected with hepatitis C (recommendation 6)

Hepatitis C is a virus that can [infect and damage the liver](#).²⁵ The report recommends that those infected with the virus and who have gone on to develop fibrosis (scarring) or [cirrhosis](#) (more severe scarring) of the liver should receive ongoing monitoring.

Specifically, it recommends that these patients should receive an annual clinical review and six-monthly liver scans using FibroScan technology.²⁶ FibroScan is a type of ultrasound scan known as transient elastography, which uses high-frequency sound waves to measure scarring in the liver.²⁷ The report observes that access to ongoing monitoring for patients is currently inconsistent, and that infection with hepatitis C increases the risk of developing liver cancer.²⁸

The report also recommends that patients who have been infected with hepatitis C should be seen by consultant hepatologists (liver specialists) wherever possible, rather than more junior clinicians.²⁹

The report highlighted concerns about follow up and ongoing monitoring of patients with hepatitis C, including those who had been successfully treated. The inquiry received evidence suggesting that there is currently an inconsistent approach, with some patients being discharged from care altogether.³⁰ To address concerns about the delivery of follow-up monitoring for patients infected with hepatitis C, the report further recommends that health service commissioners, responsible for overseeing the services available in their local area, should publish reports outlining how they have ensured that services meet these patients' needs.³¹

In June and September 2024, NHS England wrote to the inquiry to seek clarification about some aspects of recommendation 6, including on the use

²⁵ NHS, [Overview Hepatitis C](#), 27 October 2021

²⁶ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p257-258

²⁷ Guy's and St Thomas' NHS Foundation Trust, [Overview FibroScan to check for liver inflammation](#), June 2022

²⁸ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p256

²⁹ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p258

³⁰ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p255

³¹ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p258

of different scanning techniques. The inquiry responded in October 2024 and clarified the purpose of the recommendation:

The objective of the Inquiry Recommendation 6 is that there should be both surveillance for hepatocellular [liver] cancer and monitoring for the progression of fibrosis and cirrhosis in the particular groups identified in Recommendation 6.³²

The inquiry noted that FibroScan, or a similar test, was appropriate for monitoring the development of fibrosis and cirrhosis, and that ultrasound scans were appropriate to monitor for the development of liver cancer.³³

In relation to hepatology services, the inquiry also confirmed that it recommended that all patients infected with hepatitis C should be offered at least one consultation with a consultant hepatologist “wherever practicable”.³⁴

Current clinical guidance for FibroScan

The National Institute for Health and Care Excellence (NICE) has published general clinical guidance for the diagnosis and care of patients with cirrhosis, including in patients with hepatitis C (irrespective of how they became infected). NICE recommends the use of transient elastography (FibroScan) to diagnose cirrhosis (NICE recommendation 1.1.3).³⁵ In relation to ongoing monitoring, the guidance currently recommends:

- Patients with hepatitis C who have not responded well to antiviral medicines should be retested for cirrhosis every two years (NICE recommendation 1.1.10).
- Patients with cirrhosis, who are not infected with hepatitis B, should be offered an ultrasound scan every 6 months to monitor them for the development of a type of liver cancer called hepatocellular carcinoma (NICE recommendation 1.2.4).

Additional NICE guidance was published in June 2023, recommending the use of FibroScan to assess liver fibrosis or cirrhosis outside hospital or specialist settings.³⁶ This guidance recommended that FibroScan should be considered in settings that will conduct over 500 scans a year, or where they might improve testing for underserved groups.

³² Infected Blood Inquiry, [Inquiry issues letter about monitoring liver damage](#), 16 October 2024

³³ Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry’s May 2024 Report – 6\) Monitoring Liver damage for people infected with Hepatitis C](#), 14 May 2025

³⁴ Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry’s May 2024 Report – 6\) Monitoring Liver damage for people infected with Hepatitis C](#), 14 May 2025

³⁵ National Institute for Health and Care Excellence, [Cirrhosis in over 16s: assessment and management](#), NICE guideline NG50, 8 September 2023

³⁶ National Institute for Health and Care Excellence, [FibroScan for assessing liver fibrosis and cirrhosis outside secondary and specialist care](#), Diagnostics guidance [DG48], 7 June 2023

In April 2024, NHS England announced £4.2 million of funding to buy 25 new FibroScan machines, as part of its ongoing work to eliminate hepatitis C infections.³⁷

Finding undiagnosed patients (recommendation 8)

The inquiry received evidence from some people who experienced delays in being diagnosed with hepatitis C.³⁸ To avoid this in the future, it recommends that:

1. When doctors become aware that a patient has received a blood transfusion before 1996, the patient should be offered a blood test for hepatitis C. A national system for reporting problems with blood transfusions was established in 1996; more details are provided in box 1 below.
2. All new patients registering at a general practice (GP) should be asked if they have ever received a blood transfusion.³⁹

On 20 May 2024, NHS England wrote to all integrated care boards, NHS trusts and primary care networks in England.⁴⁰ The letter asked NHS bodies to promote local hepatitis C testing options, and a new national service offering [at-home tests for hepatitis C](#).⁴¹

Existing NICE guidance on testing for hepatitis B and C already recommends raising awareness of these infections and testing for them in different settings.⁴² This guidance says that people who received a blood transfusion before 1991, or blood products before 1986 are at increased risk of hepatitis C infection. These dates reflect the introduction of screening tests for donated blood (see box 1 below). It recommends that GPs, practice nurses, antenatal services, and local community services that serve migrant populations should all offer testing to people at increased risk, including newly registered patients. However, it does not specify that new patients are asked about their history of blood transfusion when they register with a new GP practice.

2.3

Improving patient safety

In its discussion of lessons to be learned from infected blood, the report emphasises the primacy of patient safety as a guiding principle:

³⁷ NHS England, [NHS expands 'one-hour' liver testing to help detect and eliminate Hep C](#), 8 April 2024

³⁸ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p268

³⁹ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p268

⁴⁰ NHS England, [Publication of the Infected Blood Inquiry final report](#) [Letter], 20 May 2024

⁴¹ NHS, [Get a free home test for hepatitis C](#), accessed 24 July 2024

⁴² National Institute for Health and Care Excellence, [Hepatitis B and C testing: people at risk of infection](#), Public health guideline [PH43], 1 March 2013

The first, and most important lesson, is that the first, and paramount consideration should always be safety. What happened would not have happened if safety of the patient had been paramount throughout.⁴³

Therefore, most of the report's additional recommendations aim to improve patient safety. These include specific proposals to improve the safety of blood transfusions and care for people with haemophilia, and wider recommendations to learn from the inquiry's findings, develop a "safety culture" and increase the influence of patients in the healthcare system.

More generally, the report makes a broad recommendation that the national healthcare administrations in England, Scotland, Wales and Northern Ireland should coordinate their approaches to patient safety.⁴⁴

Safety of blood transfusions (recommendation 7)

The report recognises that past measures taken to reduce the risk of infection from blood transfusions have been successful (see box 1 below). Most serious problems with blood transfusions are now the result of errors or mistakes in the transfusion process.⁴⁵

It recommends that health services and professionals should take steps to reduce the number of blood transfusions that are needed by increasing the use of [tranexamic acid](#) (which helps to prevent or reduce bleeding) before patients undergo surgery. The report notes that existing guidance on the use of this medicine has not been fully implemented and that increasing its use could reduce the number of blood transfusions needed.⁴⁶

1 Screening donated blood today

Today, all blood donations and donations of blood components (like plasma or platelets) are [screened for a range of infections](#), including syphilis, hepatitis viruses and HIV. Blood donors complete a questionnaire about their medical history and laboratories test donated blood samples for different infections. If they find an infection, the [affected blood is removed from the supply chain](#) and donors are notified about their test results.

NHS blood services began [screening for different infections at different times](#). Routine screening for hepatitis B began in 1972, for HIV in 1985 and for hepatitis C in 1991. Parts 5.4 and 5.5 of the Infected Blood Inquiry final report discuss the [introduction of HIV and hepatitis C screening](#).

In 1996, the [Serious Hazards of Transfusion \(SHOT\) scheme](#) was established to collect and publish information about risks and problems arising from blood

⁴³ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p201

⁴⁴ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p250

⁴⁵ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p258

⁴⁶ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p261

transfusions. The inquiry report concluded that there was a risk of infections until this scheme began operating.

NHS Blood and Transplant says that it no longer routinely imports blood from other countries, but sometimes [imports very small quantities of very rare blood types](#) for individual patients where no UK donors are available. All imported blood and blood products must meet [quality and safety standards](#) that require them to be screened for infections, including hepatitis C and B, and HIV.

NICE guidance for blood transfusions

The relevant existing guidance is the 2016 NICE quality standard on blood transfusion, which stated that adults who undergo surgery and are expected to have “moderate blood loss” should be offered tranexamic acid.⁴⁷

NHS Blood and Transplant assesses compliance with the NICE quality standard in England. Its 2023 audit found that 67.5% of patients meeting the NICE criteria received tranexamic acid.⁴⁸ In 2021, the figure was 67%.

The UK Royal Colleges Tranexamic Acid in Surgery Implementation Group is a joint group made up of members of the Royal College of Surgeons of England, the Royal College of Anaesthetists, and the Royal College of Physicians. In 2022, the group published [Tranexamic acid for safer surgery: the time is now](#).⁴⁹ This report estimated that full compliance with the quality standard would prevent over 15,000 cases of bleeding during surgery and save 30,000 units of blood. The Royal College of Surgeons has published guidance and supporting evidence on the use of tranexamic acid to help support its increased use.⁵⁰

Further proposals to improve safety

To further improve the safety of blood transfusions, the report sets out five additional proposals:

- NHS England and NHS Scotland should review existing plans to improve clinical and laboratory blood transfusion processes, and set out the next steps to continue to improve these services.⁵¹ The relevant plans are the

⁴⁷ National institute for Health and Care Excellence, [Blood transfusion](#), Quality standard [QS138], 15 December 2016

⁴⁸ NHS Blood and Transplant, [2023 National Comparative Audit of NICE Quality Standard QS138](#), 7 March 2024

⁴⁹ The UK Royal Colleges Tranexamic Acid in Surgery Implementation Group, [Tranexamic acid for safer surgery: the time is now](#), British Journal of Surgery, Vol 109, No 12, December 2022

⁵⁰ Royal College of Surgeons, [Tranexamic acid to reduce surgical bleeding](#), 13 June 2024

⁵¹ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p262

[Transfusion 2024](#) report for England, and the [Scottish Transfusion Team strategy](#).⁵²

- Hospital transfusion laboratories should ensure adequate staffing levels. The report notes that most blood transfusion complications are related to laboratory errors and that inadequate staffing can contribute to these mistakes.⁵³
- The bodies responsible for undergraduate and postgraduate training for NHS clinicians should ensure that there is adequate training on blood transfusion, defined standards to assess this training, and accountability for this training.⁵⁴
- All NHS organisations in the UK should have a mechanism to implement the recommendations of [Serious Hazards of Transfusion \(SHOT\) reports](#).⁵⁵ SHOT is an independent scheme that collects and publishes information on risks and problems arising from blood transfusions (see box 1 above).⁵⁶ The report recommends that implementing SHOT recommendations should be mandatory and monitored by healthcare regulators.⁵⁷
- NHS England should implement a system to collect information about the outcomes of every transfusion (of blood or blood components).⁵⁸ The aim of this system would be to monitor and improve blood transfusion practice and to share information throughout the UK. The report acknowledges that in Scotland, the [Account for Blood system](#) has been in use since 2010 to collect information about blood transfusions in Scotland but there is currently no equivalent in the other parts of the UK.⁵⁹

The report also notes that the Transfusion 2024 report recommended the development of a “vein-to-vein” tracking system that would allow oversight of blood stocks, demand and outcomes for patients receiving transfusions.⁶⁰ In May 2024, the then Northern Ireland Health Minister, Robin Swann, launched the Blood Production and Tracking project, which will establish the first “vein-to-vein” system in Europe in Northern Ireland by 2027.⁶¹

⁵² Shubha Allard and others, [Transfusion 2024: A 5-year plan for clinical and laboratory transfusion in England](#), *Transfusion Medicine*, Vol 31 No 6, December 2021; NHS National Services Scotland, [Transfusion Team strategy](#), 20 April 2022

⁵³ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p263

⁵⁴ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p264

⁵⁵ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p265

⁵⁶ Serious Hazards of Transfusion, [SHOT Terms of Reference](#), no date, accessed 6 June 2024

⁵⁷ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p265

⁵⁸ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p267

⁵⁹ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p266

⁶⁰ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p266

⁶¹ Health and Social Care Business Services Organisation, [Blood Production and Tracking \(BPAT\)](#), no date, accessed 25 July 2024

In July 2024, the National Blood Transfusion Committee, NHS Blood and Transplant and NHS England hosted the Transfusion Transformation Symposium and discussed several recommendations from the inquiry report.⁶² The press release for this event announced that a follow-up strategy to Transfusion 2024 was being developed and is expected to be published in 2025.⁶³

Safety of haemophilia care (recommendation 9)

The report also makes recommendations to improve the safety of patients with haemophilia. To support the continuous review and improvement of services, the report endorses the existing practice of peer review of haemophilia care by consultant specialists.⁶⁴ It recommends that this should continue, with each treatment centre being reviewed at least once every five years. It also recommends that NHS trusts and health boards should be required to consider the findings of these peer reviews, and “give favourable consideration” to implementing changes identified during these exercises.

To further support shared learning to improve patient care, and to avoid specialists becoming isolated from each other, the report recommends that hospital trusts, integrated care boards and service commissioners should provide resources to set up formal regional networks for clinicians who treat haemophilia and other inherited blood disorders.⁶⁵

The inquiry report found that the views of a small number of doctors had “overly influenced” the government’s response to infected blood. In particular, the former chair of the UK Haemophilia Centre Doctors’ Organisation, Professor Arthur Bloom, was criticised for downplaying the risk and impact of infections in patients with haemophilia.⁶⁶ In recognition of the inquiry’s finding that “the influence of one or two voices can ... have a damaging effect on the safety of patient care”, the report recommends that networks of clinicians who treat haemophilia should be regional, multidisciplinary and involve patients.⁶⁷

The [National Haemophilia Database](#) collects information on diagnosis and outcomes of haemophilia patients in the UK. It is operated by the UK Haemophilia Centre Doctors’ Organisation (a professional group of specialist doctors) and funded by the NHS, pharmaceutical companies and charitable donations. The inquiry report recognises the use of this database for research

⁶² NHS Blood and Transplant, [NHS senior leaders meet to plan how to make blood transfusion even safer](#), 22 July 2024

⁶³ NHS Blood and Transplant, [NHS senior leaders meet to plan how to make blood transfusion even safer](#), 22 July 2024

⁶⁴ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p269

⁶⁵ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p270

⁶⁶ Infected Blood Inquiry, [The Report: What happened and why?](#) 20 May 2024, p268-274

⁶⁷ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p270

and to identify trends in patient care and outcomes; it recommends additional central funding to support it.⁶⁸

Use of recombinant factor products for von Willebrand disorder

The report also makes a specific recommendation about the treatment of patients with severe von Willebrand disease. Von Willebrand disease is an [inherited blood disorder](#) that causes people to bleed more easily. The inquiry received evidence that people with this condition are sometimes treated with plasma-based factor products. These products are derived from donated human blood plasma and help to make blood clot. The report recommends that, wherever clinically appropriate, recombinant coagulation factor products should be used instead.⁶⁹ Recombinant factor products are an alternative to plasma-based products that are made in a laboratory, and carry no risk of infection.

In 2020, NHS England began purchasing Vonicog alfa (sold as Veyvondi) to treat and prevent bleeding in adults with von Willebrand disease.⁷⁰ This medicine is the first recombinant factor product to be licensed for this condition. It is routinely commissioned for use in adults with some types and severity of von Willebrand disease, when existing treatments are ineffective or cannot be used.⁷¹

2.4

Learning from the inquiry and preventing future harm

The inquiry report expresses concern that the “lessons to be learned” from infected blood may be forgotten:

A very real danger is that the lessons of the past are forgotten when a fresh history is being made in the years to come, and only then, after another disaster, are remembered.⁷²

The report recognises that previous inquiries and investigations into “multiple high profile failures of care” have identified similar systemic failures in the healthcare system, and that there have been many previous initiatives that aimed to improve patient safety.⁷³ Among others, these include the inquiry into the Mid Staffordshire NHS Foundation Trust (the Francis report), the investigation into maternity and neonatal services at the University Hospitals

⁶⁸ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p271-272

⁶⁹ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p270

⁷⁰ NHS England, [Vonicog alfa for the treatment and prevention of bleeding in adults with von Willebrand disease](#), 24 September 2020

⁷¹ NHS England, [Clinical Commissioning Policy: Vonicog alfa for the treatment and prevention of bleeding in adults with von Willebrand disease](#), Version 2, January 2021, p13

⁷² Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p223

⁷³ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p225

of Morecambe Bay NHS Foundation Trust (the Kirkup report), the report of the Independent Medicines and Medical Devices Safety Review (the Cumberlege report) and the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust (the Ockenden review).⁷⁴

Healthcare professionals' training (recommendation 3)

In response to these concerns, the inquiry report proposes first that the lessons of the inquiry that relate to clinical practice should be incorporated into doctors' training, that this training should include "excerpts from oral and written testimony" of those directly affected and that the inquiry website should be maintained online (recommendation 3).

The duty of candour (recommendations 4 and 5)

The report makes a series of recommendations with the aim of "achieving a safety culture" in the NHS (recommendation 4). Several of the proposals in this area focus on the operation of the "duty of candour" in the NHS. In England, Scotland and Wales, NHS organisations have a legal duty to be open and transparent about mistakes that cause patients harm.⁷⁵ The report recommends:

- Introducing a statutory duty of candour in healthcare in Northern Ireland.⁷⁶ In 2021, the Department of Health in Northern Ireland consulted on introducing a statutory duty but legislation has not yet been introduced.⁷⁷
- Completing an ongoing review of the statutory duty of candour in England, and reviews of how well the duty works in Scotland and Wales.⁷⁸
- Extending the statutory duty of candour to cover individuals in leadership positions, such as executives and board members. The report recommends that these individuals should be required to record, consider, and respond to all potential patient safety problems, and that they should be held personally accountable for any failure to do so.⁷⁹ The report envisages that this duty would be included as a job requirement,

⁷⁴ Mid Staffordshire NHS Foundation Trust Public Inquiry 2013, [Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry](#), 6 February 2013; Morecambe Bay Investigation, [Morecambe Bay Investigation Report](#), 3 March 2015; Independent Medicines and Medical Devices Safety Review, [First Do No Harm – The report of the IMMDS Review](#), 8 July 2020; Department of Health and Social Care, [Final report of the Ockenden review](#), 30 March 2022

⁷⁵ [Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2014](#); [Duty of Candour Procedure \(Scotland\) Regulations 2018](#); [Duty of Candour Procedure \(Wales\) Regulations 2023](#); NHS Resolution, [Duty of candour animation](#), 30 March 2022

⁷⁶ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p248

⁷⁷ Department of Health (Northern Ireland), [Public Consultation on the introduction of a statutory Duty of Candour in Northern Ireland](#), 12 April 2021

⁷⁸ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p249

⁷⁹ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p249

but also “underpinned by secondary legislation”, although it does not specify the exact nature of this legislation.

The report suggests that making leaders accountable for the culture in their organisations could help to address the existing “culture of defensiveness, lack of openness, failure to be forthcoming, and being dismissive of concerns about patient safety”.⁸⁰

Recommendation 5 extends these considerations beyond the health services. It asks the government to consider whether the (non-statutory) duties described in the existing [Civil Service Code](#) and [Ministerial Code](#) are sufficient to ensure that civil servants and ministers are honest and open. Part 7.3 of the inquiry report, “Lines to Take”, describes the development and repetition of government positions and statements about infected blood. The report argues that not only did the civil service provide inaccurate information to ministers, but also that ministers repeatedly failed to query it:

Not only must the Civil Service ensure that information provided to, and promulgated by, ministers is accurate, but ministers must probe and query the evidential basis for any lines to be taken, particularly when they are historical in nature and prone to the malleable corporate memory for the Civil Service, and make bold claims that what was done was the very best that was possible. This simply was not done, again and again.⁸¹

Therefore, recommendation 5 sets out an aim to end “a defensive culture in the Civil Service and government” by reviewing existing duties for civil servants and ministers. It also proposes introducing a statutory duty of accountability for senior civil servants, who would become responsible for the “candour and completeness” of advice given to permanent secretaries and ministers and responses to concerns raised by staff or members of the public.⁸²

In July 2024, the King’s Speech proposed introducing legislation to establish a duty of candour for public servants, known as the Hillsborough Law.⁸³ The briefing notes that accompanied the speech said that the legislation is intended to “address the unacceptable defensive culture prevalent across too much of the public sector”, as identified in the Infected Blood Inquiry report.⁸⁴

Healthcare regulation (recommendation 4)

The inquiry report argues that the current regulatory framework for healthcare in the UK is overly complex and creates uncertainty for patients

⁸⁰ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p249

⁸¹ Infected Blood Inquiry, [The Report Response of Government \(Volume 7\)](#), 20 May 2024, p127

⁸² Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p254-255

⁸³ Prime Minister’s Office, 10 Downing Street, [The King’s Speech 2024](#), 17 July 2024

⁸⁴ Prime Minister’s Office, 10 Downing Street, [The King’s Speech 2024: background briefing notes](#), 17 July 2024

and professionals.⁸⁵ In response, the report calls for the regulatory framework to be simplified.⁸⁶

The report also proposes that healthcare administrations in each part of the UK follow practice in other industries and consider implementing safety management systems.⁸⁷ Industries including aerospace, aviation, maritime, rail, oil and gas, defence, and nuclear power utilise safety management systems that are designed to provide a structured approach to safety management. The Health Services Safety Investigations Body (HSSIB), the body responsible for investigating patient safety concerns in England, published a report on safety management systems in October 2023 and defined them as follows:

An SMS [safety management system] is a proactive and integrated approach to managing safety. It sets out the necessary organisational structures and accountabilities and will continuously be improved. It requires safety management to be integrated into an organisation's day to day activities.

Patient records (recommendation 4)

Finally, the inquiry report makes a recommendation about the ongoing digitisation of patient records in the UK. It proposes a formal audit of the success of this work, with a focus on what patients need and want from digital records.⁸⁸

The report recommends that the audit should consider how easily patients can access their medical records and identify and correct any errors, as well as professionals' confidence in the detail, accuracy, timeliness and completeness of records. In addition, it should consider the interoperability of systems used in different hospitals and GP practices (that is, how well they work together), and between the different parts of the UK.

The NHS committed to introduce electronic patient records in 2014.⁸⁹ In February 2022, the then Secretary of State for Health and Social Care, Sajid Javid, set a target for 90% of NHS trusts to use electronic patient records by the end of 2023, and 100% by March 2025.⁹⁰ In November 2023, NHS England reported that the 90% target had been reached.⁹¹

NHS England has also published information on its work to improve the interoperability of IT systems across the NHS and shared care records, that allow patient data to be shared between different parts of the health and

⁸⁵ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p226

⁸⁶ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p249

⁸⁷ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p249

⁸⁸ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p250

⁸⁹ Commons Library research briefing 07103, [Patient health records: Access, sharing and confidentiality](#)

⁹⁰ Department for Health and Social Care and NHS England, [A plan for digital health and social care](#), 29 June 2022

⁹¹ NHS England, [90% of NHS trusts now have electronic patient records](#), 16 November 2023

social care system.⁹² Similar work to digitise and link patient records is underway in Scotland, Wales and Northern Ireland.⁹³

Giving patients a voice (recommendation 10)

The inquiry report says that the failure to listen to patients was “one of the most striking aspects of the evidence” it received.⁹⁴ To address this deficit, recommendation 10 sets out actions to “enable and empower” the voice of patients within the healthcare system:

- Measures of patient satisfaction or concern should be included in all clinical audits (assessments of health care services).
- The government should take steps to increase awareness of the Medicines and Healthcare products Regulatory Agency’s [Yellow Card reporting system](#) among those receiving medicines, biological products or transfusions. The Yellow Card system allows anyone to make a report about a suspected side effect or safety concern about a medicine or medical device (including blood and blood products).

To strengthen the voice of patients from the infected blood community, the report recommends that the government should:

- Provide funding for patient advocacy to the charities the UK Haemophilia Society, the Hepatitis C Trust, Haemophilia Scotland, the Scottish Infected Blood Forum, Haemophilia Wales, Haemophilia Northern Ireland, and the UK Thalassaemia Society.
- Consider offering funding to other charities and organisations that were named as [core participants in the inquiry](#) for at least 18 months.
- Work with the charities the UK Thalassaemia Society and the Sickle Cell Society to consider how the needs of patients with these conditions can be met. This recommendation follows the inquiry’s recognition that relatively few people with these conditions were prepared to give evidence to the inquiry.⁹⁵

2.5

Public inquiries

Recommendations 11 and 12 focus on how public inquiries themselves are conducted. The report found that the harm done to people infected and

⁹² NHS England, [Interoperability](#), no date, accessed 26 July 2024; NHS England, [Shared care records](#), no date, accessed 26 July 2024

⁹³ Scottish Government, [Health and social care: data strategy](#), 22 February 2023; Welsh Government, [Digital and data strategy for health and social care in Wales](#), 27 July 2023; Department of Health (Northern Ireland), [Digital revolution for NI patient records](#), 3 October 2023

⁹⁴ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p272

⁹⁵ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p274

affected by infected blood was compounded by the government's failure to establish a public inquiry until 2017.⁹⁶

It calls for a greater role for the Commons [Public Administration and Constitutional Affairs Committee](#) in deciding if there should be a public inquiry and in monitoring the government's response to recommendations made by statutory inquiries.⁹⁷

In relation to the Infected Blood Inquiry report specifically, it recommends:

- The government should consider and respond to the recommendations made in its report within 12 months, and it should report its progress to Parliament before the end of 2024.
- This timetable should not affect the government's response to the recommendations made in the inquiry's second interim report (on compensation).
- The Public Administration and Constitutional Affairs Committee should review the government's progress in responding to and implementing the inquiry's recommendations.⁹⁸

⁹⁶ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p7

⁹⁷ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p279-280, 284

⁹⁸ Infected Blood Inquiry, [The Report Overview and Recommendations \(Volume 1\)](#), 20 May 2024, p284

3

Response to the inquiry report

The government published an initial response to the infected blood inquiry report in December 2024 and a final full response on 14 May 2025.⁹⁹ The UK Government and devolved administrations in Scotland, Wales and Northern Ireland say that they have accepted all the inquiry's recommendations in full, or in principle. No recommendations were rejected.

Government ministers and senior managers in the NHS have apologised to those infected and affected by contaminated blood and blood products.

Charities and campaigners have also responded to the inquiry report and to the government's response and actions. Some campaigners have called for criminal investigations into those responsible for infected blood.

3.1

Government response to the inquiry report

The government published an [initial response](#) to the infected blood inquiry in December 2024 and a [full response](#) on 14 May 2025.¹⁰⁰ It says that the UK Government and devolved administrations accept the inquiry's recommendations in full or in principle, "in accordance with the latest evidence-based care and clinical guidelines".

In a statement in the House of Commons on 14 May 2025, the Paymaster General and Minister for the Cabinet office, Nick Thomas-Symonds, explained that the implementation of the inquiry's recommendations was underway, but that some would depend on future spending decisions:

The UK and devolved Governments have accepted the inquiry's recommendations either in full or in principle, and implementation is under way across Government, arm's length bodies and healthcare settings. Where recommendations are accepted in principle, we have sought to explain the rationale for doing so, balancing agreement with the spirit of the recommendations and their implementation. Some are subject to future spending decisions by the Department of Health and Social Care.¹⁰¹

⁹⁹ Cabinet Office, [Government Response to the Infected Blood Inquiry](#), 17 December 2024; Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry's May 2024 Report](#), 14 May 2025

¹⁰⁰ Cabinet Office, [Government Response to the Infected Blood Inquiry](#), 17 December 2024; Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry's May 2024 Report](#), 14 May 2025

¹⁰¹ [HC Deb 14 May 2025 c381](#)

Recommendations accepted in full or in principle

The government's response to the infected blood inquiry says that it accepts the report's recommendations "in full" or "in principle". It explains that recommendations have been accepted "in principle" where the government (or a devolved administration) accepts the rationale and need for change, but considers that further work is required to consider how they should be implemented:

Further work is required to fully understand the implications of implementing complex recommendations, the long-term costs, and to better understand where existing programmes of work can achieve the recommended outcome, rather than the specific approach set out by the Inquiry. The recommendations that we are accepting in principle are complex and far-reaching and rushing their delivery may lead to unintended adverse consequences that the Government wishes to avoid.¹⁰²

Broadly, the UK Government and devolved administrations accepted the inquiry's recommendations about compensation, memorials and healthcare professionals' training ("learning from the inquiry") in full.

Other recommendations focused on healthcare, patient safety and public inquiries received differing responses across the UK. In these cases, some recommendations and sub-recommendations were accepted in full, and others were accepted in principle. Where recommendations were accepted in principle, the government response describes the implementation issues affecting these.

Table 1 summarises the inquiry's recommendations and the response of the UK Government and devolved administrations to each one. It shows which recommendations are accepted in full and which are accepted in principle in each part of the UK.

A fuller version of this table is available in Appendix 1 of this briefing.

¹⁰² Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry's May 2024 Report](#), 14 May 2025

Table 1 Summary of infected blood inquiry recommendations and responses accepted in full (F) or in principle (P)

Recommendation	UK Government	Scottish Government	Welsh Government	Northern Ireland Executive
1 Set up a compensation scheme now	F	F	F	F
2 Recognise and remember what happened to people	F	F	F	F
3 Learning from the inquiry	F	F	F	F
4 Preventing future harm to patients: achieving a safety culture	F/P	F/P	F/P	F/P
5 Ending the defensive culture in the civil service and government	P			
6 Monitoring liver damage for people infected with hepatitis C	F/P	F/P	F/P	F/P
7 Patient safety: blood transfusions	F/P	F/P	F/P	F/P
8 Finding the undiagnosed	F	F	F	P
9 Protecting the safety of haemophilia care	F/P	F	F/P	P
10 Giving patients a voice	F/P	F/P	F/P	F/P
11 Responding to calls for a public inquiry	P			
12 Giving effect to the recommendations of the infected blood inquiry	F/P			

Source: Adapted from [Government response to the Infected Blood Inquiry](#), 14 May 2025.

F = accepts in full; P = accepts in principle; F/P = different responses to different sub-recommendations.

Compensation, recognition and remembrance, and learning from the inquiry (recommendations 1-3)

The UK Government, Scottish Government, Welsh Government and Northern Ireland Executive all accepted the inquiry's recommendations in these areas in full. The Library briefing [Infected Blood Inquiry: compensation](#) provides more information about these recommendations and the implementation of the compensation scheme.¹⁰³

¹⁰³ Commons Library research briefing CBP-10099, [Infected Blood Inquiry: compensation](#)

In its May 2025 response to the inquiry, the government set out its plans in relation to recommendations 2 and 3:

- It said that it would appoint the chair and members of a steering committee to determine the form and location of memorials, and publish terms of reference and timelines for this work. It also noted that input from the infected blood community was “integral” to this work and that it had engaged with stakeholders to identify suitable candidates for the role of Chair.
- It said that the General Medical Council and NHS England were surveying medical schools to identify current practice in blood transfusion training and working to identify gaps.

Healthcare for infected patients (recommendations 6 and 8)

The recommendations in this area focused on monitoring patients infected with hepatitis (recommendation 6) and identifying undiagnosed patients.

Different aspects of recommendation 6 were accepted in full or in principle by the UK Government, Scottish Government and Welsh Government. The Northern Ireland Executive accepted recommendation 6 in principle. The government response says that it must consider existing clinical guidance and the need to provide equitable treatment to all patients:

We accept this recommendation but will balance its implementation against NHS England’s role to promote equitable access for all, the principle that patients should receive the same treatment irrespective of how the disease was acquired, the practicality of implementing different pathways for cohorts of patients, and the latest evidence-based care and clinical guidelines.¹⁰⁴

The UK Government said that it had checked current care pathways to ensure that patients with hepatitis are treated in line with NICE guidance, and that it would introduce an NHS cirrhosis registry, to improve long-term monitoring of patients with cirrhosis.¹⁰⁵

The Scottish Government said that the inquiry’s recommendations for monitoring were in line with current guidance in Scotland. The Welsh Government said it could meet the recommendation “in general” and would seek a common position across the UK. The Northern Ireland Executive said most patients with cirrhosis received monitoring in line with the inquiry’s recommendations, and that the Office of the Chief Medical Officer Northern

¹⁰⁴ Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry’s May 2024 Report – 6\) Monitoring Liver damage for people infected with Hepatitis C](#), 14 May 2025

¹⁰⁵ Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry’s May 2024 Report – 6\) Monitoring Liver damage for people infected with Hepatitis C](#), 14 May 2025

Ireland and expert clinicians were being consulted on the implications of the recommendations.¹⁰⁶

In relation to identifying undiagnosed patients, the UK Government, Scottish Government and Welsh Government accepted recommendation 8 in full. The Northern Ireland Executive accepted this recommendation in principle.

The UK Government said that a new online GP registration service for England would be used to identify undiagnosed patients.¹⁰⁷ On 19 May 2025, NHS England announced that from 16 June 2025 around 400,000 people a year would now be asked if they had received a historic blood transfusion and offered a hepatitis C test if appropriate.¹⁰⁸

The Scottish Government and Welsh Government both reported that recommendation 8 had been implemented.¹⁰⁹ In Northern Ireland, information about hepatitis C tests was shared with healthcare professionals via a circular, but the NI Executive said that the Department of Health was still determining the best approach to change GP registration practices.¹¹⁰

Safety of blood transfusions and haemophilia care (recommendations 7 and 9)

Recommendation 7 focused on the safety of blood transfusions, and recommendation 9 on the care of patients with haemophilia. Different aspects of these recommendations were accepted in full or in principle in each part of the UK. The Scottish Government accepted all of recommendation 9 in full.

On the safety of blood transfusions, the government response noted that the recommendations are complex, likely to take “several years” to implement, and will require funding that “has not yet been identified”.¹¹¹ The UK Government says that it has established a working group, with experts from each part of the UK, the National Blood Transfusion Committee and Serious Hazards of Transfusion (SHOT) to consider the recommendations in this area.¹¹²

¹⁰⁶ Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry’s May 2024 Report – 6\) Monitoring Liver damage for people infected with Hepatitis C](#), 14 May 2025

¹⁰⁷ Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry’s May 2024 Report – 8\) Finding the undiagnosed](#), 14 May 2025

¹⁰⁸ NHS England, [New GP drive to find undiagnosed infected blood patients](#), 19 May 2025

¹⁰⁹ Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry’s May 2024 Report – 8\) Finding the undiagnosed](#), 14 May 2025

¹¹⁰ Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry’s May 2024 Report – 8\) Finding the undiagnosed](#), 14 May 2025

¹¹¹ Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry’s May 2024 Report – 7\) Patient Safety: Blood Transfusions](#), 14 May 2025

¹¹² Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry’s May 2024 Report – 7\) Patient Safety: Blood Transfusions](#), 14 May 2025

The UK Government and Northern Ireland Executive reported that many of the inquiry's recommendations for haemophilia care reflected current practice. The Scottish Government reported that all parts of recommendation 9 had largely been implemented in Scotland.

In addition, the UK Government reported that NHS England was updating the [haemophilia and related bleeding disorders service specification](#) to require services to participate in peer review, and was setting up a “task and finish group” to consider the National Haemophilia Database.¹¹³

Recommendation 9e proposed that recombinant factor products should be used instead of plasma-derived products for specific groups of patients. Each part of the UK reported on the use of these medicines:

- The UK Government said that NHS England had begun [funding recombinant Von Willebrand factor for some patients](#) in August 2024 and that a review of the clinical and cost-effectiveness of different uses of recombinant factor products was underway.
- The Welsh Government said recombinant factor product was routinely available in Wales for some patients and under consideration for long-term use to prevent bleeding.
- The Northern Ireland Executive said that without guidance from NICE, the Scottish Medicines Consortium or the All Wales Medicines Strategy Group, there is currently no route to make these medicines available for long-term preventive use in NI. It said it would consider any guidance produced by these bodies.¹¹⁴

The duty of candour and culture change in the civil service and government (recommendations 4 and 5)

Different aspects of recommendation 4 were accepted in full or in principle by the UK Government and the devolved administrations. The UK Government accepted recommendation 5, to end the defensive culture in the civil service and government, in principle. It noted that the proposals in this area were being considered in relation to the planned ‘Hillsborough Law’.

The UK Government referred to its [consultation on the regulation of NHS managers](#). It argued that implementing recommendations to increase the accountability of NHS leaders could have “significant resourcing and employment law implications” and may be “counter-productive”. It also said that DHSC was consulting on including a new pledge in the NHS Constitution:

¹¹³ NHS England, [Consultation on service specification for haemophilia and related bleeding disorders \(adults and children\): background information](#), 20 May 2025

¹¹⁴ Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry's May 2024 Report – 9\) Protecting the safety of haemophilia care](#), 14 May 2025

To provide a culture of accountability where NHS leaders ensure that the statutory duty of candour is correctly followed in their organisation, and that they ensure systems and processes exist for responding to patient safety concerns.¹¹⁵

On the statutory duty of candour in healthcare, the Northern Ireland Executive said that its [Health and Social Care Three Year Plan](#) includes a proposal to introduce a statutory duty. The plan says that legislative proposals for Northern Ireland will be introduced by September 2025.¹¹⁶ The Scottish and Welsh Government accepted the recommendations to review the duty, and the UK Government said it was preparing the final report of its review of the duty in England.

In addition, the UK Government, Scottish Government and Welsh Government accepted recommendations to extend the statutory duty of candour to cover NHS leaders, and to make leaders accountable for patient safety, in principle. The Scottish and Welsh Governments expressed support for a UK-wide approach.

Healthcare regulation (recommendation 4c(i-iii))

The inquiry's recommendations on reviewing existing healthcare regulation and introducing safety management systems (recommendations 4c(i-ii)) were accepted in full by the UK Government and Welsh Government, and accepted in principle by the Scottish Government and Northern Ireland Executive.

The UK Government said it had asked Dr Penny Dash, the chair of NHS England, to conduct a review of patient safety. It says the review will focus on six bodies with responsibility for different aspects of patient safety: the Care Quality Commission (CQC), The National Guardian's Office, Healthwatch England (HWE) and the Local Healthwatch network, the Health Services Safety Investigation Body, the Patient Safety Commissioner and NHS Resolution. The review's [terms of reference](#) were published in October 2024.¹¹⁷

It also noted that NHS England had established a safety management system group to explore using these principles in the NHS, but that research showed that "there is no single most effective approach to patient safety" and that the approach should be adapted to fit a specific context.¹¹⁸

The Scottish Government said that it was engaging with work led by a "UK-wide Inter-Ministerial Group" on regulation, and that it was working with Healthcare Improvement Scotland on quality and safety management, and

¹¹⁵ Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry's May 2024 Report – 4\) Preventing future harm to patients](#), 14 May 2025

¹¹⁶ Department of Health, [Health and Social Care NI – Three Year Plan](#), 10 December 2024

¹¹⁷ Department of Health and Social Care, [Review of patient safety across the health and care landscape: terms of reference](#), 15 October 2024

¹¹⁸ Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry's May 2024 Report – 4\) Preventing future harm to patients](#), 14 May 2025

that it would work with its counterparts in the rest of the UK to share learning and promote patient safety.¹¹⁹

Patient records (recommendation 4d)

Recommendation 4d, to assess the success of the digitisation of patient records, was accepted in principle by the UK Government, Welsh Government and Northern Ireland Executive. It was accepted in full by the Scottish Government.

The UK Government said that patient data was being digitised and that ongoing “Digital Maturity Assessments” captured most of the information called for in the recommendation. It said that plans to capture other information and to make the information public were being developed.¹²⁰

The Scottish Government said it was committed to digitising patient records and that it was developing a new national digital health and social care service, which would help patients to “interact” with their health information. It said that existing Digital Maturity Assessments would be used to assess progress in digitisation.¹²¹

The Welsh Government said it had introduced the NHS Wales App and that it was commissioning an electronic health record for secondary care settings (like hospitals) that would make it easier for doctors and patients to access health information.¹²²

The Northern Ireland Executive said that it was implementing electronic patient records to cover acute care, secondary care, social care and mental health care settings. It reported that this was scheduled to be complete by May 2025 and that it would be followed by a review and audit, including consideration of meeting the inquiry’s recommendations.¹²³

Patient voice (recommendation 10)

Different aspects of recommendation 10 were accepted in full or in principle by the UK Government and the devolved administrations.

In relation to using measures of patient satisfaction in clinical audits, the UK Government noted that the Health Secretary, Wes Streeting, had an ambition

¹¹⁹ Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry’s May 2024 Report – 4\) Preventing future harm to patients](#), 14 May 2025

¹²⁰ Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry’s May 2024 Report – 4\) Preventing future harm to patients](#), 14 May 2025

¹²¹ Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry’s May 2024 Report – 4\) Preventing future harm to patients](#), 14 May 2025

¹²² Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry’s May 2024 Report – 4\) Preventing future harm to patients](#), 14 May 2025

¹²³ Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry’s May 2024 Report – 4\) Preventing future harm to patients](#), 14 May 2025

for the NHS to return to “the highest patient satisfaction in history”.¹²⁴ The UK, Scottish and Welsh Governments reported on existing measures to incorporate measures of patient satisfaction in clinical audits and other patient involvement initiatives. The UK Government said that NHS England was working to understand gaps in reporting and identify the most appropriate measures of patient experience.

In addition, the UK Government accepted in full recommendation 10a(ii) to fund the charities named in the inquiry report, and recommendation 10a(iii), to give “favourable consideration” to other groups named as inquiry core participants. It said that £500,000 of funding would be provided to named charities and that it was considering how to support others. The Scottish Government also noted that it had agreed grant funding for Haemophilia Scotland and the Scottish Infected Blood Forum for 2025-26. The Welsh Government said it “continues to work with” Haemophilia Wales and the Northern Ireland Executive said it had held “discussions” to identify the best approach to support local voluntary and community sector organisations.

Public inquiries (recommendations 11 and 12)

The UK Government accepted recommendation 11 in principle, and said it welcomed the recommendation that Parliament should play a role in recommending the establishment of public inquiries.¹²⁵ However, it said it was for Parliament to decide if and how these recommendations were accepted and implemented. It said that if Parliament decided to adopt the proposals recommended by the inquiry, that the government would accept its obligation to publish reasons when it disagreed with a recommendation to establish a public inquiry.

The UK Government accepted recommendations 12a, 12b and 12c in full.¹²⁶ These referred to the timetable for responding to the Infected Blood Inquiry, and the government has now met these requirements. It accepted recommendations 12d and 12e, setting out a reviewing role for the Public Administration and Constitutional Affairs Committee, in principle. However, the government said that these were also for Parliament to decide. The committee has not published any response.

The government further noted that its response to the House of Lords Statutory Inquiries Committee included a commitment to update Parliament on its plans to reform public inquiries.¹²⁷

¹²⁴ Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry’s May 2024 Report – 10\) Giving patients a voice](#), 14 May 2025

¹²⁵ Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry’s May 2024 Report – 11\) Responding to calls for a Public Inquiry](#), 14 May 2025

¹²⁶ Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry’s May 2024 Report – 12\) Giving effect to the recommendations of this Inquiry](#), 14 May 2025

¹²⁷ Cabinet Office, [Government Response to the House of Lords Statutory Inquiries Committee report: Enhancing public trust](#), 10 February 2025

3.2

Government apologies

Following the publication of the final inquiry report, the governments of all four parts of the UK issued apologies to those infected and affected by infected blood:

- The then Prime Minister, Rishi Sunak, offered a “wholehearted and unequivocal apology” to those infected and their families. He committed to the payment of compensation to those infected and affected, and to study the report’s other recommendations in detail and provide a full response.¹²⁸
- Additional statements from the then Minister for the Cabinet Office (John Glen) and Secretary of State for Health and Social Care (Victoria Atkins) also included apologies and commitments to review the report’s recommendations.¹²⁹
- On 26 July 2024, the Paymaster General and Minister for the Cabinet Office, Nick Thomas-Symonds, offered a “deep and heartfelt sorry” on behalf of the new Labour government, and said that it would update Parliament on its response to the report’s recommendations before the end of 2024.¹³⁰
- The Scottish First Minister, John Swinney, apologised “unreservedly” to everyone who had been affected by infected blood, and committed the Scottish Government to working with the UK Government to establish the compensation scheme. In addition, he said that the Scottish Government would take steps within its own areas of responsibility to consider the report’s other recommendations.¹³¹
- The then Welsh Cabinet Secretary for Health and Social Care (later First Minister), Eluned Morgan, apologised “to all those who were infected or have been affected” by infected blood, and committed to considering the inquiry report’s recommendations in detail.¹³²
- The then Health Minister for Northern Ireland, Robin Swann, apologised to those who had been “failed by the system”, and said that the Department of Health would carefully consider the report’s

¹²⁸ Prime Minister’s Office, 10 Downing Street, [PM statement on the Infected Blood Inquiry](#), 20 May 2024

¹²⁹ Cabinet Office, [Infected Blood Compensation Scheme](#), 21 May 2024; Department of Health and Social Care, [Secretary of State responds to the Infected Blood Inquiry Report](#), 21 May 2024

¹³⁰ Cabinet Office, [Update on the Government response to the Infected Blood Inquiry](#), 31 July 2024

¹³¹ Scottish Government, [UK Infected Blood Inquiry – final report: First Minister’s response](#), 21 May 2024

¹³² Welsh Government, [Written Statement: Infected Blood Inquiry: Initial Response to its Report](#), 20 May 2024

recommendations and engage with its counterparts across the UK in developing its response.¹³³

The government has since reiterated these apologies, including in its published [initial response](#) and [full response](#) to the inquiry report.¹³⁴ The full response begins with this apology:

We would all like to reiterate our wholehearted and unequivocal apology on behalf of current and previous governments to every single person impacted by this scandal. We are clear that nothing of this nature can ever happen again, but for this to be anything more than words, tangible action must be taken.¹³⁵

3.3

NHS and healthcare bodies

Multiple NHS organisations have also acknowledged the publication of the inquiry report and issued apologies to those infected and affected. The Chief Executive of NHS England, Amanda Pritchard, committed to respond to the report’s recommendations.¹³⁶

The blood and transfusion services in all four parts of the UK have also issued apologies.¹³⁷ In addition, the SHOT scheme welcomed the report and its recommendations about blood transfusion safety.¹³⁸ In its annual report, published in July 2024, SHOT supported the “complete implementation of the [Infected Blood Inquiry] report recommendations to improve healthcare systems and optimise safety”.¹³⁹

Other healthcare and professional bodies have also acknowledged the report’s findings and made various commitments to consider them further:

- The General Medical Council (GMC) said that healthcare systems had “harmed and let down” patients, and that it would reflect on the report’s recommendations.¹⁴⁰ In August 2024, it was reported that the GMC had identified 19 registered doctors named in the inquiry report and that it

¹³³ Department of Health (Northern Ireland), [Final report of the Infected Blood Inquiry](#), 20 May 2024

¹³⁴ Cabinet Office, [Government Response to the Infected Blood Inquiry](#), 17 December 2024; Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry’s May 2024 Report](#), 14 May 2025

¹³⁵ Infected Blood Compensation Authority and Cabinet Office, [Full Government Response to the Infected Blood Inquiry’s May 2024 Report](#), 14 May 2025

¹³⁶ NHS England, [Publication of the infected blood inquiry final report](#), 20 May 2024

¹³⁷ NHS Blood and Transplant, [Infected Blood Inquiry](#), no date, accessed 26 July 2024; Scottish National Blood Transfusion Service, [Infected Blood Inquiry: SNBTS response to the publication of the IBI report](#), no date, accessed 26 July 2024; Velindre University NHS Trust, [Infected Blood Inquiry: Velindre University NHS Trust statement](#), 21 May 2024; Northern Ireland Blood Transfusion Service, [Infected Blood Inquiry](#), no date, accessed 26 July 2024

¹³⁸ Serious Hazards of Transfusion, [Statement from SHOT in response to the IBI report](#), no date, accessed 31 July 2024

¹³⁹ Serious Hazards of Transfusion, [Annual SHOT report 2023](#), July 2024

¹⁴⁰ General Medical Council, [Statement following publication of the Infected Blood Inquiry report](#), 21 May 2024

was “actively considering the information the report contains” about those doctors.¹⁴¹

- The Royal College of Physicians described the report as “essential reading for all healthcare professionals”, and the Royal College of Pathology said it was “detailed and thorough”. Both royal colleges said they would consider where its recommendations could be implemented in their areas of work.¹⁴²

The British Medical Association said the publication of the report was a “day of shame for the NHS” and called for all those involved to apologise. It said it would consider the report’s implications for the medical profession and doctor-patient relationships.¹⁴³

3.4

Patient organisations and charities

Organisations representing patients have also responded to the report.

The Patients Association campaigns for improvements to health and social care services in England and Wales. It described the inquiry’s findings as “horrifying” and called on the government to act on its recommendations, especially in relation to compensation, incorporating the report’s findings into doctors’ training, embedding a patient safety culture in the NHS and extending the duty of candour.¹⁴⁴

The Haemophilia Society issued a statement that included an apology for its failures in relation to infected blood. In particular, it acknowledged the report’s findings that it had been too slow to act on the risk of HIV infection, had relied too heavily on the advice of the haemophilia doctor Professor Arthur Bloom, and failed to discourage its members from using factor concentrate.¹⁴⁵

The Hepatitis C Trust called on the government to respond quickly to the report and commit to implementing all of its recommendations and “taking the lessons learned to ensure absolutely nothing like this can ever happen again”.¹⁴⁶ On 20 May 2025, The Hepatitis C Trust said that many had been “left in despair” in the year following the publication of the inquiry report.¹⁴⁷ The

¹⁴¹ The Daily Mail, “[Government offers police chiefs ‘full co-operation with any future criminal investigation’ into blood contamination scandal](#)”, 19 August 2024

¹⁴² Royal College of Physicians, [Royal College of Physicians responds to Infected Blood Inquiry](#), 20 May 2024; Royal College of Pathologists, [The Infected Blood Inquiry](#), 20 May 2024

¹⁴³ British Medical Association, [BMA responds to the Infected Blood Inquiry’s report](#), 20 May 2024

¹⁴⁴ The Patients Association, [Patients Association statement on Infected Blood Inquiry’s final report](#), 20 May 2024

¹⁴⁵ The Haemophilia Society, [Statement to our members about the Infected Blood Inquiry’s findings](#), 21 May 2024

¹⁴⁶ The Hepatitis C Trust, [Infected Blood Inquiry Report: Hepatitis C Trust response](#), 21 May 2024

¹⁴⁷ The Hepatitis C Trust, [One Year On From the Infected Blood Inquiry’s Report](#), 20 May 2025

charity drew attention to problems with the compensation scheme, and also to the lack of progress in implementing other recommendations in the report:

In terms of the other key recommendations of the report, we are still yet to see many forward steps. Very little has been done in terms of a memorial and the Government's 'Hillsborough Law', aimed to introduce a duty of candour to government and civil service has been described as 'a betrayal' of the families of the victims of the 1989 disaster at Hillsborough Stadium.

Progress has also been limited in regards to improvements in patient safety and liver screening for those infected with hepatitis C. It is welcome, however, to see NHS England announce this week that all new patients registering at GP practices are to be asked if they had a blood transfusion before 1996.¹⁴⁸

3.5 Calls for criminal investigations

Writing in the Guardian, the chair of the Tainted Blood campaign group, Andy Evans, called for further action to identify the organisations and individuals responsible for infected blood and for criminal prosecutions to be considered.¹⁴⁹

On 28 July 2024, the Sunday Times reported that Donna Jones, the then chair of the Association of Police and Crime Commissioners, had written to the Home Secretary seeking support for a national police investigation on infected blood.¹⁵⁰ In her letter, she requested that the [National Police Chief's Council](#) (NPCC) review the findings of the Infected Blood Inquiry, "to establish what criminal offences might have been committed and who could be investigated."

In September 2024, the Paymaster General confirmed that he had written to the NPCC on 9 August 2024 to "make it clear that the Cabinet Office, and, indeed, the Government will co-operate fully and make any evidence within our control and possession available, as appropriate, so that decisions can be made about people being held to account".¹⁵¹

The government has repeatedly stated that decisions about criminal prosecutions rest with independent prosecuting authorities.¹⁵²

¹⁴⁸ The Hepatitis C Trust, [One Year On From the Infected Blood Inquiry's Report](#), 20 May 2025

¹⁴⁹ Andy Evans, "[After years of despair, infected blood victims like me will be compensated. Now to identify the guilty](#)", The Guardian, 21 May 2024

¹⁵⁰ Sunday Times, "[Tainted blood scandal: police chief calls for criminal inquiry](#)", 28 July 2024

¹⁵¹ [HC Deb 2 September 2024 c79](#)

¹⁵² [HC Deb 26 July 2024 c927](#), [HC Deb 2 September 2024 c79](#), PQ 50946 [on: [Public Sector: Misconduct](#)] 16 May 2025

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Appendix 1: Full summary of recommendations and government responses

Full list of infected blood inquiry recommendations accepted in full (F) or in principle (P)				
Recommendation	UK Government	Scottish Government	Welsh Government	Northern Ireland Executive
1 Set up a compensation scheme now	F	F	F	F
2 Establish a permanent memorial and memorial dedicated to children infected at Treloar's School, and facilitate/fund events for the infected blood community	F	F	F	F
3 Ensure that medical education bodies incorporate lessons from infected blood into doctor's training and develop training materials that use oral and written testimony from the infected blood community	F	F	F	F
4a (i-iii) Introduce a statutory duty of candour in Northern Ireland, review the duty in Wales and Scotland, and complete the review in England	F	F	F	F
4a (iv-v) Extend a statutory duty of candour to NHS leaders, and require these individuals to record, consider and respond to patient safety concerns	P	P	P	
4b Address the culture of defensiveness, by making leaders accountable for culture	P	P	P	P
4c (i-ii) Review and simplify regulation of safety in healthcare and explore the use of safety management systems	F	P	F	P

4d Complete a formal audit to assess the success of digitised patient records across the UK before the end of 2027	P	F	P	P
4e Consider how more coordination across the UK could identify patterns of patient harm, and how responses to harm could be coordinated	F	F	F	F
5a Consider if existing non-statutory duties in the Civil Service Code and Ministerial Code, and legal duties, are sufficient to secure candour	P			
5b Introduce a statutory duty of accountability for senior civil servants for candour and completeness of advice to Permanent Secretaries and Ministers, and responses to members of the public and staff	P			
5c Consider if Ministers should be subject to a duty beyond their existing duty to Parliament under the Ministerial Code	P			
6a (i) Offer six-monthly scans and annual clinical reviews to patients diagnosed with cirrhosis	F	F	F	P
6a (ii) Provide the same care for those with fibrosis	P	P	P	P
6a (iii) Provide the same care if there is uncertainty if a patient has fibrosis	F	F	F	P
6a (iv) Use Fibroscan technology for liver imaging	F	F	F	P
6a (v) Patients infected with hepatitis C should be seen by a consultant hepatologist (liver specialist) wherever practicable	P	P	P	P
6a (vi) Organisations responsible for commissioning hepatology (liver) services should publish information to demonstrate that services met the needs of people harmed by NHS treatment	F	F	F	P

7a (i) In England, take steps to ensure surgical checklists include consideration of tranexamic acid, and report on its use	P			
7a (ii) In Scotland, Wales and Northern Ireland, tranexamic acid should be a preferred treatment for all eligible surgery		F	P	P
7a (iii) Consider standardisation and benchmarking transfusion performance across hospitals	F	F	F	F
7b Review progress in implementing the Transfusion 2024 recommendations (in England) and review the Scottish five-year plan in or before 2027	P	F	P	P
7c Staff and resource transfusion laboratories adequately	P	P	P	P
7d Ensure healthcare professionals receive adequate training about transfusion, define standards and accountability for this training	P	P	P	P
7e Ensure all NHS organisations can implement recommendations from Serious Hazard of Transfusion (SHOT) reports	P	P	P	P
7f (i-ii) Establish a framework to record outcomes for patients who receive blood or blood products and provide bespoke funding for this if necessary	P	F	P	P
7f (iii) Prioritise funding for enhanced electronic clinical systems for blood transfusion	P	P	P	P
8a Patients who received a blood transfusion before 1996 should be offered a test for hepatitis C	F	F	F	P
8b New patients registering with a GP practice should be asked if they have received a blood transfusion before 1996	F	F	F	P
9a-c Peer review of haemophilia care should continue at least once every five years and consideration given to its findings	P	F	P	P

9d Administrative and clinical resources should be provided for multi-disciplinary regional networks to discuss the care of people with haemophilia and other inherited bleeding disorders	P	F	P	P
9e Recombinant coagulation factor products should be offered in place of plasma-based products if appropriate (and should be funded)	P	F	P	P
9f The National Haemophilia Database should receive additional central funding	P	F	P	P
10a (i) Clinical audit should routinely include measures of patient satisfaction/concern	P	P	F	P
10a (ii-iii) The UK Haemophilia Society, Hepatitis C trust, Haemophilia Scotland, Scottish Infected Blood Forum, Haemophilia Wales, Haemophilia Northern Ireland and the Thalassaemia Society should receive funding for patient advocacy, and other organisations that were core participants in the inquiry should be supported for at least 18 months	P	P	P	P
10a (iv) Alongside the UK Thalassaemia Society and Sickle Cell Society, consider the needs of patients with these conditions	P	P	P	P
10a (v) Give greater prominence to the Yellow Card system	F	F	F	F
11a-d Ministers should retain the power to call a public inquiry, but if they do not and there is sufficient support in Parliament, a matter should be referred to the Public Administration and Constitutional Affairs Committee, and the committee may recommend an inquiry. If a minister disagrees, they should publish detailed reasons for this.	P			
12a-b The government should consider and respond to the inquiry's recommendations within 12 months,	F			

report to Parliament on progress made during that time, and this timetable should not interfere with its response to the inquiry's second interim report				
12d-e The Public Administration and Constitutional Affairs Committee should review progress in responding to the inquiry's recommendations, and play a similar role in future statutory inquiries	P			
Source: Adapted from Government response to the Infected Blood Inquiry , 14 May 2025. F = accepts in full; P = accepts in principle.				

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